Bundle Quality, Safety & Experience Committee 2 November 2021

9.30am via Teams
Public Agenda v3.0

1 OPENING BUSINESS

1.1 09:30 - QS21/160 Patient Story : Gill Harris

Recommendation:
The Committee is asked to receive and reflect upon the patient story.

An audio version will be played in the meeting

QS21.160 Patient Story_approved.docx

1.2 09:50 - QS21/161 Apologies for Absence

Dave Harries
Louise Brereton

1.3 09:51 - QS21/162 Declarations of Interest

1.4 09:52 - QS21/163 Minutes of Previous Meeting Held in Public on 7.9.21 for Accuracy

QS21.163 Minutes QSE 7.9.21 Public V0.2 no tracking.docx

1.5 09:54 - QS21/164 Matters Arising and Table of Actions

QS21.164 Summary Action Log QSE Public_updated 28.10.21.docx

1.6 10:04 - QS21/165 Report of the Chair - Lucy Reid

Verbal

1.7 10:09 - QS21/166 Report of the Lead Executive - Gill Harris

Verbal

2 STRATEGIC ITEMS FOR DECISION - THE FUTURE

2.a DEVELOPING NEW STRATEGIES OR PLANS

2.a.1 10:14 - QS21/167 Quality Strategy Interim Priorities - Gill Harris

Recommendation:
The Committee is asked to note this report and approve the interim quality priorities

QS21.167 Quality Strategy Interim Priorities_approved.docx

2.a.2 10:24 - QS21/168 Implementation of New Liberty Protection Safeguards - Gill Harris

Recommendation:
The Committee is asked to:
1. Accept the position report in preparation for the implementation of Liberty Protection Safeguards (LPS) on the 1st April 2022.
2. Note the progress made and actions to be taken in relation to the implementation of the Liberty Protection Safeguarding (LPS) within BCUHB.

QS21.168 Liberty Protection Safeguards_approved.docx

2.b MONITORING EXISTING STRATEGIES OR PLANS

2.b.1 10:34 - QS21/169 Nurse Staffing Levels (Wales): Adult Acute Medical And Surgical Inpatient wards and Paediatrics - Gill Harris

Alison Griffiths to attend

Recommendations:
The Committee is asked to receive this report to gain assurance in relation to the following:
1. Betsi Cadwaladr University Health Board (BCUHB) is meeting its statutory 'duty to calculate' the nurse staffing level in all wards that fall under the inclusion criteria of Section 25B of the Nurse Staffing Levels (Wales) Act 2016.
2. BCUHB is meeting its statutory duty to provide an annual presentation to the Board detailing calculated nurse staffing levels

The Committee is also asked to note that:
3. As of 1 October 2021 the extension of section 25B of the Nurse Staffing Levels (Wales) Act 2016 has been extended to include paediatric inpatient wards. The Annual Presentation and Summary of Nurse Staffing Levels for wards where Section 25B applies will therefore include Adult acute medical inpatient wards; Adult acute surgical inpatient wards; and Paediatric inpatient wards.
4. Ongoing reasonable steps taken to monitor and as far as possible maintain nurse staffing levels in line with the Act and during times of unprecedented pandemic pressures.
5. Potential financial implications arising from the organisations statutory duty to calculate and take all reasonable steps to maintain nurse staffing levels will be considered by the Executive Team as part of the financial planning process for 2022/23.

QS21.169a Nurse Staffing Levels_approved.docx

QS21.169b Nurse Staffing Appendix 1 - Annual Presentation of Nurse Staffing Levels.docx

QS21.169c Nurse Staffing Appendix 2 - Summary of Nurse Staffing levels for 25B wards.docx

2.c 10:44 - POLICY MATTERS

2.c.1 10:49 - QS21/170 NU06 Prevention & Management of Adult In Patient Falls Policy - Gill Harris

Recommendation:
The Committe are asked to review the policy and ratify (for launch pan BCUHB November 2021).

QS21.170a Falls Policy report_approved.docx

QS21.170b Falls Policy NU06 V3.1 Appendix 1.pdf

QS21.170c Falls Policy NU06 Appendix 2 EQIA.pdf

3 QUALITY SAFETY AND PERFORMANCE - THE PRESENT

3.1 10:54 - QS21/171 Board Assurance Framework - Simon Evans-Evans

Recommendation:
That the Quality, Safety and Experience (QSE) Committee:
1. Approve the transfer of the monitoring of BAF21-07 – Mental Health Leadership Model; and BAF21-11: Culture-Staff Engagement from the QSE Committee to the Partnerships, People and Population Health (PPPH) Committee;
2. Approve the increase in the current risk score for BAF21-19: Impact of Covid-19 to 16 (4x4), from 12 (4x3) in light of ongoing high levels of community transmission;
3. Approve the increase in the current risk score for BAF21-01 Safe and Effective Management of Unscheduled Care to 20 (5x4) from 16 (4x4) in light of ongoing pressures; and
4. Note that further work to review and update the Key Field Guidance is continuing, including consultation with the Good Governance Institute for their advice and opinion.

QS21.171a BAF cover report v1.0_approved.docx

QS21.171b BAF Appendix 1.pdf

QS21.171c BAF Appendix 2.docx

3.2 11:04 - QS21/172 Corporate Risk Register - Simon Evans-Evans

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

QS21.172a CRR Cover Sheet V2.0_approved.docx

QS21.172b CRR Appendix 1.pdf

QS21.172c CRR Appendix 2.pdf

3.2.1 11:14 - COMFORT BREAK

3.3 11:24 - QS21/173 Quality & Performance Report - Sue Hill

Sue Hill to attend

Recommendation:
Members of the Quality, Safety and Experience Committee are requested to scrutinise the report and advise any areas to be escalated for consideration by the Board.

QS21.173a Quality and Performance Report_approved.docx

QS21.173b Quality and Performance Report QSE Appendix 1 November 2021 (September Position)_FINAL.pdf

3.4 11:39 - QS21/174 Quality Highlight Report - Gill Harris

Recommendation:
The Committee is asked to note this report.

QS21.174 Quality Highlight Report v2 updated 1.11.21.docx

3.5 11:54 - QS21/175 Covid19 Update - Gill Harris

Recommendation:
The Committee is requested to note the position outlined in this report and provide comments on progress of the programmes and issues raised.

QS21.175 Covid 19 update v4_approved.docx

3.6 12:09 - QS21/176 Quality Awards, Achievements & Recognition - Gill Harris

Recommendation:
The Committee is asked to note this report.

QS21.176 Quality Awards and Achievements_approved.docx

3.7 12:14 - QS21/177 Vascular Steering Group Update : Nick Lyons

Recommendation:
The Committee is asked to note the update from the Vascular Steering Group and approve the attached Terms of Reference

QS21.177a Vascular_approved.docx

QS21.177b Vascular Appendix 1 Draft Action Plan at 24.10.21.pdf

QS21.177c Vascular Network TF Steering Group ToRs Appendix 2.docx

3.8 12:29 - QS21/178 Operational Report : Children's Services - Chris Stockport

Liz Fletcher (Assistant Area Director - Children) to attend

QS21.178 Children's Services Update v3_approved.pptx

3.9 12:44 - QS21/179 Immunisation Programme Delivery in BCUHB to September 2021 - Teresa Owen

Recommendation:
The Quality, Safety and Experience Committee is asked to scrutinise the report and advise if any areas are to be escalated to the Board.

QS21.179a Immunisation Report_approved.docx

QS21.179b Immunisation Appendix 1 BCUHB Strategic Immunisation Plan 2019 -22.pdf

4 LEARNING FROM THE PAST

Independent Assurance Reviews inc HIW, AW, PSOW
Internal Assurance Reviews

4.1 12:54 - QS21/180 Quality Governance Self Assessment Action Plan - Gill Harris

Recommendation:
The Committee is asked to note the report and update of the Quality Governance Self-Assessment Action Plan.

QS21.180 Quality Governance Self-assessment Update_approved.docx

4.2 12:59 - QS21/181 Quality Assurance Review – Morfa Ward, Llandudno General Hospital - Gill Harris

Recommendation:
The Quality, Safety and Experience Committee is asked to receive this report for assurance

Tracey Williamson & Amy Kerti (Consultant Nurses - Dementia) and Reena Cartmell (Associate Director of Nursing) to attend together with patient / service user Mr John Stewart and his wife Mrs Anne Stewart

QS21.181 LLGH Independent Review Report_approved.docx

4.2.1 13:19 - LUNCH BREAK

4.3 13:39 - QS21/182 Welsh Ambulance Services NHS Trust - Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover - Gill Harris

Recommendation:
The Committee is asked to note the attached HIW report and the Health Board's action plan response

QS21.182a HIW Review WAST Handover Delay Paper_approved.docx

QS21.182b HIW Review WAST Handover Delay Appendix 1.pdf

QS21.182c HIW Review WAST Handover Delay Action Plan appendix 2.docx

4.4 13:49 - QS21/183 Public Service Ombudsman for Wales - Public Interest Report (Urology Services) - Gill Harris

Recommendation:
The Committee is asked to note the Public Service Ombudsman for Wales' Public Interest Report for information which was published on 09 September 2021.

QS21.183a Urology Ombudsman Public Interest Paper_approved.docx

QS21.183b Urology Ombudsman Public Interest Report Appendix 1.pdf

QS21.183c Urology Ombudsman Public Interest Report Appendix 2 Action Plan.docx.doc

QS21.183d Urology Appendix 3 Draft ToR v0.4.docx

4.5 QS21/184 Royal College of Physicians President's Visit to Wrexham Maelor Hospital - Nick Lyons

Verbal

5 13:59 - ANNUAL REPORTS FOR INFORMATION

5.1 QS21/185 Radiation Protection Annual Report 2020-21- Adrian Thomas

Recommendation:
The QSE Committee is asked to approve the Annual Report of the Radiation Protection Committee (2020/21)

QS21.185 Radiation Protection annual report_approved.docx

5.2 QS21/186 Annual Organ Donation Report - Adrian Thomas

Recommendation:
The Committee is asked to note for information the report contents and future aims and objectives of the Organ Donation Committee.

QS21.186a Organ Donation Annual Report v0.2_approved.docx

QS21.186b Organ Donation Annual Report appendix 1.pdf

QS21.186c Organ Donation Annual Report appendix 2.pdf

QS21.186d Organ Donation Appendix 3.pdf

5.3 QS21/187 Public Services Ombudsman for Wales Annual Letter 2020/21- Gill Harris

Recommendation:
The Committee is asked to receive and note the report and appended PSOW Annual Letter

QS21.187a PSOW Annual Letter paper_approved.docx

QS21.187b PSOW Annual Letter Appendix 1.pdf

5.4 QS21/188 Annual Clinical Audit Report 2020-21- Nick Lyons

Recommendation:
The Committee is asked to consider and approve the annual report.

QS21.188a Clinical audit report_approved.odt

QS21.188b Clinical Audit Annual Report 2020-2021 updated Appendix 1.odt

6 14:09 - CHAIR'S ASSURANCE REPORTS FOR INFORMATION

6.1 QS21/189 Patient Safety Quality Group (September) - Gill Harris

QS21.189 PSQ Chair September Report_approved.doc

6.2 QS21/190 Patient Safety Quality Group (October) - Adrian Thomas

QS21.190 PSQ Chair Report October v1.0_approved.doc

6.3 QS21/191 Clinical Effectiveness Group - Nick Lyons

QS21.191 CEG Chair report_approved.docx

6.4 QS21/192 Strategic Occupational Health and Safety Group - Sue Green

To follow

QS21.192 SOHSG Chair's Report Workshop 16.09.21_approved.docx

6.5 QS21/193 Patient and Carer Experience Group - Gill Harris

QS21.193 PCE Chair Report_approved.doc

7 CLOSING BUSINESS

7.1 14:14 - QS21/194 Issues Discussed in Previous Private Session

Recommendation:
The Comittee is asked to note the report

QS21.194 Issues discussed in previous private session.docx

7.2 14:16 - QS21/195 Documents Circulated to Members

6.9.21 Follow on action regarding neurodevelopment assessments
6.9.21 Follow on action regarding HMP Berwyn Covid outbreak
22.9.21 Briefing note on CAMHS

7.3 14:18 - QS21/196 Agree Items for Chair's Assurance Report to Board

To include any items to be referred to another Committee

7.4 14:20 - QS21/197 Review of risks highlighted in the meeting for referral to Risk Management Group

7.5 14:22 - QS21/198 Review of Meeting Effectiveness

7.6 14:24 - QS21/199 Date of Next Meeting

11.1.22

7.7 14:25 - QS21/200 Exclusion of Press and Public

Resolution to Exclude the Press and Public - "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 2nd November 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Patient Story : Elizabeth's Vascular Story
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris (Executive Director Nursing and Midwifery/Deputy CEO)
Awdur yr Adroddiad **Report Author:**	Eleri Anderson (Deputy Lead, Patient and Carer Experience) Carolyn Owen (Acting Assistant Director, Patient Safety & Experience)
Craffu blaenorol: **Prior Scrutiny:**	Matthew Joyes (Acting Associate Director, Quality Assurance) Gill Harris (Executive Director, Nursing and Midwifery/Deputy CEO)
Atodiadau **Appendices:**	1. Patient Story Transcript

Argymhelliad / Recommendation:

The Committee is asked to receive and reflect upon the patient story.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Appendix 1

Betsi Cadwaladr University Health Board
Patient Stories Transcript Form

Who took the story?	Facilitators name: Eleri Anderson Facilitators role / department: Patient and Carer Experience Date taken: 11 October 2021 Venue taken: Patient's home, Anglesey	
What is the title of the story?	Elizabeth's Vascular Story	
What area does the story relate to? E.g. Cancer Services	Vascular	
What is the format of the story?	Written ✓ Audio ✓ Video Other:	**Please note, Committee members can access the audio file on the Health Board network by clicking here.**
Overview of the story	The Patient and Carer Experience Team were given the contact details of Elizabeth following her extensive vascular surgical procedure that was undertaken at Ysbyty Glan Clwyd in August 2021. This story is a personal account of her experience in her own words, and describes how her stay in hospital was made as comfortable as possible during the third COVID-19 outbreak. Although Elizabeth has nothing but praise for the staff, it captures an honest account of how the staff delivered holistic and personalised care under difficult circumstances, which ensured that Elizabeth was constantly kept updated, how information and communication pathways were maintained, and how a positive outcome was delivered at the end of the process. <u>Elizabeth's story</u> Elizabeth first saw her consultant, Mr Jeremy Jones, in October 2019, with a possible diagnosis of Cerratic Rheumatism in her right and left leg. This was becoming extremely painful for Elizabeth, making it extremely difficult for her to mobilize any distance, and limiting her wellbeing, mobility and day to day living. She already was suffering from Osteoarthritis in her neck, and initially the consultant, Mr Jones, thought that both her legs were going the same way. It was during this consultation that Mr Jones, whilst examining her feet, discovered that there was no pulse present in her left foot. This suggested further exploration was needed by the vascular team, which by now	

	considered being an urgent case. This also explained the severity of her pain, the loss of ability to walk, and her calf seizing up when mobilizing, and her feet constantly being numb. Following this, unfortunately lockdown occurred, there were no appointments sent out, and although Elizabeth was an urgent case, they did not consider at this stage of her care for it to be in the serious category and life threatening. When lockdown restrictions were partially lifted, and when appointments were eventually sent out, Elizabeth saw Mr Shake who conducted Doppler examinations of both feet. Following this, the actual depth of the damage was made apparent, in particular the right leg that was much more affected than the left. Elizabeth was put on the list for a femoral bypass surgery, and although she was not seen immediately, she was aware that her case was being discussed as being a priority. Elizabeth understood that it was not an emergency, as she knew that she was not in any imminent danger, and that the situation was being reviewed regularly. On Monday the 23 of August 2021, Elizabeth got a call from the hospital to go for a COVID-19 test that day. She was then to go to Ysbyty Gwynedd on the 25th of August for a scan of her heart, and then to present herself at Ysbyty Glan Clwyd on the 26th of August at 7am for her actual surgery to take place, which she did. Elizabeth signed the consent form and then had the surgery on the 27th of August 2021. Elizabeth was advised that the expected surgery time for her procedure would been 3-5 hours long, but it actually took 9 and half hours to undertake. Elizabeth woke up the next day and saw Mr Shake, who said that the damage was indeed a lot more extensive than at first thought. Elizabeth had a Popiteal bypass and two lots of stents inserted due to the veins in her leg being very blocked. If they would not have had done this surgery then Elizabeth would have lost her leg. Elizabeth felt the recovery was long and drawn out, all the days merged into one. Although the time on the ward was difficult and long, Elizabeth felt all the staff made it much more bearable, they were so kind and thoughtful, always referring to her by her first name and attended to all of her needs. If anything that Elizabeth wanted was not available, they would try their upmost to help her. Elizabeth felt that the staff looked after her so well and during this time when visitors were not permitted. *‘It was like they were your family, and made me feel special’.*

	"They would be there for you at all times, they washed you, brushed your hair and took care of you, and it was as if they were there, always on hand." Elizabeth was in hospital for 4 weeks, and during this time made to feel so comfortable, with the standard of care excellent, which made such a difference. They took care of her mental health and wellbeing, and as she was in hospital for so long, this made such a difference. They were hard working staff who Elizabeth said cannot be praised enough. *"When you were feeling low, they were there just to hold your hand and just stroke your hair, and just said that everything was ok."* As the days went on, Elizabeth unfortunately acquired an infection in her groin wound; it needed intravenous antibiotics and regular pain relief, but the staff always ensured that these were regularly given without her being in too much pain. It came to the stage that the infection was so bad that Mr Shake decided to debride the wound on the ward to remove the tissue that was infected and necrosed. This was a very unpleasant experience for Elizabeth. Mr Shake advised Elizabeth that there was no room on his surgical lists to do this procedure; he decided to undertake it on the ward. Elizabeth understood why this had to be done, as Mr Shake informed her that to remove this tissue here, and at this time it was necessary to aid her recovery. Elizabeth was given pain relief and the use of Entonox 'Gas and Air' to relieve the pain, and throughout the procedure, a student nurse called Jack held her hand and said it would be ok, *"bless him, he was only young but he was so caring."* This procedure, although not a nice experience, helped to take 12 months off her recovery, and Elizabeth was discharged home soon after, without a wound drain, which was amazing. The physiotherapists were also a vial part of the team that helped Elizabeth's recovery. The made her exercise every day, even on those days which she felt unable to move, they encouraged her to do just a little movement as it would eventually benefit her recovery. There was one occasion that her family brought some property for her at the door and she was allowed to see them through the glass. This helped her mental health no end, just be able to speak with them and to say that she was ok. The surgeons also came to her every day, they asked everyone if they were ok, and it was so good to see them. They went above and beyond to help, they were sometimes on the ward for hours on end.

	The student nurses were also excellent; *"their enthusiasm really got to you and made you feel positive."* Elizabeth saw a few students qualifying whilst they were on this ward, and seeing them wearing their blue uniforms for the first time was lovely. *"Everyone got treated the same, all the staff were amazing."* Elizabeth said: *'I shall be eternally grateful of the care that I was given, and the chance I have had on saving my leg. I am now home, and I have two legs! I am so thankful. Even the care by the Community Team has been good, everybody really busy, but nothing too much trouble. A good and humbling experience'.*
Key themes emerging and lessons learned	• Positive communication between service and patient/carer. • Positive communication between services, ensuring coordinated and integrated care is delivered throughout the patient's journey. • Positive staff attitude, approach, caring, and empathy delivered by all members of staff and every grade. • Treating staff sensitively and empathically. • Joined up care/support. • Positive after care following discharge from hospital.
Summary of where story shared:	• With the vascular service and hospital and community teams • QSE Committee – 2nd November 2021 • Board – 18th November 2021

Quality, Safety and Experience (QSE) Committee
DRAFT Minutes of the Meeting Held in public on 7.9.21 via Teams

Present:

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

In Attendance:

Jackie Allen	Chair of Community Health Council (CHC)
Mark Butler	Good Governance Institute (*observing)*
Jane Christmas	Interim Head of Clinical Effectiveness (*observing)*
Kate Dunn	Head of Corporate Affairs (*for minutes*)
Gareth Evans	Chair of Healthcare Professional Forum (*part meeting)*
Simon Evans-Evans	Interim Director of Governance
Sue Green	Executive Director of Workforce and Organisational Development (OD) (*part meeting)*
Dave Harries	Internal Audit
Gill Harris	Executive Director of Nursing and Midwifery / Deputy Chief Executive (*part meeting)*
Debra Hickman	Secondary Care Nurse Director (*part meeting)*
Matthew Joyes	Acting Associate Director of Quality Assurance (*part meeting)*
Nick Lyons	Executive Medical Director (*part meeting)*
Melanie Maxwell	Senior Associate Medical Director/Improvement Cymru Clinical Lead
Teresa Owen	Executive Director of Public Health (*part meeting*)
Justine Parry	Assistant Director Information Governance and Risk (*part meeting)*
Mike Smith	Interim Director of Nursing for Mental Health and Learning Disabilities (MHLD) (*part meeting)*
Chris Stockport	Executive Director Primary and Community Services (*part meeting)*
Adrian Thomas	Executive Director Therapies & Health Sciences (*part meeting)*
Kamala Williams	Acting Head of Performance (*part meeting)*

Agenda Item Discussed	Action By
QS21/121 Chair's Report **QS21/121.1** The Chair welcomed everyone to the meeting. She acknowledged that ongoing operational pressures had led to challenges in terms of the timeliness of publication of some of the papers. She requested that Executives take ownership of their respective areas to ensure that the ask was clear for authors and teams in future agendas. She also noted that this was the first meeting of the Committee under the new Integrated Governance Framework and that there would be a transitional period moving from the former to new cycle of business to achieve a more risk focused	

agenda. She would welcome the input from the Good Governance Institute to help achieve this. Finally it was noted that some of the Executives would need to leave and rejoin the meeting to respond to urgent operational pressures.	
QS21/122 Amanda's Story - A Long Covid Patient Story **QS21/122.1** The Executive Director of Therapies and Health Sciences confirmed that the patient story had been received at the Patient Care Experience Group and the Patient Safety and Quality Group. He added that the key themes for learning were set out in the paper and highlighted the importance of linking in with national research to build up meaningful data on Long Covid. He informed members that BCUHB had established a Long Covid Group with 4 workstreams and that a pathway was being developed. The full audio version of the story was played for the Committee's benefit. **QS21/122.2** The Executive Director of Public Health noted the need to plan ahead to move this work forward and she highlighted the associated inequalities which must be monitored. The Executive Medical Director suggested there were some parallels to draw against the lack of understanding around ME some years ago, which further highlighted the importance of educating healthcare professionals. **QS21/122.3** An Independent Member felt that the story also highlighted the need to support staff through the implications of Long Covid. She enquired regarding the involvement of primary care and it was confirmed that there was national work to ensure that primary care were being kept informed of the developing evidence regarding presenting symptoms and referral pathways. A standard evaluation tool would be used across Wales. The Chair suggested that ongoing communications would be needed to ensure that GPs were fully aware of the Long Covid pathway and how they could refer a patient onto support services. **QS21/122.4** The Chair of the Healthcare Professional Forum noted there remained a lot to be learnt about Long Covid which would help the organisation plan its services appropriately. In terms of inequalities he felt this reinforced the need to work with partners in terms of the broader impact. **QS21/122.5** An Independent Member suggested that other sufferers of Long Covid may have less supportive employers. She also asked whether learning opportunities would be sought on a UK, national or international basis and this was confirmed. **QS21/122.6 It was resolved that** the Committee receive and reflect upon the patient story.	
QS21/129 Lead Executive's Report *[Agenda item taken out of order]*	

QS21/129.1 The Executive Director of Nursing and Midwifery acknowledged that across the organisation staff were very tired, and managers were supporting them as best as they were able, including encouraging them to take annual leave. She reflected there was a nervousness about the coming winter months and the associated challenges coupled with ongoing Covid and unscheduled care pressures, and that an increase in harms was evident. Thanks were extended to all frontline staff who continued to go the extra mile including supporting the vaccination and Test Trace Protect programmes. **QS21/129.2** In terms of current shortfalls in domiciliary and care home staff there was a concern at the potential impact on the quality of care. There was a workshop arranged with Local Authority partners to discuss potential actions to address this risk, and Executive colleagues had also had a conversation about stepping back up preparedness to mitigate against wider operational risks. **QS21/129.3** Finally it was reported that the 'We Will' statements had been shared with senior nursing teams who would now be looking to develop their own.	
QS21/123 Apologies for Absence Louise Brereton.	
QS21/124 Minutes of Previous Meeting Held on 6th July 2021 in Public for Accuracy QS21/124.1 The minutes were approved as an accurate record.	
QS21/125 Matters Arising and Summary Action Log **QS21/125.1** Updates were provided to the summary action log. There were no additional matters arising.	
QS21/126 Matters Referred to or from other Committees **QS21/126.1** Nothing to report.	
QS21/127 High Level Outputs from QSE Workshop Held 24.8.21 **QS21/127.1** The Chair wished to record her thanks to everybody's input into the workshop. She confirmed that the Independent Members had supported the "We Will" statements and the workshop covered a range of issues including what quality and safety meant to members, areas for improvement in terms of reporting and analytics, adult mental health services and CAMHS (Child Adolescent Mental Health Services). The Chair indicated she would work with the Executive Director of Nursing and	

Midwifery to take up the key discussion points and develop a proposal as to how they could be taken forward.	LR GH
QS21/128 Declarations of Interest **QS21/128.1** Jackie Hughes declared an interest in agenda item QS21/134 (Radiation Policy) in respect of her substantive post with the Health Board being within radiology.	
QS21/130 Board Assurance Framework (BAF) [*Justine Parry joined the meeting]* **QS21/130.1** The Interim Director of Governance presented the paper on behalf of the Board Secretary. He noted that the BAF risks remained fairly operational but would become more strategic as the refresh of the Living Healthier Staying Well (LHSW) Strategy progressed and that the Good Governance Institute (GGI) would be supporting the Board in the development of the next phase of the BAF. He also noted that the BAF risks required mapping across to the revised Committee structure but this would not entail major changes. **QS21/130.2** An Independent Member queried the appropriateness of reducing the risk score relating to infection prevention and control given the current outbreaks and ongoing concerns around removing of restrictions. She also suggested that the psychological impact of staff returning to work post-isolation should be built into a relevant risk either on the BAF or Corporate Risk Register (CRR). **QS21/130.3** An Independent Member felt that the actions against BAF21-04 (planned care) were unlikely to address the risk by March 2022 as was indicated. The Chair agreed that actions did need to be meaningfully targeted on mitigating the described risk. It was felt this risk should be taken back to the Risk Management Group (RMG) for a deep dive comparison alongside the very different approach taken with the Security risk. **QS21/130.4** The Chair reflected that the Committee had previously raised the need to consider the consistency of scoring across risks both for the BAF and the Corporate Risk Register - in particular regarding the impact to the service, should the risk be realised. She suggested that this be raised with the Audit Committee through her Chair's report to enable all Corporate Risks and Board Assurance Framework risks to be considered as a whole. She would also highlight to the Board the need for it to clearly demonstrate learning using an evidence based assurance approach aligned to risk and to recommend that the Board consider quality and safety deep dive discussions in future workshops. **QS21/130.5** The Chair recognised that there would not always be an update against each risk but there were examples where out of date information was still included (eg; BAF21-06). The Interim Director of Governance confirmed that all risk leads had been asked to provide updates as per the agreed process. The RMG would undertake	SG LB/SEE LR

prioritised deep dives as part of a rolling check and challenge programme and would make any recommendations for amendment up to the Executive Team. **QS21/130.6 It was resolved that** the Committee: (1) review and note the current position on the principal risks assigned to the Committee, as set out in the BAF risk sheets at Appendix 1 (2) note the plan for a wholescale review of the BAF to review the principal risks in line with the Living Healthier, Staying Well strategy, including a re-evaluation of risk appetites in light of the new Risk Management Strategy and Policy, a particular focus on any target score higher than the refreshed risk appetite, and a re-allocation of risks to committees in response to the governance review and resulting changes to the committee structure. (3) note for information the full list of BAF risks assigned to Committees, as requested at the last QSE meeting.	
QS21/131 Corporate Risk Register **QS21/131.1** The Interim Director of Governance presented the paper which set out a range of changes in scores and some additional risks for inclusion as highlighted within the detailed recommendations section of the paper. In terms of format it was requested that future reports include the risk title against the CRR reference number on the narrative front report template. **QS21/131.2** The Chair referred to CRR20/01 (asbestos) and felt that the reduction in likelihood from a 4 to 2 seemed to be significant and that gaps in controls did not support this reduction in the likelihood risk score. The Interim Director of Governance responded that a range of housekeeping processes were now in place so it was far less likely that contractors would come across asbestos on the BCU estate. It was accepted there remained some gaps in controls although it was encouraging to note a recent internal audit report was positive. The Executive Director of Workforce & OD suggested that the likelihood be put to a 3 until further evidence was available via reviews. The Committee supported this. **QS21/131.3** The Chair raised a general concern around whether the correct balance was being achieved in terms of scoring risks. It was accepted that consistency of scoring remained an issue, but the point was made that non-compliance with legislation would score very highly. The Executive Director of Workforce & OD added that to some extent dynamic risk management was normalised as clinicians assessed risk professionally and culturally on a daily basis. **QS21/131.4 It was resolved that** the Committee review the detailed recommendations as set out within the paper	SEE SEE
QS21/132 Quality Awards, Achievements & Recognition **QS21/132.1 It was resolved that** the Committee note the report.	

QS21/133 Committee Terms of Reference

QS21/133.1 It was resolved that the Committee note the Terms of Reference and recommend their approval to the Board through the Committee Chair's Report

QS21/134 Ionising Radiation Policy (RP01)

QS21/134.1 It was resolved that the Committee approve the minor amendments to the RP01- Ionising Radiation Protection Policy in order to comply with the requirements of regulations related to the safe use of ionising radiation principally Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation(Medical Exposure)Regulations 2017 {IR(ME)R17}

QS21/135 Quality & Performance Report (QaPR)

[Kamala Williams joined the meeting]

QS21/135.1 The Acting Director of Performance presented the report and highlighted a range of key points including:

- The QaPR did not include a section on Covid as this was subject to a separate agenda item.
- Performance was slightly below target for smoking cessation.
- The cumulative rate of laboratory confirmed bacteraemia cases had increased at an all Wales level in contrast to the position in BCUHB where improvements in EColi, S.aureus bacteraemia and C Difficile rates could be seen.
- Performance against the 26 week target for children awaiting neurodevelopment assessment remained poor at 32.79% although there had been an improvement on the 26.84% reported previously. The all Wales position was 34.6% and one Board did achieve the measure. The planned validation exercise on the waiting list had been delayed. There was non-recurrent funding identified to address the performance but the underlying issue would need to be addressed in terms of sustainability.
- A deteriorating position was demonstrated in terms of referrals into Child Adolescent & Mental Health Services (CAMHS) at 26.8% against 80% target. Rates for children starting therapy had again declined.
- Performance accountability meetings continued to be held supported by oversight meetings on particular areas of concern.
- The 28 day assessment target for adult mental health services was on a downward trajectory in terms of length of wait.

QS21/135.2 In terms of CAMHS therapy performance the Chair stated that BCU needed to learn from those Health Boards who were delivering the target. The Executive Director of Primary Care and Community Services confirmed that conversations were ongoing with Aneurin Bevan but there were key structural differences in terms of referrals and BCU was more challenged in that its integrated

approach with Local Authority education had meant that assessments had been adversely affected by school closures. He undertook to cover this area off in a CAMHS update outside of the meeting. **QS21/135.3** The Chair made a comment around the robustness of some performance information when headline narrative and rhetoric was compared to the actual break down of data. The Acting Director of Performance noted that weekly reports were scrutinized at Executive Team level and teams were encouraged to challenge the data. She also accepted that the profiling of never events data over 6 months wasn't ideal. **QS21/135.4** An Independent Member sought assurance that sepsis bundle compliance was still being addressed given all the other ongoing pressures facing the organisation. The Senior Associate Medical Director/Improvement Cymru Clinical Lead felt that the Committee could be reassured that sepsis mortality rates were stable. She added there were continued capacity issues within the team but there would be a heightened focus over the coming months. She suggested that some additional audit work may be required in order to obtain an accurate baseline. **QS21/135.5** The Healthcare Professionals Forum Chair referred to the fractured neck of femur measure and suggested that local data such as the role of geriatricians was also crucial information alongside the national delivery measures. The Acting Director of Performance added that revised national delivery measures had been published in draft and would provide an opportunity to review what was reported **QS21/135.6** The Chair welcomed the significant improvement in psychological therapy waits for adults. **QS21/135.7 It was resolved** that the Committee scrutinise the report and advise any areas to be escalated for consideration by the Board.	CS
QS21/136 Vascular Steering Group Update **QS21/136.1** The Executive Medical Director presented the paper. He highlighted that the case note review was still outstanding and he was anticipating further actions from the report. He confirmed that the improvement action plan had not been shared with the Committee at this stage as he was not content with the robustness as yet. He advised that he could not provide assurance to the Committee at this point in time due to the need to review the action plan and mitigations in place. It was noted that the Executive Medical Director would personally chair the newly established Vascular Oversight Group. **QS21/136.2** An Independent Member was disappointed to see that the Vascular Network Manager was an interim appointment. It was explained that a substantive appointment had been made but the individual had moved onto another role and the most recent interim appointment was to ensure progress could be made whilst substantive recruitment was again made. The Independent Member also felt that the	

paper was lacking in terms of the staff experience element although she recalled that a survey had been undertaken of all vascular service staff some months ago. The Executive Medical Director accepted the point and suggested that the survey may not have addressed all the necessary components. In terms of strengthening the patient experience elements, the CHC Chair confirmed that some 15-20 events were now arranged. **QS21/136.3** The Chair emphasised that future updates need to be evidence based and include clear timelines for completion. It was also requested that the revised terms of reference for the group be shared with the Committee. **QS21/136.4 It was resolved that** the Committee receive the update from the Vascular Steering Group and note the updated approach in responding to the first stage of the Royal College of Surgeons report on the Vascular Surgery Service	NL
QS21/137 Pharmacy & Medicines Management Key Risks **QS21/137.1** The Chair stated that she had requested this paper in order to increase the profile of medicines management at Committee level and she had agreed with the Chief Pharmacist that as a minimum the Committee be sighted on key risks. The Executive Medical Director reflected that the paper demonstrated the complexity of the medicines management agenda which covered a breadth of care provision. **QS21/137.2** The Chair felt that some learning opportunities were being missed. She referred to medication incidents and the Executive Medical Director accepted that the focus tended to be on incidents of wrong dose however there was potential for greater harm around readmissions as a result of drug reactions. The Executive Director of Nursing and Midwifery suggested that she and the Executive Medical Director work with the Acting Associate Director of Quality Assurance to see if the information could more meaningfully be incorporated into other reporting mechanisms. **QS21/137.3** The Chair also recalled the matter of pharmacy support to mental health teams being flagged several years ago and was disappointed that this had not been addressed. The Executive Medical Director would follow this concern up. **QS21/137.4** The Chair also expressed concern that electronic prescribing within primary care remained unresolved when Welsh Government had indicated back in 2015 that this would be a priority. An Independent Member shared this concern and also noted that patients regularly reported long waits for their medication when being discharged from an acute site. **QS21/137.5 It was resolved that** the Committee note the Pharmacy & Medicines Management key risks and actions being taken to mitigate them.	GH NL MJ NL

QS21/138 Covid19 Update

QS21/138.1 The Executive Director of Nursing and Midwifery delivered a presentation which covered:

- Increased community levels impacting on GP contacts and staff having to isolate following a close contact.
- Increased in-patient levels in West and Centre.
- Vaccination programme continued successfully with JCVI guidance awaited on booster programme and a decision regarding the vaccination of children.
- The organisational approach to command and control had been updated including reinstating of Cabinet.
- Impact on planned care.
- Currently over 300 medically fit for discharge patients.
- A workshop was being held that afternoon with Local Authority partners.
- Operational delivery and impact on unscheduled care performance.
- An outbreak had been declared in Ysbyty Gwynedd on 26.8.21 affecting 3 wards plus 2 in Ysbyty Eryri.
- There was long standing fatigue amongst staff.
- Pressures were rising in care homes with 38 red rated homes currently.

QS21/138.2 An Independent Member enquired about a further outbreak on the Ysbyty Glan Clwyd site and the Executive Director of Nursing and Midwifery reported that she would be updated on this later but she understood it to be a Level 2 outbreak. The Independent Member added her concern at the effect on care homes and that all bodies needed to work collaboratively.

QS21/128.3 The Executive Director of Public Health noted that with the current numbers of community cases there was a need to think about the onward effect of hospital care. There was a public health discussion around how to support communities to make the right decisions.

QS21/128.4 The Chair referred to the closure of minor injury units (MIUs) and the challenges in communicating urgent decisions. The Executive Director of Primary Care and Community Services noted that MIUs were often small and dependent on a small number of staff. Every effort was made to redirect or relocate staff from other units and Area Teams ensured that the 111 service were kept informed.

QS21/139 Board Commissioned External Review – Ysbyty Gwynedd (YG) Outbreak 2021

[Debra Hickman joined the meeting]

QS21/139.1 The Executive Director of Nursing & Midwifery presented the paper which set out the independent investigation into circumstances leading to previous outbreak on the Bangor site, undertaken by Hilda Gwilliams. She drew attention to appendix iii which provided an update against the lessons learnt from the review recommendations. Members were informed that the review had not identified any significant immediate issues of concern. The Executive Director of Nursing and Midwifery confirmed that the Safe Clean Care (SCC) programme had been stepped up but there remained much to

do as unscheduled care pressures were impacting on the Board's ability to maintain infection prevention and control standards. She also reiterated that the current YG outbreak had been escalated in an extremely timely manner with the Outbreak Control Team having been stepped up within 24 hours. **QS21/139.2** The Committee were informed that dynamic risk assessments were being undertaken across all sites however the movement of patients from Emergency Departments (EDs) onto a ward and then onto a subsequent ward continued to create an inherent risk. The Executive Director of Nursing and Midwifery confirmed that the unscheduled care improvement group and the SCC group were working to maximise the mitigation of risks. Members noted that whilst Covid infections were the predominant headline, there would undoubtedly be other outbreaks such as influenza and norovirus. **QS21/139.3** An Independent Member enquired how it was planned to ensure that progress against the recommendations was sustainable. The Executive Director of Nursing and Midwifery set out the role of the SCC group in monitoring progress and providing assurances via metrics. The Secondary Care Nurse Director acknowledged there were a range of transactional actions and also some relating to behaviours. She highlighted the need to ask staff to identify the challenges facing them and how they could be supported to move forward. This work would be closely linked to the Stronger Together programme. **QS21/139.4** An Independent Member felt that the report content and style supported it being completed independently but wondered if there was an omission regarding the involvement of Trade Union partners in the review, and that whilst students and bank staff were mentioned there was no reference to agency staff nor volunteers. She also stressed the importance of sharing learning and key messages widely across all staff disciplines through a range of mechanisms. The Executive Director of Nursing and Midwifery confirmed that targeted communication was being prepared and the report had been circulated to senior nurses for reflection. **QS21/139.5** The Chair reflected that there was an emerging concern around a fatigued workforce and a level of nervousness amongst staff around future challenges in terms of both Covid and wider operational pressures. She asked that learning from a human factors perspective be taken into consideration to provide specific guidance to assist staff in developing coping mechanisms and techniques. The Executive Director of Nursing and Midwifery would take this away as an action wider than Covid related. **QS21/139.6 It was resolved that** the Committee: 1. Receive the report, subsequent findings and recommendations. 2. Receive the progress report against each of the actions and the update against the SCC improvement programme. *[Debra Hickman left the meeting]*	GH
QS21/140 Patient Carer Experience Report April to July 2021	

QS21/140.1 The Acting Associate Director of Quality Assurance presented the report and highlighted there had been an improvement since the last reporting period in terms of complaints responded to within 30 days however performance was still below with target with many people waiting too long for a response. This had been exacerbated by current pressures impacting on the ability to focus on complaints responses. In response it was noted that the new processes were embedding effectively and a targeted approach continued to be taken to identify staff who had not yet taken up the opportunities around training. It was also noted that reviews into the effect of the pandemic and Covid-19 in terms of harm caused were ongoing. In addition a new patient feedback system was being rolled out and there was a move towards the provision of digital video patient stories. **QS21/140.2** An Independent Member enquired how learning from patient experience was fed back into the service in a timely fashion. The Acting Associate Director of Quality Assurance responded that there was a daily triage process and a daily SITREP email to divisional and corporate leaders, supported by regular conversations between governance leads and Hospital Management Teams to ensure appropriate cross referencing. An Independent Member also asked how feedback from social media was captured and it was confirmed that these were fed back from the corporate communications team. The Independent Member observed that a recurring theme on social media was around dissatisfaction amongst patients and families in terms of being able to communicate with hospital wards. The Acting Associate Director of Quality Assurance responded that the Patient Advice & Liaison Service (PALS) and complaints phone lines were now one North Wales service and PALS staff always aimed to resolve issues quickly. The Executive Director of Workforce and OD referred to a previous pilot to provide additional ward clerks to free up nursing time and there were discussions ongoing regarding reinvigorating this in some way. **QS21/140.3** The Chair acknowledged the progress that had been made in terms of patient and carer experience, and provided an improved level of confidence. **QS21/140.4 It was resolved that** the Committee note the report	
QS21/141 Review of Urology services and patient experience **QS21/141.1** The Executive Director of Nursing and Midwifery presented the paper which set out the background, current mitigations, and planned further actions in tackling the complex issues confronting urology services across North Wales. She reported that the Executive Team had proceeded at risk to recruit to additional urology posts which would be advertised shortly. The Committee were asked to note the fragility of the service and that there were concerns around the strength of leadership. A cancer partnership group was being established and the governance elements were being worked through. The Executive Director of Nursing and Midwifery concluded by acknowledging that the Committee had previously raised concerns over the number of urology related never events and serious untoward incidents (SUIs), and it was noted that the publication of a related Public Sector Ombudsman Wales (PSOW) report was	

also awaited. The recommendation to commission an external urology review remained subject to further discussion with the Health Board Chair and Chief Executive. **QS21/141.2** An Independent Member enquired about risk stratification of the 9000 patients who were waiting over 36 weeks and the Executive Director of Nursing and Midwifery confirmed this was taking place and acknowledged that even with the additional planned capacity the numbers waiting may still increase. The Independent Member asked a further question around the stated risk of secondary care not being able to provide a major urology cancer services, which had been scored a 9 which she felt was low. The Executive Director of Nursing and Midwifery responded that this was based on whether the organisation was managing to maintain essential services and came back to the prioritisation of patients. **QS21/141.3** An Independent Member expressed her concern over the statement within the paper regarding a never event, and it was clarified that the request for an external review had not taken place and an internal process was followed instead. The process had subsequently been tightened with 24 hour review of SUIs now in place. The internal review of this particular event had been reviewed and provided limited assurance however it had been deemed it would be counter-productive to reopen the never event as the incident action plan was now in place. **QS21/141.4** In response to a question, the Executive Director of Nursing and Midwifery confirmed that some cancer patients were being cancelled but on a risk-assessed basis and alternative pathways of care were identified. The Executive Medical Director stated that good clinical leadership was key and he would be laying out his expectations for professional standards and behaviours following conversations with the acute site directors. He acknowledged there was the potential for more formal conversations with individuals depending on the outcome of the urology external review. The Chair confirmed support for the recommendations given the ongoing level of concern over the urology service and the lack of evidence based assurance in terms of its safety. **QS21/141.5 It was resolved that** the Committee note the paper and approve the suggested actions to address the issues identified namely: • Support the commissioning of an external clinical review of urology services from the Royal College of Surgeons. The lead time for such a review is likely to be 6 months • Approve the immediate establishment of a North Wales Improvement Plan for urology to assess standards, identify current good practice and gaps in practice, with executive leadership and QSE oversight. • Note the development of a business case to achieve a sustainable capacity position, taking into account the backlog arising during the pandemic, and the potential for Regional Treatment Centres. In the interim the Board will proceed with additional clinical appointments • Acknowledge that action plans have been developed in response to previous and current PSOW reports which will need to be refreshed.	

• Note the recruitment actions being taken • Support the progression of the Getting it Right First Time (GIRFT) work	
QS21/142 Nurse Staffing Levels (Wales) Act Triennial report **QS21/142.1** The Executive Director of Nursing and Midwifery confirmed that the report had been submitted to Welsh Government (WG) and was broadly unchanged since the last submission. **QS21/142.2** An Independent Member noted it was a very complex and detailed report and sought clarity whether the Health Board was breaching the Act and if so whether harm was being caused. The Executive Director of Nursing and Midwifery responded that the Health Board would breach the requirements of the Act and this was one reason for the re-establishment of the Cabinet. **QS21/142.3** The Independent Member asked about recruitment and the need to think more widely in terms of apprenticeships, developing the role of Healthcare Assistants (HCAs) and the use of Physicians Assistants. The Executive Director of Nursing and Midwifery confirmed that a number of avenues were being explored including working with Local Authorities around domiciliary care. She also noted there was substantial work in terms of learning events around falls and the implementation of an associated improvement plan. The Executive Director of Workforce and OD added that corporate workforce teams were working closely with nursing leads across primary care, community services and mental health. Consideration was also being given to the reinvigoration of the cadet scheme. In terms of HCAs there was a qualification issue related to NVQ requirements which was being built into workforce planning conversations. **QS21/142.4 It was resolved that** the Committee: 1. Note the updated report of the Triennial Nurse staffing report with updates from closed investigations for the 2020/21 reporting period. 2. Continue to support the ongoing recruitment and retention initiatives already in progress. 3. Note Paediatric requirements in line with the revisions to the Nurse Staffing levels (Wales) Act are subject to a separate report and business case once triangulated reviews are complete	
QS21/144 Annual Return - All Wales Standard for Accessible Communication & Information for People with Sensory Loss **QS21/144.1 It was resolved that** the Committee note the report.	
QS21/145 Investigation into Quality Concerns at Llandudno Hospital	

QS21/145.1 The Executive Director of Nursing and Midwifery provided a verbal update and indicated that it had been hoped to have a report available by the end of August, however, as some of the external support had come started later than planned the timeline had been extended to allow for full input and engagement. The Committee were informed that where concerns had been raised of a professional nature they were undergoing a parallel investigation by workforce colleagues and there had been onward referrals to professional bodies in some cases. The patient experience was also important as part of the escalation more widely across the hospital site. Discussions had also taken place already with the University in response to the students raising concerns.	
QS21/146 Mental Health – Ligature Risk Reduction and Adult Inpatient Service Development Exception Report **QS21/146.1** The Interim Director of Nursing for Mental Health and Learning Disabilities (MHLD) presented the report which highlighted the ongoing progress of the programme of work to reduce the incidence of and the risk from ligature incidents within the Division, and to improve the safety and quality of experience for patients. He highlighted the increased onus on the Division to strengthen leadership and stability over the past few years. He suggested that accidental death and suicide often became conflated and members were advised that reducing ligature harm was wider than merely removing ligature points. The work commenced in September 2020 but there have been two catastrophic inpatient ligature incidents within the Division in the last few months. The programme of work includes a holistic approach to risk reduction to include the availability of both high and low ligature/anchor points across the Health Board estate whilst addressing the therapeutic and emotional support environment. Members were advised that previously, the majority of suicides were from hanging at height and the high ligature points which had been previously addressed as a priority. However, the use of low ligature points or anchor points was now presenting a risk and there is a programme of work to address this across the Health Board estate. **QS21/146.2** An Independent Member welcomed the reference to the reassessment of environmental risks within CAMHS and was also pleased to see that a whole premises audit would be undertaken and enquired as to the timeline. She was informed that all the work described within the paper was on track within the agreed timeframes and that a senior manager had been allocated to oversee the audit whole process. The Interim Director of Nursing MHLD noted there was however some delay in the procurement of new furniture where this had been recommended as a result of audits. He also clarified that the external review report was anticipated at the end of September and that the ligature awareness training was on track. **QS21/146.3** The Executive Director of Workforce and OD reminded the Committee that there had been a previous Regulation 28 linked to ligatures outside of the MHLD Division and there was a need to ensure that this work was shared and implemented across the organisation. The Interim Director of Nursing MHLD replied that steps were being taken to implement the learning more widely and the Division was working	

closely with Health and Safety colleagues. He also confirmed that there would be a single action plan for each mental health unit following the review of the catastrophic incidents. *[Mike Smith and Adrian Thomas left the meeting]* **QS21/146.4** The Executive Director of Workforce & OD suggested it might be helpful to identify where there were other relevant external regulatory matters or ongoing investigations. The Executive Director of Public Health wished to acknowledge the significant undertaking within the MHLD Division and more widely to address these concerns and she hoped that the Committee had found the paper helpful. *[Nick Lyons left the meeting]* **QS21/146.5** The Chair raised the issue of environment and whilst the need to keep people safe was paramount she felt there was a balance to be met in terms of the very sterile environments that were often utilised. She also noted that the profiling of beds and ligature risks had previously been highlighted in the Holden report and asked whether the Board had failed to implement relevant learning from that report. The Interim Director of Nursing MHLD acknowledged there were challenges with ensuring that the estate was fit for purpose. He confirmed that there were issues within the Holden report relating to the wider estate and the use of adult facilities for children and young people, together with points around gender specific facilities. It was confirmed that the Holden report did not directly explore the management of ligature risks and there were no specific recommendations around ligature. The Executive Director of Public Health also reminded the Committee that the Health Board was in Targeted Intervention and Improvement for the area of mental health, with ligature work being one element to be addressed alongside estates, culture and workforce to ensure the best possible care is provided. **QS21/146.6 It was resolved that** the Committee to note the update from the Mental Health Division on its progress with ligature risk reduction and adult inpatient service development.	
QS21/147 Public Services Ombudsman for Wales (PSOW) Final Public Interest report **QS21/147.1** An Independent Member was keen to see learning shared from the report and for best practice to be followed in terms of appropriate discharge to a care home setting. The Acting Associate Director of Quality Assurance assured members that all the identified actions would be checked through with the relevant service and submitted to the PSOW as soon as possible after the 20th October. **QS21/147.2 It was resolved that** the Committee note the Public Service Ombudsman for Wales' Public Interest Report for information and the Health Board's action plan response for assurance.	
QS21/148 Patient Safety Quality Group	

The report of the meeting held on 13.7.21 was noted	
QS21/149 Strategic Occupational Health and Safety Group - Sue Green The report of the meeting held on 3.8.21 was noted	
QS21/150 Patient and Carer Experience Group - Gill Harris The report of the meeting held on 24.6.21 was noted	
QS21/151 Documents Circulated to Members **QS21/151.1** It was noted that the following had been circulated: • 23.6.21 Follow on action re staff redeployment • 21.7.21 Follow on action re Procedure Admission of Children to an Acute Psychiatric Inpatient Unit • 9.8.21 Briefing re Staff Vaccinations	
QS21/152 Review of Meeting Effectiveness **QS21/152.1** Members were invited to reflect on the meeting effectiveness to inform and improve future meetings. Elements of time-keeping continued to be of concern and the Chair would have a conversation with Mark Butler of the Good Governance Institute to seek his reflection on the meeting.	LR
QS21/153 Agree Items for Inclusion in Chair's Assurance Report to Board To be determined	
QS21/154 Exclusion of Press and Public Resolution to Exclude the Press and Public - "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."	
QS21/155 Date of Next Meeting 2.11.21	

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**
2nd March 2021				
S Green	**QS21/41.2** Include demographic breakdown including socio-economic and ethnicity factors into next H&S report, together with themes from the Make it Safe reviews.	21.4.21 (deadline for May papers)	26.4.21 Following agenda setting meeting, Chair had indicated she did not require stand-alone H&S report to May meeting. 4.5.21 L Reid would have wished to have seen H&S themes included within the Covid report. S Green confirmed that these elements had been provided and should have been incorporated. 22.6.21 The combined report on COVID did include H&S information. Sally Baxter has been approached for regarding the inclusion of this information in the Q1 report, as team were previously advised it was not required. 6.7.21 S Green advised that demographic vaccination data had been provided within the Covid paper and she would welcome advice on what further detail Committee members would wish to be included. 7.9.21 Based on updates previously provided the Committee members were content to close this action.	July September closed
4th May 2021				
M Joyes G Harris	**QS21/72.3** The Chair was pleased to note evidence of improved triangulation coming through in the report, however, she still felt that the reporting of never events could be strengthened in terms of closing the loop. She would wish to discuss further with the	1.6.21	11.6.21 The Chair, Executive Director of Nursing and Midwifery and the Acting Associate Director of Quality Assurance met to discuss. A specific thematic paper on Never Events is being presented at the meeting in July 2021. Additionally,	~~Closed~~

M Joyes	Executive Director of Nursing and Midwifery and the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience.		a workshop learning event is planned for August 2021. 6.7.21 L Reid asked that the action be re-opened to ensure a short update from the learning event can be provided within the action log at the next meeting. 7.9.21 M Joyes to provide closing update. 18.10.21 Following discussion between M Joyes, the Chair and the Executive Lead, the reporting format is being updated to provide clarity between the QPR data, Patient Safety Report data and a new Quality Highlight Report. The Patient Safety Report will be further amended to reflect the focus on thematic analysis and evidence of learning and improvement.	September October Closed
S Green	**QS21/76.2** In response to a question from the Chair as to whether people had returned to the organisation post redeployment, it was agreed that the Executive Director of Workforce and OD would follow up this data.	1.6.21	23.6.21 data circulated to Committee members. IMs subsequently sought further context around the issue which related to the numbers of (nursing) staff having left the organisation because of redeployments who then did or did not return and whether this was problematic. 6.7.21 S Green confirmed she was now clear on the action and was working with corporate nursing team to interrogate leavers information. The information to be circulated to members and if it was felt the matter needed more scrutiny this could be addressed within next nurse staffing report. 7.9.21 S Green confirmed that the relevant data had been reviewed and there was no trend as had been suggested. A flag has been built into leaver information that is included within regular staffing reports.	August Closed

L Brereton	**QS21/78.2** A wider point was raised around the management of clinical policies and the route for approval. The Board Secretary confirmed she was looking at the governance route for policies with the Interim Director of Governance. The Executive Director of Workforce and OD suggested it might be helpful to consider the tiered approach taken by the Remuneration and Terms of Service Committee.	July	29.6.21 Review of policy on policies due to commence shortly, informed by governance review and approach across the Health Board. Process due for completion by September 21. 31.8.21 Governance review complete and new Integrated Governance Framework approved by Board. Further work required to identify and determine approval groups for different categories of documents (policies/procedures etc.). The review of the Policy on Policies (PoP) has commenced. However, due to significant staffing issues within the Office of the Board Secretary, the expected completion date has been put back. Provisional target date for approval at Audit Committee is now December. A project support manager has been appointed to support policy work (start date pending recruitment checks).	September December
6th July 2021				
G Harris	**QS21/97.3 QPR** An Independent Member noted that 11 patient falls with harm had been reported for May 2021 which was of concern. The Executive Director of Nursing and Midwifery indicated there was a planned conversation at the Executive Management Group around the falls programme and the Chair suggested that a thematic review on falls would be helpful for the Committee at a later date.	TBA	7.9.21 Included on CoB and scheduling will be confirmed as part of agenda setting process	Closed
K Williams	**QS21/97.4 QPR** The Chair also referred to a narrative comment about GP consultation	August	31.8.21 the separate COVID reports routinely include information on GP consultations.	closed

	performance but noted that no data had been provided. The Acting Head of Performance agreed to look at this		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.	
S Green	**QS21/97.4 QPR** In response to comments around delays in recruitment due to complex workforce processes The Executive Director of Workforce and OD agreed to take an action away to work through assumptions around recruitment processes that had caused this phrase to be used.	Sept	7.9.21 S Green reported that a review of recruitment processes had been commissioned to ensure that concerns over delays or duplication can be built into the improvement work.	Closed
S Evans Evans	**QS21/99.5 CRR** Arrange for ET discussion around consistency of RAG rating terminology as it was noted that green in the CRR meant completed whereas in the annual plan it meant on track but not necessarily complete.	August	7.9.21 S Evans-Evans to progress	November
~~A Guha~~ M Joyes N Lyons	**QS21/103.5 Vascular** Work to utilise experiences shared by vascular patients around service improvement as formal patient stories for the next Committee meeting.	Sept	7.9.21 N Lyons and M Joyes to progress 18.10.21 A vascular patient story is on the agenda for QSE. Quality and patient experience will be part of the refreshed vascular improvement group.	November Closed
J Hughes	**QS21/104.2 H&S** Circulate a useful video on social distancing.	July	7.9.21 J Hughes apologised this wasn't available for circulation.	Closed
M Smith	**QS21/105.4 Mental Health** Provide a thematic analysis on psychological services to the November meeting.	November	21.7.21 Division seeking confirmation that this should be joint adult and CAMHS format.	~~November~~

			7.9.21 C Stockport clarified this would be a joint report. 22.10.21 Paper deferred to January meeting	January
7th September 2021				
L Reid G Harris	**QS21/127.1 Outputs from Workshop** Work to develop proposal for taking forward outputs and key points from workshop	November	Chair will update verbally at November meeting.	
S Green	**QS21/130.2 BAF** Consider whether the psychological impact of staff returning to work post-isolation should be built into a relevant risk either on the BAF or Corporate Risk Register	November	14.10.21 Staff who are returning to work who have been shielding have a site specific risk assessment (RA) undertaken on their return with adjustments made to ensure a Covid safe environment is in place with enhanced PPE if required. A consultant medical practitioner, the manager, HR Team and OH&S, supports the RA process. The staff wellbeing support service provides a range of emotional/psychological support services brought together to meet a range of needs for staff encompassing counselling (through the Occupational Health and Wellbeing service and RCS), clinical psychology, coaching and the support of a network of Wellbeing Champions. A pathway to support staff in crisis is also being finalised with the MHLD Division. A Strategic Lead for the Staff Wellbeing Service has been recruited – who is a Consultant Clinical Psychologist – who will manage and continue to further develop the staff wellbeing service across the Health Board, working with and leading a multi-disciplinary Wellbeing Cell to take forward this work, the latter reporting to the newly re-established Health and Wellbeing Group, which met in September 2021. Reports and risks	Closed

			identified are escalated via the WOD Risk Management Group and report to the Strategic Occupational Health and Safety Group. If significant risks are identified, they will be escalated through the governance structure.	
L Brereton S Evans-Evans	**QS21/130.3 BAF** Take BAF21-04 (planned care) back to RMG for deep dive comparison alongside different approach taken with security risk	November	25.10.21 Deep dive on planned care BAF risk planned for December RMG. Deep dive on Security and H&S BAF risks undertaken at the October RMG.	December
L Reid	**QS21/130.4 BAF** Raise consistency of scoring issue within Chair's report to Board	September	Included within Chair's report to Board on 23.9.21	Closed
S Evans-Evans	**QS21/131.1 CRR** Ensure that future reports include the risk title against the CRR reference number on the front narrative report.	November	22.9.21 Included in Template Cover Report which will be used for all future reporting	Closed
S Evans-Evans	**QS21/131.1 CRR** Amend likelihood of CRR20-01 (asbestos) to a 3 until further evidence was available to support reduction to a 2	September	22.9.21 Completed and will be presented for further discussions at the next RMG and ET meetings before further submission to QSE	Closed
C Stockport	**QS21/135.2 QaPR** Circulate further update on CAMHS performance including therapy referrals.	October	22.9.21 Briefing note circulated	Closed
N Lyons	**QS21/136.3 Vascular** Share revised terms of reference with the Committee	October	25.10.21 Provided as part of committee paper ro November meeting	Closed
G Harris N Lyons M Joyes	**QS21/137.2 Pharmacy & Medicines Management** Work to determine if learning from medication incidents could be more meaningfully incorporated into other reporting mechanism	November	19.10.21 A meeting has taken place with key executive, clinical and quality leaders and a paper is being submitted to QSE outlining the issues with a full action and improvement plan at the QSE meeting in January 2022.	January

N Lyons	**QS21/137.3 Pharmacy & Medicines Management** Follow up the issue of pharmacy support to mental health teams	November	25.10.21 Recruitment has been progressed and an update will be provided in Jan 2022	January
G Harris	**QS21/139.5 YG Outbreak review** Consider learning from human factors perspective in developing guidance for staff on coping mechanisms and techniques, on a scale wider than just Covid.	November		
L Reid	**QS21/152.1 Meeting Effectiveness** Seek GGI reflections of the meeting	October	Meeting held with Mark Butler of GGI. Comments will feed into their wider review of the Health Board's governance.	closed

28.10.21

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 2nd November 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quality Strategy – Interim Priorities
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing & Midwifery/Deputy CEO
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Acting Associate Director of Quality Assurance Gill Harris, Executive Director of Nursing & Midwifery/Deputy CEO
Atodiadau Appendices:	1. Interim Quality Priorities

Argymhelliad / Recommendation:

The Committee is asked to note this report and approve the interim quality priorities.

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

Sefyllfa / Situation:

The Health Board's previous *Quality Strategy* concluded in 2020. The COVID-19 pandemic has delayed development of the successor strategy as a result of competing priorities, staff redeployment and the limitations on wide engagement. The revised aim is to have a new strategy in place for 2022-2025. This revised timetable does allow for alignment with more recent developments, such as the refresh of *Living Healthier, Staying Well*, development of the *Clincal Strategy* and the work of *Stronger Together*. Therefore, the revised timetable will in fact lead to greater alignment of organisational priorities and alignment with new national drivers detailed below. In the immediate term, it has been agreed between the Executive Lead for Quality and the Chair of the Quality, Safety and Experience (QSE) Committee that an interim set of priorities will be developed. This paper sets out those proposed priorities for agreement.

Cefndir / Background:

A Healthier Wales sets out a long-term vision that everyone in Wales should have longer, healthier and happier lives. It proposes a whole-system approach to health and social care which is equitable, and where services are designed around individuals and groups based on their unique needs and

what matters to them, as well as quality and safety outcomes. The first NHS Wales core value described in *A Healthier Wales* is “Putting quality and safety above all else – providing high-value evidence-based care for our patients at all times.”

Healthcare organisations in Wales are focused on meeting the quadruple aim of excellence in population health and wellbeing, personal experiences of care, best value from resources and an engaged and committed workforce. The philosophy of value-based, prudent, health and care underpins this and will continue to be a distinctive feature of the Welsh system. The recent Health and Social Care (Quality and Engagement) (Wales) Act 2020 places both an enhanced duty of quality and an organisational duty of candour and will strengthen the approach to high quality, safe care. National guidance on this new Act is being developed at the current time.

The recently-published *National Clinical Framework* provides a clinical interpretation of *A Healthier Wales* and describes a learning health and care system, centred on clinical pathways that focus on the patient, grounded in a life-course approach.

The *Quality Strategy* for the Health Board will bring together all these drivers into set of quality priorities and objectives (with outcome measures) for 2022-2025, underpinned by a quality management system. In this context, quality is defined as patient safety, patient and carer experience and clinical effectiveness.

The *Quality Strategy* will sit underneath the refreshed *Living Healthier, Staying Well* vision for the Health Board and alongside the *Clinical Strategy* and other key strategies such as the *Digital Strategy*, etc.

The Committee received a presentation on the strategy development work at its workshop in August 2021. Over the next few months further engagement will take place around the strategy and it will be further refined, finalised and presented to the Committee for approval. This work will align with the other key organisational and national work highlighted above.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – As detailed in the report.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.

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Betsi Cadwaladr
University Health Board

Appendix 1

Interim Quality Priorities – 2021/22

Our Quality Vision		
We will provide healthcare that is person centred, safe and effective for all		
Our Quality Priorities		
Priority 1: **We will provide safe healthcare**	**Priority 2:** **We will provide clinically effective healthcare**	**Priority 3:** **We will put patients and carers at the heart of our services**
Actions: The incident process will be strengthened and improved The safety alert process will be reviewed and improved A new concerns management system (Datix) will be implemented A new Speak out Safely process will be implemented Improvement work will take place regarding the WHO Checklist A falls reduction improvement plan will be developed The ligature risk reduction process will be improved	**Actions:** A new Transformation and Improvement Service will be created A new approach to the development of clinical pathways will be developed A clinical lead for mortality review will be appointed Corporate and local quality teams will be aligned Board Member Quality Walkabouts will be introduced A Learning from Excellence process will be introduced A Quality Dashboard will be developed	**Actions:** The complaints process will be strengthened and improved A new patient information process and Readers Panel will be implemented A carer experience assessment framework will be developed A new real-time patent feedback system will be implemented Digital patent stories will be introduced Patient and Carer Experience Champions will be introduced Patient use devices will be rolled out

These interim quality priorities will apply for 2021/2022 whist the new Health Board Quality Strategy for 2022-2025 is developed. These priorities and actions reflect the work being done in 2021/22 to improve quality, based on identified risks and concerns and feedback from strategy development work so far. They will become part of the new strategy with clear outcome measures developed.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 2nd November 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Implementation of the new Liberty Protection Safeguards (LPS)
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Michelle Denwood, Associate Director of Safeguarding Gill Harris, Deputy CEO/Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Chris Walker, Head of Safeguarding Adults MHLD, supported by Michelle Denwood, Associate Director of Safeguarding
Craffu blaenorol: **Prior Scrutiny:**	Michelle Denwood, Associate Director of Safeguarding and Gill Harris, Deputy CEO/Executive Director of Nursing and Midwifery.
Atodiadau **Appendices:**	Appendix 1 - LPS Implementation Task and Finish Group Structure/Reporting Flow Chart

Argymhelliad / Recommendation:

The Committee is asked to:

1. Accept the position report in preparation for the implementation of Liberty Protection Safeguards (LPS) on the 1st April 2022.
2. Note the progress made and actions to be taken in relation to the implementation of the Liberty Protection Safeguarding (LPS) within BCUHB.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Sefyllfa / Situation:

The Mental Capacity Act 2005 was amended in May 2019 and this is referred to as the Mental Capacity (Amendment) Act 2019.

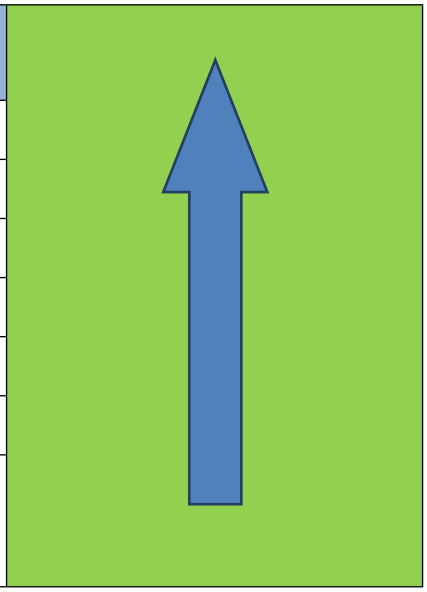
This amended Act will change the Mental Capacity Act Code of Practice and Deprivation of Liberty Safeguards (DoLS) to create new statutory regulations known as Liberty Protection Safeguards. A new Code of Practice and regulations to accompany the Act were due to be in place by October 2020 and this revised legislation has an expected implementation date of April 2022.

UK Government have acknowledged the delay in the publication of the draft Code of Practice, with the Code now due to be available for consultation during October 2021. With regard to the implementation date of the 1st April 2022, we have been advised this is subject to change and is under continuous review by the UK Government.

Table 1 shows the total number of BCUHB DoLS applications have increased annually as evidenced below, this impacts upon service provision.

Table 1

Year	Total DoLS Applications
2014/15	414
2015/16	787
2016/17	854
2017/18	792
2018/19	744
2019/20	1014
2020/21	1460 based on the current increase of 44% during Q1 and Q2.



As a result it is expected that BCUHB will have in excess of 3200 annual applications under LPS, this is an additional 1800 applications based upon the current DoLS data.

A priority action identified for 2021-22 is to create a strategic LPS Implementation Task and Finish Group and supporting Operational Programme Task Groups to support the implementation of the LPS framework across the Health Board. The draft LPS Implementation Task and Finish Group Terms of Reference (ToR) is following the Board's assurance and consultation process to ensure ratification and implementation.

The Safeguarding Governance and Performance Group received the Terms of Reference on the 13th October 2021 and they are to be discussed and agreed at the Safer Patient and Quality Group on 9th November 2021. A flow chart (appendix 1) is included to highlight the reporting framework and the intended implementation of operational programme task groups, which will provide assurance of the implementation of the LPS legal framework at a clinical care level across BCUHB.

Challenges continue, as we do not have the specific detail of the changes in legislation due to the delay in the publication of the Code of Practice.

Corporate Safeguarding, on behalf of BCUHB, currently attend Local, Regional and National working groups in relation to LPS to ensure that BCUHB remain informed of any developments.

We have received draft LPS assessment forms from Welsh Government and these are now subject to scrutiny via the national working group, which is chaired by Welsh Government. In addition, Welsh Government have communicated an update in relation to the proposed LPS training programme and has confirmed Social Care Wales will be responsible to provide and develop the training.

Welsh Government have advised Statutory Bodies to refrain from undertaking any localised training and to await both the publication of the Code of Practice and an agreed National Training Framework. This activity will be monitored via the North Wales Safeguarding Board Training Group.

On the 24th September 2021 NWSSP Legal & Risk Complex Patient Team hosted an afternoon to review some key issues relating to the transition to LPS. They advised that the interface between the Mental Health

Act (MHA) and Mental Capacity Act (MCA) will remain unchanged and key changes from the current DoLS framework will result in a 'Necessity and Proportionate' assessment rather than the current Best Interests Assessment.

This will result in a total change in the way that BCUHB patients are assessed for LPS with the emphasis placed upon a good understanding of the MCA. Frontline staff will be responsible for the completion of assessments with support and expert advice provided by the new Approved Mental Capacity Practitioner (AMCP).

Cefndir / Background:

The UK Government have advised that no LPS training should be undertaken prior to the publication of the LPS Code of Practice. Training programmes are yet to be submitted for consultation (UK Government advise that a 3 month consultation process will be enacted).

Welsh Government announced on the 25th of August 2021 that additional time limited funding for Mental Capacity Act 2005 / Deprivation of Liberty Safeguards (DoLS) application backlogs and advanced MCA training was available. The Welsh Government aims to provide an interim additional resource ahead of the planned implementation of the Mental Capacity (Amendment) Act 2019 and the Liberty Protection Safeguards (LPS) in Wales.

In line with the funding provided for DoLS in 2020/2021 it was recognised that individual organisations will have different needs in relation to addressing the backlog of DoLS authorisations, and 2 million pounds would be allocated following receipt of proposals from Health Boards and Local Authorities across Wales. The proposal by BCUHB included information on the current backlog of DoLS authorisations and how the funding would be allocated to address this. Funding is for the current statutory application of the Mental Capacity Act (MCA) 2005 and DoLS.

Health Boards and Local Authorities were encouraged to include bids for funding to support required MCA training as part of the proposals.

Corporate Safeguarding can confirm that in total £344,058 was secured by BCUHB to address the activities as follows:

1. Funding for DoLS assessments (backlog) - £145,600
2. MCA training - £198,457.50

Addressing the current DoLS application backlog is a challenge to the service. Due to a 44% increase in DoLS applications during Q1 and Q2 2021-22 there is a need to review the current DoLS/MCA team structure and invest further to ensure statutory compliance with the legal framework. Welsh Government recognise the challenges facing Health Boards and Local Authorities, and the provision of funding to address the issues is a welcomed resource. Corporate Safeguarding have analysed the current DoLS figures and calculate that an additional five (5) applications per week will need to be completed to offer assurance that by April 1st 2022 the current DoLS application backlog will be in line with statutory guidance.

The addition of weekend and evening working, with agreed set fees for the completion of Best Interest Assessments was a positive factor within BCUHB's bid for funding. External resource will need to be sourced to compliment and to assist in the undertaking of assessments.

The funding for the Mental Capacity Act training will ensure that BCUHB staff have the understanding and awareness of the Mental Capacity Act. This will not only improve decision making and ultimately patient care but it will prepare the organisation for the implementation of Liberty Protection Safeguards. The National training events are led by the Welsh Government and Social Care Wales is the training facilitator.

The National training package will ensure that all Health and Social Care staff are afforded the correct level of training and education in relation to LPS.

The recognised challenge is the delay in preparation and roll out, and due to the large workforce some staff may have had a limited understanding when the Act comes into force. Therefore following the successful bid for funding Corporate Safeguarding will work in partnership with internal (and where necessary external) services to ensure that MCA training, education and understanding is embedded across the identified workforce.

The funding secured for MCA training identified the need for additional training resources. This includes the recruitment of experienced MCA trainers who can deliver training packages both within normal working hours and during evenings and weekends.

In addition Corporate Safeguarding have engaged with a leading Barrister to support and facilitate bespoke LPS training to key staff. He is awarded the contract in England to provide the Approved Mental Capacity Professional (AMCP) training and currently provides Best Interest Assessor (BIA) refresher courses to qualified BIAs.

In addition Corporate Safeguarding have engaged with a leading Barrister, Mr Neil Allen QC, to support and facilitate bespoke LPS training to key staff. He has been awarded the contract in England to provide the Approved Mental Capacity Professional (AMCP) training and currently provides Best Interest Assessor (BIA) refresher courses to qualified BIAs.

We remain in contact with Mr Allen as this commissioned piece of work was funded in 2020-2021. In addition to the training package, leaflets will be available for front line staff to support clinical practice
The increase in activity will result in the need to strengthen the business/administrative aspect of the DoLS/MCA team. Working in partnership with workforce services we will look at the need to recruit into the service on an initial temporary basis with a view to securing permanent resource as part of the Safeguarding Business Case.

Asesu a Dadansoddi / Assessment & Analysis

The Safeguarding Business Case is under development and will be submitted and presented for consideration by the Deputy CEO/Executive Director of Nursing and Midwifery and BCUHB's Executive Team in October 2021.

Finalisation of the Business Case had experienced a four (4) week delay due to the requirement of a review following to the identification of additional challenges. Final financial calculations are taking place with the aim if agreed, to introduce additional resource over an eighteen (18) month period.

The increase in activity and demand under LPS will result in unprecedented numbers of applications to the Health Board, estimated at in excess of 3000 applications. The strengthening of the current DoLS/MCA team is paramount to ensure that BCUHB staff are supported throughout the transition to LPS. The Safeguarding Business Case has identified the need to expand the service to provide adequate support for staff. This includes the additionally of staff at all levels of the service but in particular, clinical expertise, training, performance, governance and administration.

The MCA/LPS legislative changes will have significant implications in terms of demand, capacity, training, financial resources and challenges for the Health Board.

The current DoLS arrangements are where practitioners known as BIAs and Mental Health Assessor (S12 (2) Doctors) undertake the necessary assessments.

Under LPS these assessments will be carried out by those already involved in the person's care, such as hospital ward staff, therapists, doctors and possibly GPs.

This will require substantial education and training to ensure the workforce are competent to complete the required assessments. The assessment documents are currently in development and will be shared with all Health Boards and Local Authorities across Wales for consultation during Q3.

The Health Board will also be responsible for authorising LPS within additional care settings for which it is commissioning, such as Continuing Health Care (CHC) funded placements, Domiciliary Care Packages and 16 or 17 year olds in any setting across England and Wales.

BCUHB will also continue to be responsible for authorising LPS for any BCUHB patients in any registered NHS Hospital, Independent Hospital and Hospice across England and Wales. Any patient objecting to an authorised LPS will have the right to be assessed by an Approved Mental Capacity Practitioner (AMCP) this new role will replace the current BIA role.

Recommendations taken from National the LPS working groups suggest the following 'All Wales' approach;

- Mental Capacity Act Training will be mandatory for all NHS staff in Wales and contracted services. LPS training requirements are being developed on a national footprint. Welsh Government have issued funding to Health Boards and Local Authorities to maximise MCA awareness and effectiveness, and support a competent workforce.

- All Health Boards to have a Mental Capacity Act Lead. This is recorded as a priority action on the Corporate Safeguarding 2021-2022 Action Plan and a Strategic MCA/LPS role has been identified within the Corporate Safeguarding Business case for agreement. This action is to be completed by April 2022.

- Additional resource has been secured by BCUHB Corporate Safeguarding and the additional funded activities need to be implemented with positive outcomes before April 2021.

In addition the NHS Wales Safeguarding Network MCA, DoLS & LPS Implementation Task and Finish group will:

- Provide a collaborative response to the LPS Code of Practice consultation (delayed until October 2021 and will be subject to a 3 month consultation period).

- Work with the Welsh Government LPS Implementation Group

- Provide expert advice to the Once for Wales Concerns Management System in respect of MCA, DoLS & LPS.

The National LPS working groups are supported by the NHS Wales Safeguarding Network, membership includes BCUHB representatives from the Corporate Safeguarding Team.

The National LPS working groups are:

- LPS Workforce and Training Group.
- LPS in relation to 16 and 17 year olds Group.
- LPS Monitoring and Reporting Group.
- LPS Transition Group.
- Welsh Government LPS Strategic Implementation Steering Group.

Corporate Safeguarding have completed the draft Terms of Reference for the BCUHB LPS Implementation Group, which includes strategic and operational membership to ensure the full implementation of the Mental

Capacity (Amendment) Act (2019) and Code of Practice relating to the Liberty Protection Safeguards.

The inaugural meeting is proposed to take place in November 2021 to allow for the publication of the Code of Practice as this will inform the group on key issues such as roles and responsibilities.

Opsiynau a ystyriwyd / Options considered

N/A

Goblygiadau Ariannol / Financial Implications

Ther are no direct financial implications as a result of this report.

However, the demand upon the MCA/DoLS Team extends not just to BIAs but also to all members of the team due to the increase in both activity and complexity, and the implications of LPS will mean a substantial change and responsibility for BCUHB. It is estimated that in excess of 55% of residents within Nursing Homes are in receipt of full CHC funding. The current responsibility for DoLS assessment or appeal lies with the Local Authority but from April 2022, this will be the responsibility of the Health Board.

The financial impact for LPS is wide ranging with a change of roles and responsibilities across the Health Board. Under LPS the Approved Mental Capacity Practitioner (AMCP) will have greater responsibility and accountability as the Act dictates that Health Boards will retain ownership of LPS for all commissioned patients. This will see a huge increase in assessment requests, with approximately a further 1200 applications, recognising that if they are not completed on time this could result in legal and financial implications and greater activity within the Court of Protection.

The business case outlines the proposed structure to provide a specialist strategic, operational and governance and administrative services. Providing an enhanced service which is an improved and is a more dynamic service with the potential for succession planning.

Dadansoddiad Risk / Risk Analysis

The risks associated with the Deprivation of Liberty Safeguards presented at QSE on the 8th September 2021 resulted in the approval of the Risk to be included within the Tier 1 Corporate Risk Register.

Risk ID 2548. The increased level of Deprivation of Liberty Safeguards (DoLS) activity may result in the unlawful detention of patients.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

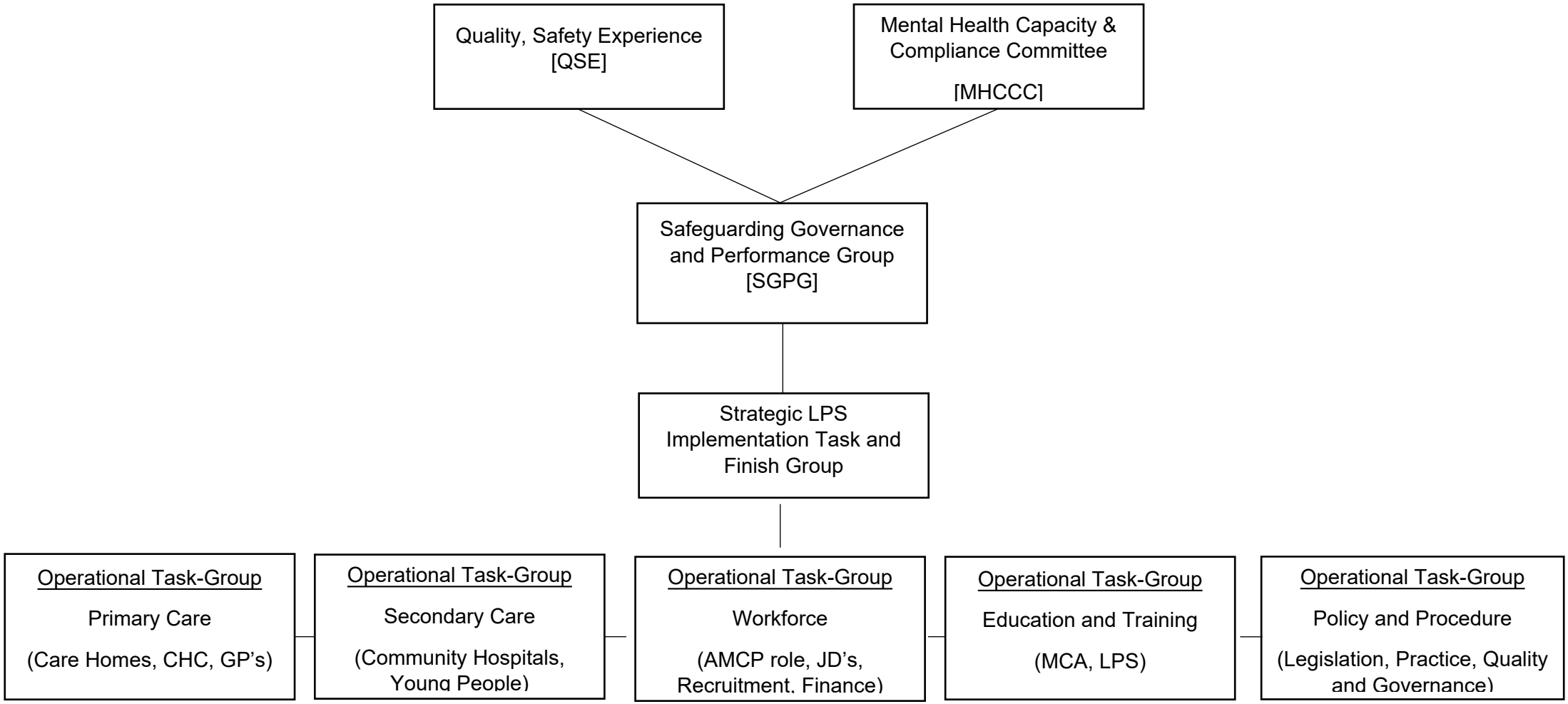
BCUHB will adhere to the Mental Capacity (Amendment) Act (2019) and Code of Practice relating to the Liberty Protection Safeguards.

Asesiad Effaith / Impact Assessment

The full impact of Liberty Protection Safeguards (LPS) on the organisation is currently unknown as we await the Codes of Practice, WG Training Materials, Assessment Documentation and the AMCP role guidelines. However, early indiciation suggests an increase in demand and activity that requires further action and engagmeent.

Appendix 1

LPS Implementation Task and Finish Group Structure/Reporting Flow Chart



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 2nd November 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Annual Presentation of Nurse Staffing Levels
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Gill Harris, Executive Director of Nursing & Midwifery& Deputy Chief Executive
Awdur yr Adroddiad Report Author:	Mrs Debra Hickman, Secondary Care Director of Nursing Mrs Alison Griffiths, Associate Director of Nursing Workforce
Craffu blaenorol: Prior Scrutiny:	Executive Director of Nursing & Midwifery & Deputy Chief Executive
Atodiadau Appendices:	1. Annual Presentation of Nurse Staffing Levels to the Board 2. Summary of Nurse Staffing Levels for wards where Section 25B applies

Argymhelliad / Recommendation:

The Committee is asked to receive this report to gain assurance in relation to the following:

1. Betsi Cadwaladr University Health Board (BCUHB) is meeting its statutory 'duty to calculate' the nurse staffing level in all wards that fall under the inclusion criteria of Section 25B of the Nurse Staffing Levels (Wales) Act 2016.
2. BCUHB is meeting its statutory duty to provide an annual presentation to the Board detailing calculated nurse staffing levels (Appendix 1)..

The Committee is also asked to note that:

3. As of 1 October 2021 the extension of section 25B of the Nurse Staffing Levels (Wales) Act 2016 has been extended to include paediatric inpatient wards. The Annual Presentation (Appendix 1) and Summary of Nurse Staffing Levels (Appendix 2) for wards where Section 25B applies will therefore include Adult acute medical inpatient wards; Adult acute surgical inpatient wards; and Paediatric inpatient wards.
4. Ongoing reasonable steps taken to monitor and as far as possible maintain nurse staffing levels in line with the Act and during times of unprecedented pandemic pressures.
5. Potential financial implications arising from the organisations statutory duty to calculate and take all reasonable steps to maintain nurse staffing levels will be considered by the Executive Team as part of the financial planning process for 2022/23.

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

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

Sefyllfa / Situation:

The statutory guidance issued in support of the Nurse Staffing Levels (Wales) Act 2016 requires that there is an annual presentation to the Board of the nurse staffing levels for all wards that fall under

Section 25B of the Act. The Quality, Safety and Experience Committee has delegated authority via the Board to receive this report in line with the organisation's governance framework.

This report and the templates within the appendices aims to assure the Committee that the legislative requirements associated with the 'duty to calculate' nurse staffing levels within all wards pertaining to Section 25B of the Act are being maintained.

The reporting period is October 2020 to September 2021.

Cefndir / Background:

There are two key reporting requirements that the statutory guidance states should be undertaken within a Health Board:

1. There should be a formal annual presentation to the Board by the designated person[1] of the calculated nurse staffing levels for each individual ward to which sections 25B of the Act pertains – to take place in November of each year.
2. There should be an annual assurance report received by the Board which is structured in a way to provide the basis of the statutory nurse staffing levels triennial report required by Welsh Government[2] - to be received by the Board in May of each year.

Asesiad / Assessment & Analysis

In line with the requirements of the Nurse Staffing Levels (Wales) Act 2016, the triangulated methodology for calculating the nurse staffing levels for all areas pertaining to section 25B has been fully and rigorously applied.

The narrative detailed within the Annual Presentation and the Summary of Nurse Staffing Levels (Appendix 2) has attempted to demonstrate the rationale/driver for any proposed changes to the nurse staffing levels. This is with the aim of identifying a distinction between those adjustments to nurse staffing levels that are anticipated to be temporary and COVID-19 related; and those considered to be permanently required adjustments which have been driven by changes to care quality outcomes, or sustained change in the pattern of patient acuity and ward activity.

Key points to note:

- The biannual review of nurse staffing levels for wards pertaining to Section 25B wards has been extremely challenging for operational teams, and their commitment to undertaking the process diligently, despite having other pressures at this time, is to be commended.
- Several wards will be supported in taking forward improvement action plans relating to care quality outcomes over the coming months, whilst other teams will be supported with training and development in particular relating to the care of frail elderly patients
- The variation in the requirements of Health Care Support Workers (HCSW) across Paediatrics requires a review to ensure the roles and potential contributions of that workforce supports a model of prudent healthcare and progressive career development.
- Budgeted Nursing & Midwifery 5830.7 WTE; vacant 636.4 WTE (11%) / Budgeted Additional Clinical Support (HCSW) 3651.3 WTE; vacant 188.6 WTE (5%)
- Triangulated methodology was applied across all wards to ensure consistency.

[1] The designated person must act within the HB's governance framework authorising that person 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, such as the Executive Director of Nursing.

[2] BCUHB Nurse Staffing Levels Triennial report was submitted to Welsh Government September 2021

- 3 paediatric inpatient wards, 22 adult medical inpatients wards, and 15 adult surgical inpatient wards met the requirements pertaining to Section 25B of the Act[3] during this reporting period

Paediatric Inpatient Nurse Staffing Levels

The first triangulated calculation of Nurse staffing levels for paediatric inpatient wards was completed in August 2021, utilising the approach consistent to that of the Adult inpatient areas. It is anticipated that this will mature over time, as greater validity is gained with data collated over time to aid comparative analysis. It was apparent from the exercise that data collection points did not provide a true reflection of service of activity in relation to occupancy, with periods of high footfall not necessarily recognised. There was a variation noted across the Health Board with the numbers of Health Care Support Workers (HCSW) in post. The outputs of the calculations identify a shortfall of both Registered Paediatric Nurses and support staff. Further Paediatric Student Nurse placements have been commissioned for North Wales, with the first outturn in Autumn 2022.

Adult Inpatient Nurse Staffing Levels - Ysbyty Wrexham Maelor (YWM)

Greater level 3 & 4 levels of care have been noted within YWM in recent acuity audits. From the triangulation of the data and professional the judgment majority of the wards do not require a change to establishments with the exception of Bonney, Fleming and Pantomine. Bonney, due to the harms profile has received the addition of further HCSW and Fleming and Pantomine have received increases in both Registered Nurse (RN) and HCSW to support escalated bed numbers to support capacity demands. Arrivals and Erddig pathways have been reconfigured to support elective pathways and aid the recommencement of elective activity.

Adult Inpatient Nurse Staffing Levels - Ysbyty Glan Clywd (YGC)

Due to the increasing dependency, vulnerability and patient harms noted supported by acuity data and intelligence from outbreak management a number of wards have seen the need for increases in both HCSWs and Registered Nurses (RNs). Wards 1, 2, 3, 5, 9 and 14 have seen an impact, with Ward 3 seeing an increase in bed capacity utilisation.

Adult Inpatient Nurse Staffing Levels - Ysbyty Gwynedd (YG)

Due to the increasing dependency, acuity, vulnerability and patient harms noted, supported by acuity data and outbreak intelligence analysis a number of wards have seen the need for increases in both HCSWs and RNs. Glyder, Hebog, Tryfan, Moelwyn, Prysor and Dulas have all been impacted with nights being a particular area of need.

Operational actions to mitigate the risk associated with nurse staffing shortfalls

In this challenging environment Workforce and Organisational Development (WOD) Department continue to work closely with senior nursing and midwifery colleagues to maximise recruitment and retention of nursing and midwifery staff. In support of this work a Health Board wide Nursing Recruitment and Retention group meets monthly and oversees a comprehensive work plan including:

1. Creation of a deployment dashboard to give high level overview of available staff and associated skills sets
2. Continued overseas nurse recruitment programme/Clinical Nurse Fellowship
3. Bachelor of Nursing FastTrack for Health Care Support Workers to “grow our own”
4. Band 4 roles undertaking extended duties on a competency assessed basis

[3] A higher number of adult wards met the requirements of Section 25B during this reporting period due to the re purposing of wards to meet the demands of COVID 19

5. Annual establishment reviews for all areas exempt from Section 25B[4]
6. SafeCare Allocate system continues to be utilised to support decisions regarding staffing on a shift by shift basis. Actions are taken by the nurse in charge/senior nurse to ensure the safe deployment of the workforce and to mitigate risk to patient safety.
7. Staff Deployment Meetings take place bi-weekly led by Director of Nursing. The meeting is informed by divisional staffing SITREP, SafeCare eroster, temporary staffing requirements/fill rates, workforce utilisation data, and COVID data.
8. Recruitment and Retention Meetings take place monthly, led by Director of Nursing. The meeting is informed by a presentation from Workforce forecasting nursing recruitment for the current financial year. Workforce intelligence is used to highlight areas of high turnover/vacancy rate and areas requiring additional WOD support in relation to the recruitment and retention of staff.
9. Workforce Utilisation Dashboard identifies the utilisation of substantive and temporary staff within rosters, and measures this against funded establishments in ESR. Staff unavailability (i.e. annual leave/sickness/training/parenting) is included in the dashboard to identify the drivers for low substantive staff utilisation, and high temporary workforce requests above agreed funded establishment.

Workforce

Band 7 Ward Managers are ordinarily supernumerary however they have been included in care delivery numbers due to increased capacity needs, and sickness/absence cover related to the COVID 19 pandemic. Data extraction identifies that YG has experienced 30% clinical support requirement higher in quarters 2 & 3 2021/22 YWM a 70% clinical support requirement higher in quarters 4 2020/21 and YGC a 48% clinical support requirement higher in quarter 1 2021/22.

Upskilling opportunities for nursing teams, non-clinical staff, allied health professionals and public volunteers remain available and further facilitate the Health Boards response to the COVID 19 pandemic, however it should be noted that this has reduced over time. Online training is now available and has facilitated refresher training for key staff groups between COVID 19 surges of activity.

The ongoing impact of Covid 19, vacancy rates and variability in skill mix continues to be a challenge which cannot be under estimated. The competency, skill and experience of the nurses providing care to patients is a crucial component that has influenced the nurse staffing requirements within the bi annual calculation. The appointment of new graduates via the streamlining process continues to be a success with the largest outturn to date due this Autumn/Winter, however commencement into posts for a number will be delayed due to the need to make up time lost during student training, of which has been more significant in this current year.

Recruitment and retention activity has prioritised areas with significant need/risk. Recruitment initiatives have specifically focussed on increasing substantive registrants and non-registrants within the Health Board, via routes such as international recruitment, Health Care Assistants graduate schemes and external supported campaigns with specific focus around band 5 Nurses. Short /intermediate term mitigation continues to be through temporary staffing of bank and agency staff and deployment of staff internally (clinical and non-clinical).

[4] All care settings require a calculation of nurse staffing levels under Section 25A of the Nurse Staffing (Wales) Act 2016. This includes areas such as Outpatient Clinics, theatres, admission units, day case areas, Critical Care, High dependency, CCU – the list is not exhaustive

Quality of care

As wards continue to be repurposed to facilitate the demands of the COVID 19 pandemic it is recognised that professional judgments made for some areas may change again at the next bi annual calculation and therefore some are recognised as interim amendments pending further review. An increase in patient acuity, dependency and reported harms alongside the impaired visibility of areas due to the introduction of additional segregation requirements and additional Personal Protective Equipment (PPE) requirements have affected staffing requirements across the services, predominantly Healthcare Support Workers.

The acuity audit supported the professional judgement of the Ward Mangers, Matrons and Heads of Nursing regarding a marked increase in the nursing needs of patients risk assessed as requiring enhanced observations. The acuity audit findings reported a sustained number of patients who meet the Welsh Levels of Care 3 and 4. The increase may be due to late presentation of a chronic illness, deterioration of chronic illness, breakdown of support at home for cognitively impaired individuals or due to clinical instability. It is not anticipated that the patient needs at Welsh Levels of Care 3 and 4 are likely to reduce. In addition to acuity, there is also noted to be an increasing dependency with patients within our care.

As there were some wards identified during this cycle of nurse staffing calculations where there remain concerns in relation to the care quality indicators, some of which it is judged require adjustments to their staffing levels as part of the improvement action plan, it is clear that there may be a negative impact on care quality if the outcome of the calculation cycle is not responded to operationally. Limiting patient numbers during this challenging time appears beyond the bounds of possibility.

Conclusion:

The report provides assurance to the Committee that in line with statutory guidance the Health Board is fully compliant with the requirements of the Nurse Staffing Levels (Wales) Act 2016 bi annual calculations for 25B adult inpatient medical and surgical wards; and paediatric inpatient wards.

There has been a greater need to staff additional areas, both by extending existing funded bed establishments of individual wards by the addition of beds or with the repurposing of areas such as day case, notwithstanding the opening of redesigned areas such as Enfys Deeside.

The response to the ongoing impact of the COVID 19 pandemic over the winter period will continue to be a dynamic one depending on demand of winter pressures, patient needs and Infection Prevention control measures. In light of the changing ‘primary purpose’ of the wards and 25B requirements the Health Board will continue to pro-actively recalculate the nurse staffing levels as wards primary purpose or speciality changes using the prescribed guidance and capture evidence of the triangulation methodology and calculation within the nationally agreed template.

References:

NMC (2016) Appropriate staffing in health and care settings
https://www.nmc.org.uk/globalassets/sitedocuments/press/safe-staffing-position-statement.pdf.
Nurse staffing Levels (Wales) Act 2016: operational guidance
http://www.assembly.wales/laid%20documents/pri-ld10028%20-%20safe%20Nurse%20staffing%20levels%20(wales)%20bill/pri-ld10028-e.pdf
National Institute for Health and Clinical Excellence (NICE) on safe staffing.
https://www.nice.org.uk/Guidance/SG1
Falling short: the NHS workforce challenge
Workforce profile and trends of the NHS in England, November 2019

https://reader.health.org.uk/falling-short

Strategy Implications
Inability to provide appropriate nurse staffing levels to ensure time to care for patients sensitively can compromise the Health Boards ability to deliver health care effectively, and compromise the reputation of Health Board nursing services.

Financial Implications
There are financial and workforce risks associated with the outcome of the work described in this paper and they remain to be addressed within the planning cycle of the Health Board. The risks relate to the ability to both finance and recruit a sufficient workforce of both registrants and support workers.

Key points to note:

1. Escalation/surge capacity remains unfunded and does not support nurse staffing levels
2. Vacancies are funded at bottom of pay scale and does not support the recruitment agenda or skill mix.
3. Previous calculations have not been translated into funded establishments due to the vacancy position.

Risk Analysis
Nurse staffing shortfalls remain a concern for the Health Board and noted on the corporate risk register (Risk ID1976).

1. The current vacancy position and its impact on wards pertaining to Section 25B of the Act
2. the impact of the COVID 19 pandemic and the repurposing of wards to meet the clinical demand

Legal and Compliance

Nurse staffing calculations are presented annually to the Health Board. Changes to ward establishments outside of the Biannual Calculation are approved by the Executive Director of Nursing. The legal risk associated with nurse staffing levels relates not to the issues described within this paper (which relate to the duty to calculate the nurse staffing levels) but rather to the potential of non-compliance with the second duty of the Nurse Staffing Levels (Wales) Act 2016 i.e. the 'duty of maintaining the nurse staffing levels'. The 'duty to maintain the nurse staffing level' requires the financial and the workforce risks detailed above to be addressed, and this poses a more significant challenge to the organisation.

Impact Assessment
Undertaken as part of the Biannual calculations

Appendix 1

Annual Presentation of Nurse Staffing Levels to the Board

Health Board	**Betsi Cadwaladr University Health Board**
Date of annual presentation of Nurse Staffing Levels to Board	**2nd November 2021 (to QSE Committee)**
Period Covered	**01 October 2020 to 30 September 2021**
Number and identity of section 25B wards during the reporting period. • **Adult acute medical inpatient wards** • **Adult acute surgical inpatient wards** • **Paediatric inpatient wards** (Ref: paragraph 26-30)	In the reporting period of 2020/2021 dynamic decisions have been taken throughout these unprecedented times and wards have been repurposed on a risk-assessed basis to ensure patients receive the right care, in the right place at the right time. COVID 19 pandemic management remains an integral factor for operational nurse staffing decisions. All adult inpatient wards have been subject to ongoing reviews where necessary outside of the biannual calculation cycle and nurse staffing plans have been outlined in SBAR format to the Board, and subsequently agreed by the Executive Nurse Director.

Adult acute **medical** inpatient wards: Total x 22

Ysbyty Gwynedd x 6	Ysbyty Glan Clwyd x8	Ysbyty Wrexham Maelor x8
Glaslyn	Ward 1	Acton
Glyder	Ward 2	ACU
Hebog	Ward 4	Bersham
Moelwyn	Ward 9	Bonney
Prysor	Ward 11	Cunliffe
Tryfan	Ward 12	Fleming
	Ward 14	Morris
	DOSA	Pantomine

Adult acute **surgical** inpatient wards: Total x 15

Ysbyty Gwynedd x5	Ysbyty Glan Clwyd x5	Ysbyty Wrexham Maelor x5
Tegid	Ward 3	Arrivals
Dulas	Ward 5	ENT
Ogwen	Ward 6 (ABH)	Erddig
Enlli	Ward 7	Mason
Tudno	Ward 8	Prince of Wales

	Paediatric inpatient wards: Total x3 (Ysbyty Gwynedd x1; Ysbyty Glan Clwyd x1; Ysbyty Wrexham Maelor x1)
Using the triangulated approach to calculate the Nurse staffing level on section 25B wards (Ref: paragraph 31-45)	The process and methodology used to inform the triangulated approach in calculating Nurse staffing levels on Section 25B wards has three steps: Step 1: Initial Review. The Site Director of Nursing leads the review to calculate Nurse staffing levels in collaboration with the Heads of Nursing, Directorate Matrons, Ward Sister/Manager, and senior colleagues from Workforce and Finance. The review is informed by both qualitative and quantitative information: ➢ Acuity data - acuity is measured by using an evidence-based workforce planning tool Welsh Levels of Care[1]. Although the SafeCare Allocate system captures acuity data on a shift by shift basis, formal Acuity Audits are undertaken every 6 months (January and June) in all wards where section 25B of the Act applies[2]. This audit data is reviewed and validated by the Site Nurse Director, Head of Nursing, Matron and Ward Manager prior to final sign off and subsequent publication (Visualiser) by HEIW. An increased level of acuity on wards may require a greater number of nursing staff to safely manage the clinical area, and sensitively care for the patients. Factors such as escalated beds, increases in demand and activity, Infection Prevention requirements and the national focus are also considered. ➢ Professional judgement – the Site Nurse Director in conjunction with relevant Head of Nursing, Matron and Ward Manager use their knowledge of the clinical area plus the evidence from the acuity audit to make an informed decision regarding the calculation of Nurse staffing levels. ➢ Quality Indicators – the review includes an analysis of quality indicators that are particularly sensitive to care provided only by a Nurse. The quality indicators shown to have an association with low staffing levels and must be reported on are: *Patient falls* - any fall that a patient has experienced whilst on the ward; *Pressure ulcers* - total number of hospital acquired pressure ulcers considered to have developed while a patient on the ward; *Medication errors* - any error in the preparation, administration or omission of medication by Nursing staff (this includes medication related never events). *Complaints* – wholly or partly about care provided to patients by nurses made in accordance with the complaint's regulations.

[1] The Welsh Levels of Care consists of 5 levels of acuity ranging from; Level 5 where the patient is highly unstable and at risk, requiring an intense level of continuous nursing care on a 1:1 basis, down to Level 1 where the patients condition is stable and predictable, requiring routine nursing care.

[2] Acuity audits in January 2021 were deferred due to pandemic demand and activity

	In addition to the factors identified within the Nurse Staffing Levels (Wales) Act 2016 Operational Guidance, details of the core information provided at the initial review and which underpins the review of nurse staffing levels in all wards includes: ➢ Current ward bed numbers and speciality, including specific treatments or procedures. ➢ Current nurse staff provision, including those that are not included in the core roster (supervisory ward manager, frailty/rehabilitation support workers, ward administrators etc). ➢ Workforce/Staffing related metric data i.e. Performance & Development Review (PADR) compliance, mandatory training compliance, sickness, maternity leave. ➢ Patient flow/activity related data for the previous 12 months. ➢ Finance related data i.e. pay/non pay expenditure/utilisation of permanent/temporary staff. In addition to the quantitative data referred to above, the ward manager provides detail of service and patient pathway changes, ward based initiatives, and improvement programmes or action plans for remedial work to specific areas where concerns have been identified by means of scrutiny and assurance processes (e.g ward accreditation). Step 2: A Health Board wide review is undertaken, taking into account national guidance and best practice evidence, led by the Secondary Care Nurse Director (Adult inpatient wards)/Area Nurse Directors (Paediatric inpatient wards) to ensure a consistent Health Board wide approach. Step 3: A Health Board wide position concerning Nurse staffing levels is subsequently presented to the Executive Director of Nursing and Midwifery as the confirmed designated person[3] and on approval; this is formally presented to the Board. The consideration of physical environment, layout and geographical positioning of wards is also considered as part of the calculation, recognising that challenges such as social distancing, segregation and repurposing of areas to provide much needed capacity have significant impacts on Nursing requirements. The acuity audits have supported the professional judgement applied to the calculation of Nurse staffing and have demonstrated a marked increase in the nursing care needs of patients. Care needs have included patients

[3] The designated person must act within the Health Boards governance framework authorising that person to undertake the Nurse staffing calculation on behalf of the Health Boards Chief Executive Officer. In view of the requirement to exercise nursing professional judgement, 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, such as the Executive Director of Nursing and Midwifery.

	requiring enhanced observations and 1:1 nursing care. The acuity audit findings have reported an increase in the number of patients who met the Welsh Levels of Care 3 and 4. This increase may be due to late presentation of a chronic illness, increasing complexity of individuals with multiple comorbidities, breakdown of support at home for cognitively impaired individuals, care withdrawn from nursing/residential homes, or due to clinical instability. It is anticipated that there will be a continued presentation of patients requiring Levels 3 and 4 as we enter the 2021 Winter period with the ongoing backdrop of the COVID19 pandemic. There is ongoing need for appropriate segregation to ensure patients are protected from the potential transmission of COVID 19 in line with infection prevention guidance. There is continued pressure on inpatient registered Nurse staffing with the requirement to further enhance separation of the inpatient elective pathway, in addition to the requirements for safe donning and doffing routines. All of the acute adult medical and surgical inpatient wards have an uplift of 26.9% for Band 5 Registered Nurses and above, and 22% for Health Care Support Workers.
Finance and workforce implications	The workforce requirements following the review and recalculation of the WTE nursing establishments required to provide the planned rosters, are summarised in Appendix 2. Financial implications of the review will be considered by the Executive Team and considered within the 2022/23 financial planning cycle. To support ongoing recruitment and retention initiatives, provide a level of stability and look to further strengthen clinical leadership, particularly in the more difficult to recruit towards revisions have been applied to the skill mix across the Health Board by way of the introduction of band 4 positions. This also provides a further route of access to registered Nurse positions as part of the Health Boards career framework. There have been and continue to be dedicated recruitment campaigns across a range of Nursing specialties as vacancy profiles indicate. A priority is increasing registrants, with initiatives such as international recruitment, Clinical Fellowship Programmes for Nursing and Health Care Assistants graduate schemes. With the upskilling of Healthcare Support worker roles at band 2 and above. Short-term mitigation remains through temporary staffing of bank and agency staff and deployment of staff internally (clinical and non-clinical). Anticipating the nature of the winter pressures and COVID 19 pandemic a dynamic staff recruitment, up skilling and deployment response continues to be required. Workforce and Organisational Development teams continue to work closely with senior nursing and midwifery colleagues to maximise recruitment and retention of nursing and midwifery staff initiatives. In support of this work a Health Board wide Nurse recruitment and retention group meets monthly and oversees a comprehensive work plan. Highlight of ongoing activities are as follows:

	- Rolling ward / role specific adverts - Targeted band 5 recruitment - Engagement of external marketing agents - Recruitment diary planned throughout the year - Established International recruitment pipeline - Streamlining programme to appoint Student Nurses as seamlessly as possible - Rolling adverts for bank registered Nurses and Health Care Support Workers to support substantive workforce with additional flexibility - Recruitment clinics to support managers to progress vacancies - Promotion of vacancies through social media. - Data analysis to support and underpin recruitment focus The process for maintaining Nurse staffing levels are supported by a number of other elements of which include: • Safe Care supports the daily review of staffing in Acute and Community Areas across the Health Board to ensure safe deployment in line with existing Safe Staffing Act. • Double sign off of nursing rosters to ensure effective deployment. • Nurse staffing policy outlines standards and escalation. • Safe staffing legislation being extended into Paediatric inpatient areas from Q3 2021. • District Nursing principle compliance review undertaken bi annually in line with All Wales approach. • Biannual staffing Inpatient reviews - reviewing establishments and association of harms with reports to Quality, Safety and Experience Committee/Board. • Workforce recruitment and retention strategy in place. • Recruitment and Retention operational group in situ with HB wide representation. • Targeted Recruitment Campaign for Band 5 nurses developed and rolled out. • Annual Commissioning requirements calculated triangulating service development / staffing review and national planning information. • International Nurse recruitment programme in place informed by data analysis. • Clinical Fellows for Nursing programme being rolled out. • Director of Nursing appointment to lead and support nurse recruitment. • Workforce/Service planning process to triangulate requirements. • Introduction of new roles to support e.g. Band 4 roles across the HB where applicable. • Daily redeployment meeting with Senior Nursing Leadership chair during pandemic surge. Currently twice weekly.

	• MDT staffing support across the Health Board during surge due to inability to respond to demand. • Objective setting via the PADR process to ensure staff are working to 'top of license' and have opportunity. • Pandemic surge plan approved by Executive Director of Nursing and Midwifery, the plan has been implemented within the Health Board. • Workforce nursing utilisation dashboard developed and introduced to senior nursing teams to optimise nurse staffing rosters. • Band 4 roles review completed with actions identified to progress identified roles through to fast track nursing studies resulting in Band 5 positions going forwards. As a Health Board there has been underpinning work to secure and assure plans for maintaining Nurse staffing levels and compliance with the Act to date, of which is ongoing. There is continual development as greater information, analysis and comprehension is gained locally and nationally. There is a range of both short and long term actions being taken by the Health Board to improve the extent to which a sufficient workforce is available to work within the Registered Nurse and Health Care Support Worker establishments across all health settings. These include: • Initiatives being led by the Workforce and Organisational Development teams and Corporate Nursing to develop and implement innovative approaches to recruitment of Registered Nurses and Health Care Support Workers • Continue to progress the overseas Registered Nurse campaign including the uplift of Practice Development Nurses to support this programme and newly qualified Nurses. • Establishing educational partnerships arrangements with Glyndwr and Bangor Universities, and Llandrillo College in relation to the creation of new courses to support the further/higher education such as Clinical Nursing Fellowship Programme/Part-time BN/Level 2- 4 NVQ • Creation of careers framework • Development of a Professional Nurse Strategy Reviewing the quality of nursing care is an important factor when calculating Nurse staffing levels. The senior nursing team via their respective internal weekly scrutiny meetings review Patient harm incidents relating to grade 3 / 4 hospital acquired pressure ulcers (HAPU's), falls which have resulted in either serious harm or death, Medication related Never events and complaints relating to nursing care for the purpose of Welsh Government reporting framework. However, it should be noted that all lower level HAPUs, Falls, Medication administration Incidents and complaints regards nursing care are reviewed using the same methodology. All reviews consider whether Nurse staffing levels have been maintained at the time of the incident or complaint, and if not, whether failure to maintain the Nurse staffing level contributed to any harm suffered by the patient. The review also considers whether there are lessons to be learnt, and good practice that can be shared.

Conclusion & Recommendations	
	The Health Board has been fully compliant with the bi annual calculation for 25B wards. The dynamic and moving nature of repurposed wards due to Covid-19 makes it difficult to determine which wards met the 25B criteria and progress to annual triangulation as required, however staffing is reviewed at each shift change over and all actions taken to mitigate risk taken and recorded via safecare with no escalation of safety issues escalated. The activity, acuity and quality data for repurposed wards cannot be compared to support a comprehensive triangulation. Specific patient outcomes of concern in a small number of wards were clearly identified during the review cycle. Actions agreed between the Head of Nursing and Director of Nursing have included undertaking a 'deep dive' into the data to ensure the root cause is clearly understood so that there is confidence that any actions taken are focussed on solving the problem; and continuing with quality improvement initiatives already commenced. Wards where care quality improvement actions are required will be monitored during the coming months, with a formal review being undertaken during the Spring 2022 in line with the Nurse Staffing Levels review cycle. This Nurse Staffing Levels review cycle has clearly demonstrated a requirement to establish two pathways (i.e. COVID-19 and non-COVID19 pathways) within many services, in particular the 'front door services' which has added significant additional workforce requirements/staffing costs to acute sites generally and to Section 25B wards specifically. The impact of these costs varies across sites, depending on the extent to which interdependencies between 'front door' clinical services (non S25B areas) and ward services (S25B areas) have impacted. A further theme to emerging from the Nurse Staffing Levels review for some wards was the specific needs of the frail elderly patients (including but not limited to those patient with cognitive impairment) who are forming an increasing proportion of our patient cohort. It is proposed that the potential for providing learning and development opportunities for staff in relation to the care of frail elderly patients will be explored and piloted as soon as possible, linking in closely with those colleagues responsible for taking forward the Health Board's strategic developments in this field. The Nurse staffing bi-annual reviews identified an increase in the reported level 3 and 4 of the Welsh Level of Care. This is attributed to the increased enhanced observation needs of complex comorbid patients, exacerbation of acuity and late presentations, increase in frail, elderly patients who may not be able to progress their care due to COVID 19 isolation guidance for care homes. Recommendations for next steps which will be monitored by the Nursing Recruitment and Retention Group include: • Increase the availability of Healthcare Support worker provision with the premise of 'grow your own' HCSW development pathways to achieve level 4 qualification and/or pursue further opportunity to become a registrant has been a proven success. • Development of a recruitment and resourcing business case to increase ability to expedite recruitment and increase volume. • Develop and retain staff through the introduction of leadership development programmes commencing with Matrons which will extend to include Ward Managers, Heads of Nursing and subsequently aspirant programmes.

	• Development of collaborative Career Clinics supported by Workforce & Organisational Development to further develop career pathway opportunities and aid stability within the current workforce. • Exploration of the Global Learning Programme which would offer a three year work-based educational opportunity for overseas nurses to work in the NHS, embedding global skills, learning and innovation. • Effective utilisation of substantive staff through the introduction of targeted monitoring across rosters, through KPI management to reduce agency expenditure and maximise substantive staff usage. • Develop a continued long term sustainable workforce via succession planning including the progression of existing band 4 roles through to fast track nurse training and supporting and progressing band 2/3 nursing roles into future band 4 roles • Succession planning for the future, ensuring we are developing our next generation leaders • Creatively co-designing our post graduate programmes as key attractors supporting the University status held by the Health Board • Analysing workforce data to better inform Nurse Retention strategies and initiatives and ongoing analytics regards leavers and 'what could we do better?'

Appendix 2 Summary of Nurse Staffing Levels for wards where Section 25B applies

Health Board/Trust:	Name: Betsi Cadwalader UHB	
Period being reported on :	Start date: October 1st 2020 End Date: September 30th 2021	
Number of wards where section 25B has applied during the period:	**Medical: YWM 8 YG 6 YGC 8**	**Surgical: YWM 5 YG 5 YGC 5**
	Paediatric inpatient wards: YWM 1 YG 1 YGC 1	

***Supernumerary i.e. 1 WTE supernumerary ward sister/charge nurse included in the establishment**

YWM Medical

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the end of the reporting period (Sept 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Acton	E	5	4	25.58	17.88	Yes	E	5	4	25.58	15.03	Yes	Yes	No	No change to staffing numbers, budget change due to realignment	No		
	L	5	3				L	5	3									
	LD						LD											
	TW						TW											
	N	4	2				N	4	2									
ACU	E	6	3	30.5	14.67	Yes	E	6	3	31.27	13.66	Yes	Yes	No	No change to staffing numbers , budget change due to realignment	No		
	L	6	3				L	6	3									
	LD						LD											
	TW						TW											
	N	5	2				N	5	2									
Bersham	E	5	3	26.58	13.67	Yes	E	5	3	25.58	13.66	Yes	Yes	No	No change to staffing numbers, budget change due to realignment	No		
	L	5	3				L	5	3									
	LD						LD											
	TW						TW											
	N	4	2				N	4	2									

E = Early shift	L = Late shift	TW = Twilight shift	LD = Long Day	N = Night duty
The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.				

Bonney	**E**	**4**	**3**	**19.9**	**16.40**	**Yes**	**E**	**4**	**4**	**19.9**	**19.13**	**Yes**	**Yes**	**Yes**	In response to harm profile and increase enhanced observation requirement.	**No**		
	L	**4**	**3**				**L**	**4**	**4**									
	LD						**LD**											
	TW						**TW**											
	N	**3**	**3**				**N**	**3**	**3**									
Cunliffe	**E**	**4**	**3**	**18.3**	**15.67**	**Yes**	**E**	**4**	**3**	**19.9**	**13.66**	**Yes**	**Yes**	**No**	No change to staffing numbers, budget change due to realignment	**No**		
	L	**4**	**3**				**L**	**4**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**3**	**2**				**N**	**3**	**2**									
Fleming	**E**	**2**	**1**	**11.37**	**5.47**	**Yes**	**E**	**4**	**4**	**19.9**	**19.13**	**Yes**	**Yes**	**Yes**	In response to added escalation beds (19)	**No**		
	L	**2**	**1**				**L**	**4**	**4**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**1**				**N**	**3**	**3**									
Morris	**E**	**4**	**4**	**17.06**	**20.61**	**Yes**	**E**	**4**	**4**	**17.06**	**20.50**	**Yes**	**Yes**	**No**	No change to staffing numbers, budget change due to realignment	**No**		
	L	**4**	**3**				**L**	**4**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**4**				**N**	**2**	**4**									
Pantomine	**E**	**4**	**3**	**15.76**	**13.67**	**Yes**	**E**	**5**	**4**	**21.32**	**17.76**	**Yes**	**Yes**	**Yes**	Staffing of escalation beds (6)	**No**		
	L	**4**	**3**				**L**	**4**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**2**				**N**	**3**	**3**									

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YWM Surgical

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the end of the reporting period (September 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Arrivals (not previously an act ward)	E	0	0				E	3	3	20.30	16.2	Yes	Yes	Yes	Stepped up as an Act ward following reconfiguration of green elective pathway	No		
	L	0	0				L	3	2									
	LD						LD											
	TW						TW											
	N	0	0				N	2	2									
ENT	E	3	2	14.21	11.86	Yes	E	3	2	14.21	10.93	Yes	Yes	No	No change to staffing numbers, budget change due to realignment	No		
	L	3	2				L	3	2									
	LD						LD											
	TW						TW											
	N	2	2				N	2	2									
Erddig	E	6	3	28.42	16.4	Yes	E	5	3	25.58	16.4	Yes	Yes	Yes	Removal of green elective complex surgical patients to super green pathway (arrivals)	No		
	L	6	3				L	5	3									
	LD						LD											
	TW						TW											
	N	4	3				N	4	3									
Mason	E	4	6	22.51	19.13	Yes	E	4	6	19.90	23.23	Yes	Yes	No	No change to staffing numbers, budget change due to realignment	No		
	L	4	5				L	4	5									
	LD						LD											
	TW						TW											
	N	3	3				N	3	3									
Prince of Wales (mon-fri)	E	3	2	12.83	8.20	Yes	E	3	2	14.42	6.44	Yes	Yes	No	No change to staffing numbers, budget change due to realignment	No		
	L	4	1				L	4	1									
	LD						LD											
	TW						TW											
	N	2	1				N	2	1									
Prince of Wales (sat-sun)	E	2	1			Yes	E	2	1			Yes	Yes	No		No		
	L	2	1				L	2	1									
	LD						LD											
	TW						TW											
	N	2	1				N	2	1									

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YG Medical

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the end of the reporting period (Sept 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Glaslyn	E	4	5	17.91	23.16	Yes	E	4	5	19.9	21.86	Yes	Yes	Yes	Acuity at night and HARM profile supports increase of RN	No		
	L	4	5				L	4	5									
	LD						LD											
	TW						TW											
	N	2	3				N	3	3									
Glyder	E	3	2	14.45	7.44	Yes	E	3	2	13.4	11.71	Yes	Yes	Yes	Less 1 RN Sat/Sun LD. Plus 1 HCA Sat/Sun LD. Increase HCA due to patient care acuity – for example, more support required in terms of intentional rounding	No		
	L	3	1				L	3	2									
	LD						LD											
	TW						TW											
	N	2	1				N	2	2									
Hebog	E	5	3	23.65	11.73	Yes	E	5	4	22.74	19.13	Yes	Yes	Yes	Increase HCA due to patient care acuity – for example, more support required in terms of intentional rounding during day and night	No		
	L	5	3				L	5	4									
	LD						LD											
	TW						TW											
	N	3	1				N	3	3									
Moelwyn	E	5	3	24.07	13.11	Yes	E	6	4	28.43	19.13	Yes	Yes	Yes	Increased activity due to aerosol generating procedures which supports the increase in both RN & HCA	No		
	L	5	2				L	6	4									
	LD						LD											
	TW						TW											
	N	3	2				N	4	3									

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Prysor	**E**	**4**	**2**	**14.67**	**8.61**	**Yes**	**E**	**4**	**2**	**13.79**	**9.56**	**Yes**	**Yes**	**Yes**	Increase in HCA on twilight due to care needs of patients requiring support with intentional rounding	**No**		
	L	**3**	**2**				**L**	**3**	**2**									
	LD						**LD**											
	TW						**TW**		**1**									
	N	**2**	**1**				**N**	**2**	**1**									
Tryfan	**E**	**4**	**2**	**20.98**	**8.75**	**Yes**	**E**	**4**	**4**	**19.90**	**19.13**	**Yes**	**Yes**	**Yes**	Due to the HARM profile- increase in HCA's will support this activity	**No**		
	L	**4**	**2**				**L**	**4**	**4**									
	LD						**LD**											
	TW						**TW**											
	N	**3**	**1**				**N**	**3**	**3**									

YG Surgical

Ward	**Planned Roster**			**Required Establishment at the start of the reporting period (October 2020)**		**Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?***	**Planned Roster**			**Required Establishment at the end of the reporting period (Sept 2021)**		**Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?***	**Biannual calculation cycle reviews, and reasons for any changes made**			**Any reviews outside of biannual calculation, if yes, reasons for any changes made**		
		RN	**HCSW**	**RN WTE**	**HCSW WTE**			**RN**	**HCSW**	**RN WTE**	**HCSW WTE**		**Completed**	**Changed**	**Rationale**	**Completed**	**Changed**	**Rationale**
Tegid	**E**	**6**	**4**	**28.44**	**19.14**	**Yes**	**E**	**6**	**3**	**28.32**	**16.40**	**Yes**	**Yes**	**Yes**	Reduction in beds – staffing reflects this	**No**		
	L	**6**	**4**				**L**	**6**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**4**	**3**				**N**	**4**	**3**									
Dulas	**E**	**5**	**4**	**22.74**	**16.40**	**Yes**	**E**	**5**	**4**	**25.58**	**19.13**	**Yes**	**Yes**	**Yes**	Due to the change of clientele and aerosol generating procedures on the ward staffing is to protect this activity	**No**		
	L	**5**	**4**				**L**	**5**	**4**									
	LD						**LD**											
	TW						**TW**											
	N	**3**	**2**				**N**	**4**	**3**									
Ogwen	**E**	**4**	**5**	**17.36**	**21.86**	**Yes**	**E**	**4**	**5**	**19.90**	**21.86**	**Yes**	**Yes**	**Yes**	Increased acuity and HARM data supports increase in particular on night duty	**No**		
	L	**4**	**5**				**L**	**4**	**5**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**3**				**N**	**3**	**3**									

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Enlli	**E**	**3**	**2**	**13.26**	**7.42**	**Yes**	**E**	**4**	**2**	**15.92**	**8.20**	**Yes**	**Yes**	**Yes**	Newly established ward – super green elective orthapedic unit who will be managing post operative patients.	**No**		
	L	**3**	**2**				**L**	**3**	**2**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**1**				**N**	**2**	**1**									
Tudno	**E**	**6**	**3**	**11.90**	**6.09**	**Yes**	**E**	**4**	**2**	**18.60**	**17.57**	**Yes**	**Yes**	**Yes**	Significant change in ward activity and now resulting in a requirement to staff the unit over night	**No**		
	L	**6**	**3**				**L**	**4**	**2**									
	LD						**LD**											
	TW						**TW**											
	N						**N**	**3**	**3**									

YGC Medical

Ward	**Planned Roster**			**Required Establishment at the start of the reporting period (October 2020)**		**Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?***	**Planned Roster**			**Required Establishment at the end of the reporting period (Sept 2021)**		**Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?***	**Biannual calculation cycle reviews, and reasons for any changes made**			**Any reviews outside of biannual calculation, if yes, reasons for any changes made**		
		RN	**HCSW**	**RN WTE**	**HCSW WTE**			**RN**	**HCSW**	**RN WTE**	**HCSW WTE**		**Completed**	**Changed**	**Rationale**	**Completed**	**Changed**	**Rationale**
Ward 1	**E**	**4**	**3**	**17.53**	**14.01**	**Yes**	**E**	**4**	**4**	**19.07**	**19.70**	**Yes**	**Yes**	**Yes**	Acuity at night and harm KPI support increase- COTE wards aligned.	**No**		
	L	**4**	**3**				**L**	**4**	**4**									
	LD						**LD**											
	TW						**TW**		**1**									
	N	**2**	**2**				**N**	**3**	**3**									
Ward 2	**E**	**4**	**4**	**17.53**	**17.87**	**Yes**	**E**	**4**	**4**	**19.07**	**19.70**	**Yes**	**Yes**	**Yes**	Acuity at night and harm KPI support increase- COTE wards aligned.	**No**		
	L	**4**	**4**				**L**	**4**	**4**									
	LD						**LD**											
	TW		**1**				**TW**		**1**									
	N	**2**	**2**				**N**	**3**	**3**									
Ward 4	**E**	**4**	**3**	**17.53**	**14.01**	**Yes**	**E**	**4**	**3**	**19.07**	**15.71**	**Yes**	**Yes**	**Yes**	Acuity at night and harm KPI support increase	**No**		
	L	**4**	**3**				**L**	**4**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**2**				**N**	**3**	**3**									
Ward 9	**E**	**4**	**3**	**17.53**	**14.01**	**Yes**	**E**	**4**	**4**	**19.07**	**19.70**	**Yes**	**Yes**	**Yes**	Acuity at night and harm KPI support increase- COTE wards aligned.	**No**		
	L	**4**	**3**				**L**	**4**	**4**									
	LD						**LD**											
	TW						**TW**		**1**									
	N	**2**	**2**				**N**	**3**	**3**									

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Ward 11	**E**	**5**	**3**	**23.33**	**12.64**	**Yes**	**E**	**5**	**3**	**27.24**	**15.71**	**Yes**	**Yes**	**Yes**	Acuity at night and harm KPI support increase. Level 1 HDU area requiring 24/7 RN cover equal to day numbers.	**No**		
	L	**5**	**2**				**L**	**5**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**3**	**2**				**N**	**5**	**3**									
Ward 12	**E**	**4**	**3**	**17.53**	**14.01**	**Yes**	**E**	**5**	**4**	**21.79**	**18.33**	**Yes**	**Yes**	**Yes**	Acuity at night and harm KPI support increase. Level 1 HDU area requiring 24/7 RN cover equal to day numbers.	**No**		
	L	**4**	**3**				**L**	**5**	**4**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**2**				**N**	**3**	**3**									
Ward 14	**E**	**5**	**3**	**23.33**	**9.91**	**Yes**	**E**	**5**	**4**	**21.79**	**18.33**	**Yes**	**Yes**	**Yes**	Acuity at night and harm KPI support increase. Level 1 HDU area requiring 24/7 RN cover equal to day numbers.	**No**		
	L	**5**	**2**				**L**	**5**	**4**									
	LD						**LD**											
	TW						**TW**											
	N	**3**	**1**				**N**	**3**	**3**									
DOSA	**E**	**4**	**3**	**17.53**	**14.01**	**Yes**	**E**	**5**	**4**	**21.79**	**18.33**	**Yes**	**Yes**	**Yes**	Acuity at night and harm KPI support increase. Level 1 HDU area requiring 24/7 RN cover equal to day numbers.	**No**		
	L	**4**	**3**				**L**	**5**	**4**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**2**				**N**	**3**	**3**									

YGC Surgical

Ward	**Planned Roster**			**Required Establishment at the start of the reporting period (October 2020)**		**Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?***	**Planned Roster**			**Required Establishment at the end of the reporting period (Sept 2021)**		**Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?***	**Biannual calculation cycle reviews, and reasons for any changes made**			**Any reviews outside of biannual calculation, if yes, reasons for any changes made**		
		RN	**HCSW**	**RN WTE**	**HCSW WTE**			**RN**	**HCSW**	**RN WTE**	**HCSW WTE**		**Completed**	**Changed**	**Rationale**	**Completed**	**Changed**	**Rationale**
Ward 3	**E**	**3**	**2**	**17.06**	**8.20**	**Yes**	**E**	**4**	**4**	**21.79**	**20.95**	**Yes**	**Yes**	**Yes**	Acuity over 24/7 period. On call vascular ward 24/7 Harm & acuity data support increase	**No**		
	L	**3**	**2**				**L**	**4**	**4**									
	LD						**LD**											
	TW						**TW**											
	N	**3**	**1**				**N**	**4**	**4**									

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Ward 5	**E**	**5**	**4**	**23.33**	**15.49**	**Yes**	**E**	**5**	**4**	**21.79**	**18.33**	**Yes**	**Yes**	**Yes**	Acuity across 24/7 period (ENT) and harm KPI support increase.	**No**		
	L	**5**	**4**				**L**	**5**	**4**									
	LD						**LD**											
	TW						**TW**											
	N	**3**	**2**				**N**	**3**	**3**									
Ward 6 (ABH)	**E**	**5**	**2**	**18.16**	**8.20**	**Yes**	**E**	**5**	**2**	**17.75**	**7.86**	**Yes**	**Yes**	**No**		**No**		
	L	**4**	**2**				**L**	**4**	**2**									
	LD						**LD**											
	TW						**TW**											
	N	**3**	**1**				**N**	**3**	**1**									
Ward 7	**E**	**5**	**4**	**18.07**	**19.58**	**Yes**	**E**	**5**	**4**	**21.79**	**18.33**	**Yes**	**Yes**	**Yes**	Acuity at night and harm KPI support increase.	**No**		
	L	**4**	**4**				**L**	**5**	**4**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**3**				**N**	**3**	**3**									
Ward 8	**E**	**4**	**3**	**17.53**	**14.01**	**Yes**	**E**	**5**	**4**	**24.52**	**18.33**	**Yes**	**Yes**	**Yes**	Acuity at night and harm KPI support increase.	**No**		
	L	**4**	**3**				**L**	**5**	**4**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**2**				**N**	**4**	**3**									

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Paediatric Inpatient Wards

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the end of the reporting period (Sept 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Wrexham Maelor	E			24.99	4.9	Yes	E			28.43	8.53	Yes	Yes	Yes	Inaugural triangulated calculation demonstrated uplift needed to meet needs of patients	No		
	L						L											
	LD	4	1				LD	5	2									
	TW						TW											
	N	4	0				N	5	1									
Glan Clwyd	E			22.75	5.69	Yes	E			28.43	11.37	Yes	Yes	Yes	Inaugural triangulated calculation demonstrated uplift needed to meet needs of patients	No		
	L						L											
	LD	4	1				LD	5	2									
	TW						TW											
	N	4	1				N	5	2									
Gwynedd	E			17.76	4.42	Yes	E			26.60	11.37	Yes	Yes	Yes	Inaugural triangulated calculation demonstrated uplift needed to meet needs of patients	No		
	L						L											
	LD	4	1				LD	5	2									
	TW						TW	1										
	N	4	1				N	4	2									

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The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.				

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 2nd November 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	NU06: The Prevention and Management of Adult In-patient Falls
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery / Deputy CEO
Awdur yr Adroddiad Report Author:	Mandy Jones, Interim Secondary Care Nurse Director Diane Read, Head of Quality Improvement (Corporate Nursing)
Craffu blaenorol: Prior Scrutiny:	Clinical Policies & Procedures Group – August 2021 Document consultation portal – August 2021. Targeted MDT consultation to ensure MDT engagement – August 2021 QSE Chair – September 2021 Patient & Safety Quality Group – September 2021
Atodiadau Appendices:	1. NU06 Policy 2. EQIA

Argymhelliad / Recommendation:

The Committe are asked to review the attached policy and ratify (for launch pan BCUHB November 2021).

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

BCUHB received a Health & Safety Executive (HSE) Notice of contravention following an Inpatient fall. HSE highlighted failings that included non-adherence to the existing policy in terms of staff training (in particular completion and action taken following risk assessment completion), sharing of information of inpatient falls risk when clinical environments change. These areas were not within the existing policy to support staff with their delivery of care.

Cefndir / Background:

Following receipt of the HSE Notice a Multidisciplinary Working Group was formed to review / update the Policy. This amended policy has been shared for consultation as follows:

- Pan BCUHB via communication channels and local networks;
- Uploaded onto the "Draft Policies and Written Control Documents for Comment" Intranet page;
- Presented to the Clinical Policies and Procedures Group on the 23rd August 2021;
- Presented to the Patient Quality & Safety Group for ratification on the 14th September 2021;
- Submitted for QSE Chair's Action in September 2021 - minor amendments advised.

Feedback (following above consultation) was then collated (to provide an audit trail should HSE require this), reviewed amended to reflect applicable feedback.
Asesu a Dadansoddi / Assessment & Analysis
Goblygiadau Strategol / Strategy Implications Please see appendix 2 (EQIA).
Opsiynau a ystyriwyd / Options considered No further options considered as older version of policy unfit for purpose following receipt of HSE notice.
Goblygiadau Ariannol / Financial Implications *N/A*
Dadansoddiad Risk / Risk Analysis *N/A*
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance Policy updated in line with HSE Notice.
Asesiad Effaith / Impact Assessment Please see appendix 2 (EQIA).

Version & Reference Number
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The Prevention and Management of Adult In-patient Falls

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Documents to be read alongside this document:	• BCUHB Policy for Using Bed Rails Safely and Effectively MD07; • BCUHB Guideline for the Management of Delirium for Adults ≥18 years in acute care and long term care settings MM17 • BCUHB Concerns Policy PTR01a • BCUHB Guidelines for Adult Patients Requiring Enhanced Observation and Engagement within Acute and Community Hospitals • BCUHB Levels of Enhanced Care for Adult Inpatients Policy NU21 • Dementia Care pathway • NICE National Institute for Health & Care Excellence Falls in Older People Quality Standard Published 25 March 2015 • Safeguarding Policy • Concerns Policy PTR01a http://www.wales.nhs.uk/governance-emanual/health-and-care-standards-supporting-gui-17
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N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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1. Introduction/Overview

Falls are the most frequently reported adult in-patient clinical incident and are a significant patient safety challenge for the NHS in Wales. There are more than 240,000 reported falls in acute hospitals and mental health trusts in England and Wales every year (that is over 600 a day) *Royal College of Physicians. National audit of inpatient falls Audit report 2015. London: RCP, 2015*. The effects of falls can range from no harm to serious injury and death. However, even those falls that do not result in serious physical harm can cause a great deal of distress, resulting in consequences that can threaten an individual's independence, confidence and general wellbeing. Betsi Cadwaladr University Health Board (BCUHB) has reported an increasing picture of falls and falls with harm and as such it is timely to ensure the necessary safeguards are in place and being carried out to minimise, not just the number of falls but also the associated complications and distress for the individual across all the health board wards.

2. Policy Statement

To ensure BCUHB incorporates the All Wales Falls and Bone Health Multifactorial Assessments (FBHMA) *(*Appendix 1) as part of the Nationally Standardised Adult Inpatient Assessment and Core Risk Assessments. This will be embedded through collaborative working and aligned to the All Wales Safeguarding Procedures to ensure the risk of all categories of harm (to all adult in-patients) caused by falls is minimised.

This policy describes the risk assessment and management of all adult in-patients admitted to BCUHB. The risk assessment and appendices are to be used to deliver safe and effective care by maintaining a safe environment and effective management of risks of patients falling whilst in our care by care planning/ prevention interventions and management of Risk Assessment findings.

Definition of a fall

For the purpose of this policy, Falls are commonly defined as

"An event which causes a person to, unintentionally, rest on the ground or lower level, and is not a result of a major intrinsic event such as a stroke) or overwhelming hazard" NICE guidance Falls: applying All Our Health August 2017 and RCN www.rcn.org.uk/clinical-topics/older-people/falls.

3. Purpose

Health care professionals have a duty of care to minimise risks to their patients. BCUHB aims to take all reasonable steps to ensure the safety and independence of its patients, and respects the rights of patients to make their own decisions about their care following an appropriate framework to support this (where the person lacks capacity to do so independently).

Inpatient falls are one of the most frequently reported incidents within BCUHB. The consequence of a fall can be more than a physical injury alone and can have a significant bearing on the individual's wellbeing and future options. Falls can be both a cause and a consequence of delayed transfer of care. Falls can impact someone's confidence not just in mobilising but in all independent tasks. There is a strong correlation between falls and age and as BCUHB's patient population increases in age and complex multi-morbidity, the challenge to reduce the number of falls (and the experience of harm from falls) is significant.

Adult inpatients on hospital wards may be at risk of falling for many reasons including:

- a history of falls;
- medically unwell;
- hypoxia (reduced oxygen levels);
- altered cognition including dementia or delirium;
- the effects of their treatment or medication;
- impaired mobility;
- visual and other sensory impairments along with their mental health and general wellbeing;
- Environmental disorientation.

Although most falls result in no physical harm or ongoing distress, falls do sometimes result in catastrophic injury, be that emotional or physical, including death. Some falls are a potential consequence of promoting patients' autonomy and encouraging recovery of mobility after acute illness or surgery with positive measured risk management continuing to be encouraged.

The purpose of this policy is to ensure all preventative measures are known and in place where applicable, all falls are reviewed and information scrutinised with lessons learned shared across BCUHB for shared learning.

4. Aims and Objectives

The aim of this policy is to demonstrate our commitment to ensuring that our staff manage the optimal prevention of falls in the inpatient setting when caring for adult inpatients who may be at risk of falls and management of patients immediately post fall.

Many falls are preventable and therefore the objectives of this policy are to:

- Support person centered care planning (including advanced care decisions where applicable).
- Ensure that effective processes are in place for assessing patients (and therefore recognising those at risk of falls).
- Ensure the completion of the All Wales Falls and Bone Health Multifactorial Assessment (FBHMA – Appendix 1) on admission for all adult inpatients.
- Implement effective, timely, multi-factorial intervention which reduces the number of patient falls and subsequent injury to those who have fallen.
- Ensure a safe environment using effective assessment and intervention.

- Ensure effective assessment, management and rehabilitation for those who have fallen or those who are at risk of falling.
- Establish a multi-disciplinary approach to FBHMA and management.
- Support patients to remain independent, empowered and safe.
- Support the implementation of the All Wales Safeguarding procedures in relation to falls.

5. Scope

This policy applies to all staff involved in the direct or indirect care of adult inpatients regardless of grade or profession and includes bank, locum and agency. The policy provides all health care practitioners with a clear framework for safe and effective practice relating to the prevention and management of the risks of inpatient falls and sets out the standards and competencies expected when performing this role.

6. Roles and Responsibilities

6.1 Chief Executive

The Chief Executive has overall responsibility for strategic direction and operational management, including ensuring that BCUHB policies comply with the legal, statutory and good practice guidance requirements.

6.2. The Health Board

The Health Board has responsibility for setting the strategic context in which this policy will be implemented and the resources required for effective training.

6.3. Patient Safety and Quality Group (PSQG)

This Group has responsibility for monitoring the assurance framework and assuring the Health Board's compliance this policy.

6.4. Strategic Falls Group (SFG)

The SFG will monitor the delivery of the FBHMA (Appendix 1) and provide assurance to the Executive Management Group (EMG) via the Executive Director of Nursing and PSQG as a routine cycle of business regarding effective progress with implementation.

6.5. Local Senior Managers e.g. Directors of Nursing and Divisional Directors

Local Senior Managers are responsible for ensuring that:

- This policy is implemented and adhered to (across their services).
- Training or education needs are identified and met.
- Requirements for implementation of the policy are built into the delivery planning process.
- Staff have received, are aware of and comply with all relevant policies and supporting documentation.

6.6. Senior clinical leads, Heads of Nursing, Matrons and Ward managers:

Senior clinical leads, Heads of Nursing, Matrons and Ward managers are responsible for ensuring that:

- Processes and arrangements are in place to support the implementation of the policy via their operational structures across all clinical areas in the divisions.
- Related investigations are completed in the applicable timeframe stated within Concerns Policy PTR01a and themes and learning from serious incidents and that Root Cause Analysis investigations are disseminated.
- Staff within their area are aware of their role and responsibilities in relation to the FBHMA (Appendix 1).
- Staff are giving adequate time to complete mandatory Adult Inpatient Falls Training (see section 13).

6.7. Corporate Health and Safety Team

The Corporate Health and Safety Team are responsible for ensuring that:

- Accessible training is provided for employees.
- Training is compliant with Module E in the All Wales NHS Manual Handling Training Passport and Information Scheme (Passport Scheme).
- Escalation if training resources are inadequate to meet the demands of the organisation.

6.8. All Clinical Staff

All Clinical staff, including bank, locum and agency staff, are responsible for:

- Compliance with the policy.
- Identifying a training need in respect of policies and procedures and bringing it to the attention of their line manager.
- Assessing all adult inpatients by completing the FBHMA (Appendix 1) and undertake interventions and signposting within their scope of practice.
- Working collaboratively with multi-disciplinary team members to manage individual FBHMA (Appendix 1) risk factors in accordance with the NHS Wales Governance e-Manual/Supporting Guidance Standard 2.3 *http://www.wales.nhs.uk/governance-emanual/health-and-care-standards-supporting-gui-17*
- Escalate through Ward Manager / Matron / Head of Nursing any resource implications, which affect completion of the FBHMA (Appendix 1) in the clinical area.
- Ensuring that the local risk register is accurate and reflects risk, controls and assurances that are in place, to minimise the risk of harm from inpatient falls.
- Ensuring escalation of FBHMA (Appendix 1) and bone health related incidents and / or trends are reported, investigated and escalated in line with BCUHB Concerns Policy (PTR01a).

7.1 Falls Assessment Process

All adult inpatients must be risk assessed using the National standardised risk assessment tool FBHMA (Appendix 1) in the following circumstances:

- Within 6 hours of admission and on transfer to other clinical areas (for example, from the Emergency Department to Acute Medical Unit, Surgical Assessment unit or any other wards).
- Following change of location within the ward (for example, adult inpatient moved / changed bed location from a shared bay area to side room).
- Adult inpatient physical or cognitive condition has changed (for example, patient undergone anaesthetic; patient has developed an infection leading to delirium, changed mobility, changed mobility aid etc).
  Weekly reassessment of all Adult in-patients using the FBHMA is mandatory (if no conditional change or ward location change or transfer between wards has required a reassessment previously).

An additional training (E learning module level 1b) to support completion of the Falls and Bone Health Multifactorial Assessment must be completed by Clinical staff responsible for risk assessing adult in-patients using the FBHMA (Appendix 1).

7.2 Falls Prevention

Once risk assessed, all adult inpatients **MUST** have the appropriate actions and interventions documented on the FBHMA tool (Appendix 1).

Mobility aids used by patients to support mobility / transfer must be within easy reach of the patient if able to mobilise independently.

Appropriate chair and bed heights should be used for adult inpatients according to their height and needs.

Bariatric adult inpatients will require specialist equipment (chairs/beds) and will require assessment for Manual handling equipment.

Call bells **MUST** be within easy reach of patients at all times. Orientation to the ward and surrounding environment **MUST** include a demonstration of how to use the call bell and patient observed using the call bell.

All patients at risk of falls **MUST** have a bed rail risk assessment completed within 4 hours admission to the ward. The bed rail assessment (Policy for Using Bed Rails Safely and Effectively: MD07) is contained within the BCUHB Adult Inpatient Risk Assessment booklet / documentation. This risk assessment informs the nurse when bed rails should be appropriately used or avoided (dependant on patient risk).

Lying and standing blood pressure must be performed on admission (if not contraindicated) to identify possible postural hypotension for all patients over 65yrs, for all patients following a fall and all patients presenting with Acute Kidney Injury (AKI). Refer to Royal College of Physicians Guidelines (Appendix 2) for taking a lying and standing blood pressure.

An underlying cause for postural hypotension should be investigated and discussed with the MDT and all actions documented in the patient medical records. The patient must be educated in steps to reduce the risk of falling as a consequence (e.g. sitting for a few minutes longer before standing).

At risk patients (where possible) should be nursed in the safest available location of the ward depending on clinical need and risk.

For at risk patients, staff are responsible for ensuring the patient has safe footwear when mobilising (Appendix 3). Patient's own well-fitting footwear is always the first choice in falls prevention. For patients who do not have access to safe footwear, double tread anti- slip socks must be provided by the area as a last resort for a short period **ONLY** (if family or carers cannot help with providing safe footwear).

All adult inpatients with a sensory deficit **MUST** have the details documented on the FBHMA (Appendix 1) and where able document discussion with patient and family / carers to ensure correct communication aids are available (such as correct glasses, hearing aids etc). All communication aids **MUST** be within easy reach and cleaned appropriately. Visual checks can be undertaken at the bedside for patients who are uncertain of their visual acuity using the Royal College of Physicians instructions for bedside vison checks (see Appendix 4).

Wards with several at risk patients **MUST** consider cohorting these patients, to allow for optimum visibility of that group whilst avoiding any mixed sex accommodation breaches.

The member of staff appointed to a cohort area on the ward cannot leave the area until he or she has another staff member to take over. If the staff member responsible for observing a cohort patients is required to perform a duty which would prevent them from maintaining eye contact with their patients (e.g. to go behind curtains to attend to another patient, or assist a patient to the bathroom) wherever possible, they must inform another member of staff to ensure continuous observation is maintained.

If a member of staff needs to hand over the responsibility for observing to another member of staff the handover **MUST** be clearly communicated between the two members of staff.

The Enhanced Care Risk Assessment and scoring tool (Appendix 5) should be used, along with the clinical judgement of staff to aid decision making.

For those patients who do require enhanced observation who are able to mobilise to a bathroom/ toilet enhanced observation **MUST** continue to be adhered to throughout all aspects of care delivery.

For those patients with mental capacity (who refuse enhanced observation) risks **MUST** be discussed with the patient and family (if applicable) and documented in patient records.

BCUHB Intentional Rounding / SKIN Bundle supports regular patient reviews for assistance with care and environmental checks in terms of clutter, mobility, and call bell access to the patient.

Nursing staff **MUST** provide patients with falls prevention educational information, and where appropriate then ask patients to teach back the key points. The provision of falls prevention education should be documented in the patient records. This process is repeated until the patient demonstrates comprehension and again if they have a fall.

For adult inpatient with a diagnosed Cognitive Condition the BCUHB Dementia Pathway (Appendix 6) **MUST** be adhered too.

At the earliest opportunity (following admission) in discussion with the Patient and /

or family / carers the 'This is me' document (Appendix 7) **MUST** be completed or reviewed/updated.

An alert symbol **MUST** be placed on the board above the bed, communicated on handover and ward safety brief ensuring all those involved in the patient's care are aware of their risk of falling. Alert symbols are contained within the Ward Accreditation E handbook to support MDT Communication.

Medical Staff are responsible for checking if patients have received a medication review by GP annually, and ensuring a timely medication review by pharmacy colleagues is completed (following inpatient admission) to ensure analysis and review of medications that may contribute to patients' risk of falling. This can be evidenced in the patient medical records (preferably at clerking or at the first opportunity to clarify patient's medications with carer or GP).

Medical staff are responsible for ensuring a cardiovascular review is conducted. The outcome of the reviews and actions required **MUST** be discussed with the multidisciplinary team and clearly documented in the patient's medical record.

Medical staff are responsible for ensuring undiagnosed or acute confusion is investigated, treated and documented within the patient records. Any actions required **MUST** be discussed with the multidisciplinary team and clearly documented in the patient's medical record. The BCUHB Guideline for the Management of Delirium for Adults ≥18 years in acute care and long term care settings (MM17) should be considered.

Medical staff are responsible for ensuring an eyesight or hearing assessment. If more comprehensive or sophisticated assessment is required, referral to Ophthalmology or Audiology must be considered. Any actions required **MUST** be discussed with the multidisciplinary team and clearly documented in the patient's medical records.

In line with assessment actions (once a referral is received by Therapy Services) the physiotherapist is responsible for ensuring a mobility review is undertaken. Any actions required **MUST** be discussed with the multidisciplinary team and clearly documented in the patient's medical records.

The Registered Nurse is responsible for ensuring the All Wales Continence/Toileting Risk Assessment is completed within 4 hours of admission to the Ward.

All staff are responsible for ensuring the environment, including bed spaces and main patient walkways remain clutter free at all times.

All staff are responsible for ensuring that drinks, call bells, mobility aids and personal belongings, including spectacles and/or hearing aids if required, are left within in easy reach of the patient on completion of care. Consideration **MUST** be given to patient's normal home routines for example bedside table on the left hand side of bed at home positioning of bedside table on left hand side as an inpatient.

On transfer of care from one clinical area to another (including the Emergency Department and Critical Care) a transfer / handover document (SBAR form) **MUST** be completed in adherence to Patient Transfer Policy NU19. Any inpatient with an identified falls risk **MUST** be clearly communicated to the receiving department. The FBHMA (appendix 1) **MUST** then be reassessed and updated by the receiving ward for all Adult inpatients.

All Staff to promote activity (where possible) to prevent deconditioning of the patient by encouraging participation and independence with activities of living such as washing, dressing, walking, standing and maintaining hydration and nutrition (PJ Paralysis Campaign).

If a patient has a potential or confirmed infection risk requiring isolation precautions in a side room (and has in addition been identified at an increased risk of falls), a multidisciplinary team (MDT) discussion of all risks should take place using clinical judgement to determine the risk for closure of the side room door. Advice can be sought from Infection Prevention Team. Prevention strategies **MUST** be put in place to mitigate any risk for the patient and the clinical area. The Registered Nurse **MUST** document rationale for side door to be open in patient records.

Falls medication review to be completed by ward pharmacist (dated and signed). This should include a review of the patients' social history, anticholinergic burden score, antipsychotic use etc. The review and actions **MUST** to be documented in the patient medical records.

For Patients who have history of fractures and possible Osteoporosis an MDT review and further investigation/screening maybe required, the review and actions **MUST** be documented in the patient medical records.

For Women within our Maternity inpatient areas (following an epidural for a planned or emergency Caesarean Section) the Registered Midwife **MUST** adhere to the guidance outlined within the BCUHB Integrated Care Pathways (ICP) for BCUHB Planned Caesarean Section ICP or BCUHB Emergency Caesarean Section ICP.

7.3 Post Falls Management

A registered practitioner **MUST** undertake appropriate action in the event of a patient fall. The post fall procedure **MUST** be followed immediately following a fall (Appendix 8) the post fall procedure should be available on view for all staff to access easily.

The correct Manual Handling Equipment **MUST** be accessed and used once the patient is safe to move from the floor to a place of safety.

Once the patient is safe and clinically stable the BCUHB Post Falls Checklist (Appendix 9) will support further on going actions to reduce the risk of another fall.

All staff on duty at the time of the inpatient fall (including members of the MDT), **MUST** complete the Hot Debrief to identify opportunities for learning and making it safe in preparation for ward handover and safety briefs, once the patient is safe and comfortable.

In the event of an inpatient fall, a full review of FBHMA (Appendix 1) and updated interventions **MUST** be documented and actioned.

All inpatients post fall **MUST** be referred to the ward pharmacist for a further medication review. The Pharmacist **MUST** document all action points within the patient medical records.

All patient falls **MUST** be reported through the Health Boards' incident reporting system: Datix.

All falls should be identified on the local measles map (Appendix 10) of the ward if applicable to that in patient area to support local Quality Improvement.

All falls of moderate harm and above are reviewed by a daily panel led by the Corporate Patient Safety Team which will identify those falls that meet the threshold for a serious incident investigation (i.e. severe, permanent harm or death). All serious incident investigations are scrutinised at a Corporate Incident Learning Panel. This panel provides senior, objective scrutiny and again provides a forum for themes or hot spots to be identified. These forums are in addition to divisional level harms panels which review harm on a weekly basis led by senior clinical staff.

Patient falls identified as a 'work-related accident' and result in either a bone fracture (excluding digits) or unconsciousness, are reportable to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). For a patient fall to be identified as work-related, one of the following must have played a significant role: either the way the work activity was carried out; or if any failure of equipment or the condition of the site or premises was contributable. The statutory timescale for reporting this category under RIDDOR is up to ten days from the date of the fall. The patients name, date of birth, address and postcode should be detailed on the Datix at the time of completion. All RIDDOR reports are made to the HSE via the HSE Website by the Corporate Health and Safety (H&S) Team. Therefore, if a patient fall results in a fracture (excluding digits) or unconsciousness, the RIDDOR box on Datix should be ticked so that the Corporate H&S Team is alerted and the initial investigation report should be uploaded onto the Datix report within three days of the date of the fall. The initial investigation report should include information in relation to the falls risk of the patient, whether the assessment of this risk had identified a requirement for mitigation and if so, whether this mitigation was in place at the time of the fall. It should also include details regarding the environment where the fall occurred and of any equipment involved. It is important that this three day timescale is met, to ensure enough time to for the Corporate H&S Team to review this information, make further enquiries if necessary and to report appropriately within the ten day statutory timescale. Any death that may be attributable at least in part to a fall should be referred to the Coroner (Coroners and Justice Act 2009).

7.4 Monitoring & Compliance

Falls incident data will be analysed and any trends, patterns or lessons learned will be shared across the organisation via the Fall's Steering group, local Falls prevention groups, Quality and Safety groups and Local Professional Forums.

Monitoring for compliance with completion of the FBHMA and required falls prevention interventions will be undertaken on a monthly basis using the Ward Manager and Matrons metrics.

Monitoring of compliance for the post fall procedure and handover process of patients deemed at risk of an inpatient fall will be undertaken on a monthly basis using the Ward Manager and Matrons metrics.

All data will be available for public view on the patient safety notice boards on entering or within inpatient wards.

7.5 Patient Transfer

Prior to any transfer (internally or externally) it is the responsibility of the Registered Nurse looking after the patient to ensure that transfer is safe, comfortable and dignified for patients. The Safe Transfer Guidance NU19 supports the transfer of patients. The Registered Nurse **MUST** complete the SBAR handover document with the receiving ward ensuring clear communication of the Falls risk of the patient before transfer. For all transfers the receiving ward **MUST** update the FBHMA (Appendix 1) within 4 hours of the patient being received.

7.6 Patient Discharge

For patients who have had a fall whilst an inpatient (or deemed at risk of further falls on discharge) the Allied Health Professional / Registered Nurse / Medical Staff are responsible for working towards agreed interventions to help safe discharge to prevent further falls. From this agreed holistic discussion, include any safety advice / environmental improvements / lifestyle / specific written advice / leaflets or any follow up required by the relevant primary care / domiciliary members (where appropriate). This should involve notification to GP practice of the risks and interventions, including clear recommendations or actions for onward monitoring, support, or input from additional community MDT services (where appropriate).

All discussions and outcomes **MUST** be documented in the patient record and discharge letter as appropriate prior to discharge.

8.1 Safeguarding

The Social Services and Well-being (Wales) Act (2014) has 11 parts. Part 7 relates to safeguarding. The provision in part 7 requires Local Authorities to investigate where they suspect that an adult or child is at risk of abuse or neglect.

Section 126 (1) of the Act defines an “Adult at Risk” as an adult who:

a) Is experiencing or is at risk of abuse or neglect;
b) Has needs for care and support whether or not the authority is meeting any of those needs;
c) As a result of those needs is unable to protect him or herself against the abuse or neglect or the risk of it.

Definition of neglect:

“Neglect’ means a failure to meet a person’s basic physical, emotional, social or psychological needs, which is likely to result in an impairment of a person’s well-being (for example: impairment of the person’s health or, in the case of a child, an impairment of the child’s development).”

The Act imposes a duty on relevant partners, (which will include Health Boards and Trusts) to report to a Local Authority if there is reasonable cause to suspect that an adult or child is at risk.

The Wales Safeguarding Procedures 2019 provide guidance for anyone working with children and adults in Wales, whether in a paid or unpaid role, in the statutory, third (voluntary) or private sector, in health, social care, education, police, justice or other services. The Wales Safeguarding Procedures 2019 builds on statutory guidance in the Social Services and Well-being (Wales) Act 2014, Part 7 Safeguarding and specifically Working Together to Safeguard People: Volumes: 5 and 6. They ensure that safeguarding practice accurately reflects statutory guidance and is standardised across agencies in Wales. They replace the All Wales Child Protection Procedures 2008 and Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse 2010 (updated 2013)

8.2 Safeguarding: *What to consider for In-Patient Falls*

A fall can be reportable under the adult at risk process when there are concerns there is abuse or neglect linked to it. There could be concerns that the fall occurred because of abuse or neglect (including self-neglect) or that care and treatment following a fall was abusive or neglectful. You will need to decide whether any of the following categories of abuse apply:

- Neglect: Person(s) responsible for the care and support needs (whether paid/unpaid) did not carry out their responsibilities as expected before or after the fall. This would include unwitnessed walls when patient is on observation, multiple falls of same patient when no clear review has taken place.
- Organisational abuse: The fall occurred because of wider systemic failures within an organisation.
- Physical abuse: Someone pushed/tripped/struck the adult which resulted in the fall.
- Self-neglect: The fall occurred because of a lack of self-care, care of one's environment or a refusal of services. Mental capacity will be a key consideration in these cases and MUST to be clearly documented in the patients records.
- Psychological / emotional: Person(s) responsible for the care and support needs (whether paid/unpaid) and or other individuals not involved in the provision of care removing mobility or communication aids or intentionally leaving someone unattended when they need assistance. Also intimidation, coercion, harassment, use of threats, humiliation, bullying, pre or post fall.

It is required that you contact your designated safeguarding person (Safeguarding Specialist) for all adult at risk concerns. The need to seek advice should never delay any emergency action needed to protect an individual or group. Contact details can be found here: *Betsi Cadwaladr University Health Board | Contact the Safeguarding Team (wales.nhs.uk)*

9. Equality Impact Assessment including Welsh Language

This document is subject to an Equality Impact Assessment (EqIA) completed alongside the development of the document, reviewed by an expert group of multidisciplinary team members and submitted at time of document approval as part of the organisations governance framework.

10. Training & Implementation

All staff **MUST** complete the Mandatory Level 1a Adult Falls training on ESR. This training **MUST** be completed every 2 Years.

Additional training for all patient facing Clinical staff Level 1b **MUST** be completed on ESR this includes instruction on how to complete the FBHMA and the care and management of a patient following an in-patient fall.

All Clinical staff caring for patients MUST complete Level 2 Adult Falls training which will be delivered in the classroom by the Manual Handling Training Team. Module E will contain an overview/recap of the FBHMA, patient care falling / fallen / collapsed person training in line with the All Wales NHS Manual Handling Training Passport and Information Scheme (Passport Scheme) which incorporates training on the prevention of falls along with the organisations Post Falls Procedures. This training **MUST** be completed before a new employee commences in post where they may be moving / handling a patient and then every two years as part of their Patient Handling refresher training.

Both level 1 and level 2 will be recorded on the Electronic Staff Record in line with the mandatory training policy (WP30) with a competency attached for Organisational and management review of compliance.

The Person Specification to ensure competent trainers can be found in the All Wales NHS Manual Handling Passport Scheme.

All Clinical staff MUST complete mandatory Level 2 Adult Safeguarding training; an element of the training will include post Falls management.

11. Implementation

This policy will be cascaded via all electronic communication channels across BCUHB for all staff, verbally via the quality and safety groups Board to ward level. Specific launch events for Falls Prevention. The policy will also be accessible to the public via the BCUHB internet site.

12. Further Information - Clinical Documents

This Policy has been developed by an expert Multidisciplinary Team who reviewed current evidence and Organisational policies that are required to be reviewed in line with this policy. The evidence base provided for this policy. Includes:

- NICE Quality Standard Falls in older people

State of the nation – Wales report Royal College of Physicians

This policy has been developed with the specific needs of the older adult in mind in addition to all Adult inpatients with specific consideration for in-patients with confirmed diagnosis of Dementia.

13. Audit

Adherence to this policy will be subject to Audit and routine monitoring of key sections such as completion of the FBMHA, interventions and post fall management through the established weekly and monthly Health Board wide Ward Manager and Matrons metrics. These metrics are a Health Board requirement for all Adult inpatient wards. Data will be shared monthly with the Strategic Inpatient Falls steering group and as a routine cycle of business for PSQG.

14. Review

This document will be reviewed following a period of 3 years (or sooner if national evidence / research available).

15. References

- SA01 Adult at Risk Safeguarding Procedures;
- Wales Safeguarding Procedures 2019;
- NICE Quality Standard Falls in Older People March 2015;
- http://www.wales.nhs.uk/governance-emanual/health-and-care-standards-supporting-gui-17
- Cochran review

16. Appendices

Appendix 1	Fall and Bone Health Multifactorial Assessment
Appendix 2	Measurement of lying & standing Blood Pressure (RCP)
Appendix 3	Falls prevention & footwear
Appendix 4	Bedside Vision Check for Falls Prevention (RCP)
Appendix 5	Enhanced Care Risk Assessment & Risk Scoring / Plan of Care: Appendix 1: Levels of Enhanced Care for Adult Inpatients Policy: NU21 (page 15, 16 +17)
Appendix 6	Care Pathway for Patients with a diagnosis of Dementia on General Wards (Acute & Community Hospitals)
Appendix 7	This is Me (Alzheimer's Society)
Appendix 8	Immediate Post Fall Protocol
Appendix 9	Post Fall Checklist updated version
Appendix 10	Falls Measles Map (example only)

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

EQUALITY IMPACT ASSESSMENT FORMS

PARTS A (Screening – Forms 1-4) and

B (Key Findings and Actions – Form 5)

For:	*NU 06 The prevention and management of Adult In patient falls*
Date form completed:	*9th August 2021*

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?	Updated NU 06 The prevention and management of Adult In patient Falls
2.	Provide a brief description, including the aims and objectives of what you are assessing.	Betsi Cadwaladr University Health Board (BCUHB) has reported an increasing picture of falls and falls with harm and as such it is timely to ensure the necessary safeguards are in place and being carried out to minimize, not just the number of falls but also the associated complications and distress for the individual across BCUHB. This policy describes the risk assessment and management of all adult in-patients admitted to BCUHB. The risk assessment, identified risks and the evidence based interventions and care planning that are to be used to deliver safe and effective care by maintaining a safe environment and effective management of risks of patients falling whilst in our care. The policy and the appendices contained within it have been assessed in terms of the potential negative impact the policy and the appendices may have on equality of our Adult In patients.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	As per the Policies' on policies approval guidance, final approval will be via the Quality and Safety Executive Committee
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	The existing policy (NU06) will have been subject to Equality Impact Assessment. This was not able to be located and as the current NU06 has been reviewed and updated a new Equality Impact Assessment has been completed. Other policies that are related to (and influenced by) NU06 The Prevention and management of Adult Inpatient falls are as follows: • BCUHB Policy for Using Bed Rails Safely and Effectively MD07;

Part A Form 1: Preparation

Please answer all questions

		• BCUHB Guideline for the Management of Delirium for Adults ≥18 years in acute care and long term care settings MM17; • BCUHB Concerns Policy PTR01a; • BCUHB Guidelines for Adult Patients Requiring Enhanced Observation and Engagement within Acute and Community Hospitals; • Dementia Care pathway; • NICE National Institute for Health & Care Excellence Falls in Older People Quality Standard Published 25 March 2015; • Safeguarding Policy.
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	The policy key stake holders are all BCUHB staff with specific reference to clinical staff. Communication strategy for the Policy includes launch events, local groups BCUHB bulletin, social media, local and BCUHB forums.
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	Lack of engagement from staff with the training. Lack of time for staff to access level 1 training on ESR and level 2 for clinical staff face to face training 2 yearly as part of manual handling update.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	The policy covers all aspects from assessment to evidence based interventions for all Adult inpatients and provides clear instructions that must be followed by BCUHB staff who are responsible for assessment of Adult In patients. The policy also provides clear instructions to follow post fall of an Adult inpatient. The policy provides clear patient safety instructions to ensure all Adult in patients receive the same evidence based care promoting equality of care for everyone.

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		Yes		NU06 The Prevention and Management of Adult Inpatients Falls is specific to all Adult inpatients and will have a positive impact on their experience as it is evidence based interventions and assessment to maintain patient safety. This reviewed policy is more comprehensive and user friendly with clear interventions for HB staff to adhere too. The policy includes the requirements for training and this will have a positive impact on our older adults. Evidence base includes NICE Quality Standards.	Not applicable
Disability	Yes		Yes		NU06 will have no negative impact on inpatients with a disability however; the policy outlines the clear completion of the risk assessment tool that **MUST** be completed on admission for all adult in patients. This has specific consideration for assessment and intervention for Adult in patients with sensory deficit, mobility and cognitive related conditions whilst promoting the individuals level of independence. Evidence demonstrates that people with	Not applicable.

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

Please answer all questions

					physical impairment and sensory impairment are more likely to fall, therefore thorough assessment and interventions and actions taken and outlined within the policy will have positive impact. In addition there is a positive impact in the mental health and wellbeing of both older and disabled people through reassurance that the risk of falls is being positively addressed by the Health Board as evidence indicates falls can lead to loss of confidence, fear of falling loss of independence and increased risk of isolation.	
Gender Reassignment		NO			There is no negative impact identified for staff or patients in terms of Gender reassignment. The policy has been updated using gender neutral language. The policy references only once gender specific term as women on the maternity unit following Caesarean Section.	Not applicable
Pregnancy and maternity		NO			No negative impact on pregnancy or maternity, NU06 references the care and safety of women following an epidural following emergency and planned Caesarean section in terms of preventing falls.	Not applicable
Race		NO			There is no negative impact on race, language used in the policy is neutral.	Not applicable

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

Please answer all questions

Religion, belief and non-belief		NO			This policy has no negative impact on staff or patients from any faith community, non-belief background. The policy does not impact any rituals or philosophical beliefs. Staff are able to maintain their staff uniform in line with BCUHB uniform guidance when complying with this policy.	Not applicable
Sex		NO			The assessment is that there is insufficient evidence to determine that this policy has a negative impact upon staff or patients in terms of being male or female. The evidence used for this policy development references Older people as opposed to male or female: NICE Quality Standard Falls in older people highlights Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. State of the nation Wales report 2020 states there are approximately 12,500 inpatient falls in Wales each year in total highlighting the magnitude of the need to prevent falls regardless of male or female.	Not applicable
Sexual orientation		NO			The assessment is that there is insufficient research, and no evidence of implications or negative impacts related to patient sexual orientation.	Not applicable
Marriage and civil		NO			The assessment is that there is insufficient research, and no evidence of implications or negative impacts related to a patient's marital status.	Not applicable

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

Please answer all questions

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

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

Please answer all questions

Human Rights:

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

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

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

Please also consider these United Nations Conventions:

UN Convention on the Rights of the Child

UN Convention on the rights of people with disabilities.

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

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

Please answer all questions

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

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

Please answer all questions

Welsh Language:

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

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

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

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

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

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

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) *for further direction on how to complete this section please click here training vid p13-18)*	*Copy from Form 1* Updated NU 06 The prevention and management of Adult In patient Falls

2. Brief Aims and Objectives: (Copy from Form 1)	Betsi Cadwaladr University Health Board (BCUHB) has reported an increasing picture of falls and falls with harm and as such it is timely to ensure the necessary safeguards are in place and being carried out to minimize, not just the number of falls but also the associated complications and distress for the individual across all health board. This policy describes the risk assessment and management of all adult in-patients admitted to BCUHB. The risk assessment, identified risks and the evidence based interventions and care planning that are to be used to deliver safe and effective care by maintaining a safe environment and effective management of risks of patients falling whilst in our care. The policy and the appendices contained within it have been assessed in terms of the potential negative impact the policy and the appendices may have on equality of our Adult In patients.

From your assessment findings (Forms 2 and 3):

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

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

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity** Senior sign off prior to committee approval:	Name	Title/Role
	Diane Read Steven Grayston Debra Hickman	Quality Improvement Team Lead Corporate Nursing Assistant Area Director Of Therapy Services (Central) Secondary Care Nurse Director
	Debra Hickman	Secondary Care Nurse Director
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

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

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 2nd November 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Board Assurance Framework Update
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Louise Brereton, Board Secretary
Awdur yr Adroddiad **Report Author:**	Brenda Thomas, Corporate Affairs (Interim)
Craffu blaenorol: **Prior Scrutiny:**	Board Secretary
Atodiadau **Appendices:**	Appendix 1 – Updated BAF principal risk sheets Appendix 2 – Overview of all current BAF risks, leads and score for information

Argymhelliad / Recommendation:

That the Quality, Safety and Experience (QSE) Committee:

1. Approve the transfer of the monitoring of BAF21-07 – Mental Health Leadership Model; and BAF21-11: Culture-Staff Engagement from the QSE Committee to the Partnerships, People and Population Health (PPPH) Committee;
2. Approve the increase in the current risk score for BAF21-19: Impact of Covid-19 to 16 (4x4), from 12 (4x3) in light of ongoing high levels of community transmission;
3. Approve the increase in the current risk score for BAF21-01 Safe and Effective Management of Unscheduled Care to 20 (5x4) from 16 (4x4) in light of ongoing pressures; and
4. Note that further work to review and update the Key Field Guidance is continuing, including consultation with the Good Governance Institute for their advice and opinion.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

The BAF incorporates the principal risks that the Board believes could adversely affect the achievement of its strategic priorities. The latest round of updates to the BAF has incorporated re-alignment in accordance with the establishment of new committees and terms of reference as a result of the recent Governance Review, the revised Board risk appetite following approval of the refreshed Risk Management Strategy and Policy in July 2021, adjusted Executive portfolios and a consolidation of the previous Annual Plan and Budget risks to reflect Integrated Medium Term Plan requirements.

This merger has reduced the number of BAF risks from 22 to 21. Each has a risk sheet setting out risk scores, controls, mitigation and gaps for action. The risk sheets are live documents that are proactively re-assessed on a monthly basis and adjusted as necessary in response to the changing risk environment.

Each risk is allocated to a designated Committee for scrutiny and monitoring purposes; the QSE Committee has oversight of 10 principal risks. This a reduction in the number of risks assigned to the Committee since the BAF was last submitted to the Committee, given the establishment of new committees, as noted above. BAF21-07 – Mental Health Leadership Model; and BAF21-11 – Culture-Staff Engagement have both been allocated to the PPPH Committee.

The nominated Risk Lead, supported by the Office of the Board Secretary, has reviewed each of these and the latest iterations of the risk sheets are presented at Appendix 1.

Cefndir / Background:

The current BAF design and monitoring arrangements were approved by the Board in January 2021. The BAF works in conjunction with the Corporate Risk Register, which is concerned with risks to the organisation's operational objectives as opposed to the BAF's focus on strategic level priorities.

Ownership of the BAF rests with the Board. Day to day responsibility for its co-ordination sits with the Board Secretary, whose team works closely with Risk Leads and other Risk Management colleagues to ensure that it remains a robust, responsive and visible tool. As well as scrutiny by nominated Committees, the BAF's principal risks are subject to ongoing monitoring by the Executive Team, Risk Management Group and ultimately the Board itself.

The principal risks have been mapped across to the Board's strategic priorities; a wholescale review of the BAF will be required in the coming months, to ensure that it remains relevant to the priorities as the Board refreshes its overarching *Living Healthier, Staying Well* strategy. The services of the Good Governance Institute have been secured to provide expert support to this process in due course.

The updated position on the BAF risks assigned to the QSE Committee is summarised below (this information is also reflected within the relevant BAF risk sheet at Appendix 1):-

- **BAF21-01 – Safe and Effective Management of Unscheduled Care:** The current risk score has been increased to 20 (5x4), from 16 (4x4) in light of ongoing pressures. Work is ongoing on the agreed priority areas in each health economy. The deliverables for October - December 2021 have been identified in each health economy. New governance arrangements became operationalised in August. A workforce group is working on single recruitment campaign for Emergency Department and Same Day Emergency Care workforce recruitment. This will ensure that the Health Board funds and recruits to a robust and sustainable model for urgent care. Workshops have been set up in November and December to redesign the front door of our hospitals and develop and agree Internal Professional Standards. It has been agreed that there will be no separate winter plan this year and that the schemes are aligned to the USC improvement programme. Proposed winter schemes are being reviewed.
- **BAF21-04 – Timely Access to Planned Care:** Key progress since the last review relates to mitigations, gaps and actions updated to reflect current developments. The subject matter expert is reviewing the validation exercises for planned care. Work currently ongoing with Welsh Government regarding the introduction of risk stratification for stages 1-3 (outpatients and diagnostics). Regarding the introduction of outsourcing to undertake activity that supports

P2-3 activity and over 52 week waiters, there are a number of strands to this work i.e. orthopaedics, ophthalmology, dental, dermatology all of which are at differing levels of procurement. Expressions of interest are currently with the market to understand how quickly regional treatment centres could be operational. The anticipated date that the target risk score will be achieved is 31 March 2022.

- **BAF21-06 – Safe and Effective Mental Health Services Delivery:** Key progress since the last review relates to ongoing work to address the continuity of interim roles within the senior leadership team. Work is now in progress and maturing in relation to the Delivery of Targeted Intervention outcomes for Mental Health, with the Targeted Intervention Evidence Group scrutinising the evidence of accomplishment of the maturity matrix. It is anticipated that the target risk score will be achieved by the end of September 2022.

- **BAF21-08 - Mental Health Service Delivery during Pandemic Management:** Key progress since the last review relates to key controls, mitigations, gaps and actions updated to reflect current developments, including extension to some timelines. Review of 2021/22 Covid-19 winter plan underway to incorporate the clinical patient pathway. The year 1 priorities of the Wellness, Work and Us Strategies are being progressed and a review of the Covid-19 action cards is underway. All documents in relation to the Business Impact Analysis have been submitted to the BCU business continuity department. Monitoring and review continues with daily Personal Protective Equipment (PPE) stock levels and fit testing staff numbers included on the daily SITREP. Monitoring and review of Attend Anywhere utilisation is taking place across divisions.

- **BAF21-09 – Infection Prevention and Control (IPC):**
  The controls, mitigations and timelines have been reviewed, and scores remain unchanged but some actions have been revised. The action to recruit to increase IPC team resource has been completed. Work is ongoing with junior doctor colleagues on designing interactive training both for induction and ongoing training. The key control description 'Major Outbreak policy (IPO5) currently in place for managing Covid 19 infections' has become a key mitigation; while the key mitigation 'All IPC policies are in date and reviewed against Welsh Government guidance and best practice', has become the key control description.

- **BAF21-10 – Listening and Learning**: Target action dates have been reviewed and updated as appropriate, acknowledging the delay in roll out of the new Datix system and postponing the full implementation until the spring, thus avoiding roll out during the height of winter pressures. The delay in the Lessons Learnt Library is to align with the launch of the new Intranet. The target risk score is aimed for 31 March 2023 reflecting that in addition to system and process improvements, culture improvement is a key component.

- **BAF21-12 – Security Services:** Scoring has been reviewed and remains currently at 20 due to the ongoing security risk including a Health & Safety Executive (HSE) investigation into a suicide and planned formal inspection on 16 November 2021. Timelines for action have been extended. Business case to identify minimum standard approach now approved for one year. The Risk Lead considers the date by which it is anticipated that the target risk score will be achieved will be March 2022. It is acknowledged that the target risk score is higher than the risk appetite due to the complexity of services including Mental Health, Community Services and Emergency Department and Prison Health. A deep dive of this risk was undertaken at the October Risk Management Group meeting, where it was challenged that the inherent and

current risk scores were both 20 (5x4) which means that either the controls are not making any difference or the inherent risk score is incorrect.

- **BAF21-13 – Health and Safety:** The controls, mitigations and timelines have been reviewed, and scores remain unchanged but action timelines have been revised. It is noted that this score is higher than the risk appetite. As with BAF21-12 above, a deep dive of this risk was undertaken at the October Risk Management Group meeting, where it was again challenged that the inherent and current risk scores were both 20 (5x4). It is anticipated that the Target Risk Score will be achieved by 31 December 2022.
- **BAF21-14 – Pandemic Exposure:** The controls, mitigations and timelines have been reviewed, and scores remain unchanged but some actions have been revised and some target dates extended. It is proposed that the target date for elimination be changed and discussion to be had around how controls could be further strengthened. Whilst the risk on having adequate PPE stocks in place and maintained has been lowered, the mitigation is completely out of BCU's control. Self-isolation guidance has been updated to reflect Government guideline, but this potentially puts staff and patients at risk. This has been mitigated with the guidance around FFP3 mask and strongly recommended this happens in outbreak areas.
- **BAF21-19 – Impact of Covid-19:** Controls, mitigations, actions and timeframes have been reviewed and updated to reflect the current position on the pandemic. The current risk score relating to the impact of Covid has been increased to 16 (4x4), from 12 (4x3) in light of ongoing high levels of community transmission, although this needs to be balanced against the effect of the vaccination booster programme and the evidence of reduced levels of severe disease and hospitalisation. Demand on healthcare from Covid is stabilising, and the risk to staffing levels due to isolation not increasing as absence rates appears to be stabilising (alongside revised guidance on isolation for vaccinated individuals). The Prevention and Response Plan is being reviewed with partners, noting that there are gaps in capacity across all partner organisations to respond to potential rising community transmission and associated increases in testing and tracing. The Risk Lead is considering the date when it is anticipated that the target risk score will be achieved.

The heat map illustrating the position on current risk scores allocated to the QSE Committee is as follows:

Current Risk Level		**Impact**				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5			BAF21-14	BAF21-04	
	Likely - 4				BAF21-09 BAF21-19	BAF21-01 BAF21-06 BAF21-10 BAF21-12 BAF21-13
	Possible - 3			BAF21-08		
	Unlikely - 2					
	Rare - 1					

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol /Strategy Implications
The BAF underpins the effective management of risks to the Board's ability to achieve its strategic priorities.

Opsiynau a ystyriwyd / Options considered
Not applicable.

Goblygiadau Ariannol / Financial Implications
The effective mitigation of risks has the potential to benefit the organisation's financial position, through better integration of risk management into business planning, decision-making and in shaping how care is delivered to patients. This has the potential to lead to better quality care, reduced waste and fewer claims.

Dadansoddiad Risk / Risk Analysis
The individual risk sheets contain details of any related risk implications.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
There are no legal and compliance issues associated with the delivery of the BAF; the Board has a duty to manage risk to the best of its ability.

Asesiad Effaith / Impact Assessment
No specific or separate EqIA has been completed for this report, as a full EqIA has been undertaken for the new Risk Management Strategy and Policy, to which the BAF reports are aligned.

Board Assurance Framework 2021/22

Strategic Priority 5: Improved Unscheduled Care Pathways

Risk Reference: BAF21-01		Risk Rating	Impact		Likelihood		Score		Appetite	
Safe and Effective Management of Unscheduled Care (formerly titled Emergency Care Review Recommendations)										
There is a risk that the Health Board may not be able to deliver safe and effective care due to being unable to commit support processes. This could negatively impact on the quality of patient care provided.		Inherent Risk	5		5		25		Low 1 - 6	
		Current Risk	5	↑	4	↔	20	↑		
		Target Risk	4		3		12			

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Unscheduled Care Improvement Group in place to oversee the improvement programme of work and monitor performance which provides regular reports to the Performance Finance and Information Governance (PFIG) Committee.	2	1) All 3 localities Health Communities have an agreed USC Improvement plan which looks at the whole system with clear priorities set. 2) Improvement and programme management support in place to support delivery of the USC improvement programme objectives 3) 111 implemented across NW in June 2021 4) USC dashboard established which captures data and monitor performance against agreed USC measures 5) Established Tactical Control Centres in place. 6) Standardised SITREP / escalation reports submitted 3x day. 7) Urgent Primary Care Centre (UPCC) established in East 8) Priority focus within each workstream of the USC Improvement Programme identified 9) Business case for additional workforce in EDs has been signed off by Executive team 10) The SDEC development proposal has been partially funded by the WG (£1.6m/£2.7m is funded)	2	1) Ward based improvement work to focus on improving inpatient flow through facilitating earlier / timely discharges and criteria led discharge 2) accurate capturing of numbers on medically fit for discharge and clear management plan for patients to return to usual place of residence 3) In line with Welsh Government (WG) directive, implement 111 (Contact) First programme that will ensure patients are seen by the right person, in the right place, first time in line with 111 implementation is ongoing to link 111 and SICAT to divert patients to the right place and manage demand. This is included within the plans for the USC improvement programme 4) In line with the agreed standards implement a uniform model for patient access to and from Emergency Departments (EDs). It is part of the national EDQDF programme which BCUHB is working with WG to deliver. 5) Fully implement Same Day Emergency Care (SDEC) services across all three acute sites. Recruitment of the additional resource to ensure consistency of the service through operating hours 6) D2R&A (discharge to rehabilitate and assess) - Home First Bureaus established in each area to support discharge planning and step up / step down model of care in the community 7) Proposals for UPCCs to be further developed in Centre and business case for implementation in the West are included within the USC improvement programme 8) Bespoke training to upskill MIU workforce has been agreed to ensure consistency of offer from all MIUs.	November 2021 December 2021 December 2021 December 2021 March 2022 December 2021 December 2021 December 2021

Annual Plan in place and agreed by the Board, with monthly monitoring and review through the Unscheduled Care (USC) Improvement Group.	2	1)Monthly USC Improvement Group meetings Chaired by the Chief Operating Officer. 2) USC scoping review undertaken to develop strategic blueprint solution for unscheduled care	1	1) Implement recommendations of Kendal Bluck ED workforce review related to unscheduled care. recruitment campaign started 2) Executives have commissioned further work by Kendall Bluck to build in acute medical model on to the ED workforce plan, taking into account improved unscheduled care pathways currently being worked through the unscheduled care improvement plan. This will ensure that the Health Board funds and recruits to a robust and sustainable model for urgent care. This work is in progress as part of the SDEC development initially funded through additional fund from WG Single recruitment campaign is being developed to support delivery of workforce plans for ED and SDEC.	March 2022 November 2021
Interim COO / Interim Director of USC overseeing the Annual plan in respect of USC and variance to the plan with regular reporting to the PFIG Committee.	2	Bi-monthly report to Finance & Performance Committee to provide assurance on unscheduled care strategic developments.	2	Establish permanent substantive posts currently covered on an interim basis, providing continuity and sustained leadership for unscheduled care. (New senior clinical lead has been appointed, a programme director for the improvement programme has been appointed on interim basis, and there will be a new programme manager to support the work which is currently being advertised - will become a mitigation).	Complete

Review comments since last report:
The current risk score has been increased to 20 (5x4), from 16 (4x4) in light of ongoing pressures.
Work is ongoing on the agreed priority areas in each Health Economy. The deliverables for October - December 2021 have been identified in each health economy. New governance arrangements became operationalised in August. A workforce group is working on single recruitment campaign for ED and SDEC workforce recruitment. This will ensure that the Health Board funds and recruits to a robust and sustainable model for urgent care.
Workshops have been set up in November and December to redesign the front door of our hospitals and develop and agree Internal Professional Standards.

It has been agreed that there will be no separate winter plan this year and that the schemes are aligned to the USC improvement programme. Proposed winter schemes are being reviewed within the following criteria:
1. Do the proposals align directly with the ambition of the USC plan?
2. Has it been done before and what metric demonstrated that it was successful?
3. Is there a realistic chance to recruit the staff against the timeline?

Executive Lead: Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery	**Board / Committee:** Quality, Safety and Experience Committee	**Review Date:** **11 October 2021**
Linked to Operational Corporate Risks:		

Board Assurance Framework 2021/22

Strategic Priority 2: Recovering access to timely planned care pathways

Risk Reference: BAF21-04		Risk Rating	Impact		Likelihood		Score		Appetite
Timely Access to Planned Care									
There is a risk that the Health Board may be unable to deliver timely access to Planned Care due to a mismatch between demand and capacity and Covid-19, which could result in a significant backlog and potential clinical deterioration in some patient conditions.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	4	↔	5	↔	20	↔	
		Target Risk	4		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Manual validation being conducted across all three sites on a daily and end of month basis.	2	Revised Monthly meetings to focus solely on planned care performance chaired by the Interim Director of Performance, aligns to Performance, Finance and Information Governance Committee. Introduction of further validation staff in Q3/4 non-recurring complete. Review of validation techniques and validation SOP completed; now ready for deployment and adoption. Subject matter expert reviewing validation exercises for planned care. [Update: Introduction of patient contact validation commenced in July for stage 1 and stage 4. This is a 9-week programme until end of October.	2	1) Validation staff being recruited on a fixed term basis to continue with validation work. 2) newly appointed head of ambulatory care will review the validation function to address unwarranted variation and move towards a corporate function	1) Complete 2) 5 January 2022
Implemented risk stratification system and process for stage 4 patients providing clinical priority with regular monitoring by local Primary targeting list (PTL) and access group.	1	1) Ensure the waiting list size is continually validated and patients appropriately communicated with. 2) System introduced that allows patients to "opt in" for treatment. allowing a communication strategy to support the Q1/Q2 plan.	1	1) Introduce risk stratification for stages 1-3 (outpatients and diagnostics). Work currently ongoing with Welsh Government. 2) Sites and areas have been completing backlog clearance plans to ensure the pre-Covid backlog is cleared by March 2022. However whilst the plan is in place slippage has been identified due to operational pressures and this is the subject of recovery plans.	1) 30 October 2021 2) 31March 2022
Head of Planned Care overseeing the plan and variance to the plan with monthly reporting to the Director of Regional Delivery and bi-monthly reporting to the Performance, Finance and Information Governance Committee.	2	Bi-monthly report to Performance, Finance and Information Governance Committee to provide assurance on planned care strategic and tactical developments.	2	Introduce substantive post into the organisation, currently covered on an interim solution, thus providing continuity and sustained leadership for planned care. Currently, the post is being filled by a further interim position whilst re-advertising for a permanent position.	31 March 2022

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Once for North Wales approach introduced to standardise and ensure consistent delivery of general surgery, orthopaedics, Ophthalmology (Stage 4), Urology and Endoscopy to reduce health inequalities.	2	1) Weekly operational group with Divisional General Managers (DGMs) to ensure operational co-ordination of the Once for North Wales approach. 2) Scoping of new strategic model of care known as the diagnostic and treatment centre approach for planned care. Strategic outline case to be presented to Board and Welsh Government. 3) Insourcing for ophthalmology introduced in February but has now been paused. 4) Over 52 week recovery plan for the 2019/20 end of March cohort as first phase agreed. 5) Ophthalmology Business Case reviewed in light of Welsh Government Strategy re Cataract Centres. 6) Additional internal activity above core has been mobilised via recovery plan. 7) Outsourcing of orthopaedic activity contract awarded to Independent Sector to assist with clearing the backlog.	1	1) Introduction of outsourcing to undertake activity that supports P2-3 activity and over 52-week waiters, therefore reducing the overall waiting times. There are a number of strands to this work i.e. orthopaedics, ophthalmology, dental, dermatology all of which are at differing levels of procurement. 2) Agree a strategy (6-point plan) for planned care over the next 3 years that will improve the business process and reduce long waiting patients. 3) Business case for orthopaedic modular ward and theatre on each site has been paused but the organisation has an expression of interest for Regional Treatment Centres as an alternative.	1) 1 December 2021 2) Complete 3) 31 October 2021

Review comments since last report:
Actions, mitigations and timelines have been updated.
Key Control - Manual validation: The subject matter expert is reviewing the validation exercises for planned care. Introduction of patient contact validation commenced in July for stage 1 and stage 4. This is a 9-week programme until end of October. The action in relation to validation of staff being recruited on a fixed term basis to continue with validation work is now completed. The newly appointed head of ambulatory care will review the validation function to address unwarranted variation and move towards a corporate function.

Key Control - Implemented risk stratification: Work currently ongoing with Welsh Government regarding the introduction of risk stratification for stages 1-3 (outpatients and diagnostics). Sites and areas have been completing backlog clearance plans to ensure the pre-Covid backlog is cleared by March 2022. However, whilst the plan is in place, slippage has been identified due to operational pressures and this is the subject of recovery plans.

Key Control - Head of Planned Care overseeing the plan and variance to the plan: With regards to introducing a substantive post into the organisation, currently covered on an interim solution, recent recruitment exercise failed to make an appointment and therefore the post is being filled by a further interim position whilst re-advertising for a permanent position.

Key Control - Once for North Wales approach: Regarding the Introduction of outsourcing to undertake activity that supports P2-3 activity and over 52 week waiters, there are a number of strands to this work i.e. orthopaedics, ophthalmology, dental, dermatology all of which are at differing levels of procurement. Expressions of interest (EoI) are currently with the market to understand how quickly regional treatment centres could be operational. Further outsourcing tenders are out to the market for ophthalmology, dental and dermatology. An assessment of insourcing capacity is being reviewed and then an EoI will be written. Work has been completed in relation to the strategy (6-point plan) for planned care over the next 3 years that will improve the business process and reduce long waiting patients. The business case for an orthopaedic modular ward and theatre on each site has been paused but the organisation has an EoI for Regional Treatment Centres as an alternative. The anticipated date that the target risk score will be achieved is 31 March 2022.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Hill, Executive Director of Finance	Performance, Finance and Information Governance Committee and Quality, Safety and Experience Committee	**27 September 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 6: Integration and Improvement of Mental Health Services

Risk Reference: BAF21-06		Risk Rating	Impact		Likelihood		Score		Appetite
Safe and Effective Mental Health Service Delivery									
There is a risk to the safe and effective delivery of MHLD services. This could be due to unwarranted variation and inefficiencies. This could lead to poorer and inconsistent outcomes, poorer use of resources, failure to learn from events or inequity of access.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	3		3		9		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Mental Health and Learning Disabilities Divisional Governance Structure is in place and aligned to corporate governance requirements, providing consistent approach across the Division.	1	1) Key divisional roles in governance and safety have been aligned to corporate reporting since 1.11.20. 2) Formal reporting and financial transfer of budget complete to ensure the alignment of governance and associated roles to BCUHB corporate. 3) Regular meetings are in place with Corporate Governance Leads.	2		
Partnership and assurance structures are in place. These are: Together for Mental Health Partnership Board (T4MHPB), Local Authority Scrutiny meetings, Local Implementation Teams (LIT), North Wales Adult Safeguarding Board is in place and the division is in attendance. All meetings are formerly minuted and reported with membership regularly reviewed according to their Terms of Reference. The East Local Implementation Team has been re-established; work is ongoing to re-establish in the other Areas. There has been a review of the Terms of Reference of the T4MHPB)	1	Partnership working and reporting assures flow of information and raising of any concerns over delivery or equity. North Wales Community Health Council have held a number of formal stakeholder listening events for the division and a report from the CHC has now been received. The Director of Mental Health meets formally with the 6 local authority directors.	1	1) The T4MH Partnership Board is now meeting regularly. Interim Deputy Director leading this key partnership agenda.	31 December 2021

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
The Mental Health Learning Disabilities Divisions Senior Leadership Team in place with regular cycle of business meetings. This is a control for the delivery of safe and effective services. Regular reports are presented to the appropriate governance body.	1	1)The Mental Health Learning Disability Division has an agreed management structure (2019). It provides timely reports to the agreed Committees of the Board and the Executive Team and is held to account by them for delivery of a safe and effective Mental Health and Learning Disability Service. 2) Divisional triumvirate in place (albeit interim cover is currently in place through to September 2022). The division has created 2 additional Deputy Directors in post reporting to the Director of Mental health to fill operating gaps in partnership and strategy development. Head of Psychology now in post.	2	1. Work is ongoing to address the continuity of the other interim roles within the senior leadership team. 2. Delivery of Targeted Intervention Framework outcomes for Mental Health. This work is now in progress and maturing with the Targeted Intervention Evidence Group scrutinising the evidence of accomplishment of the maturity matrix.	1 September 2022 31 March 2022

Review comments since last report:
Action and timelines reviewed which include:- 1. Regular meetings are in place with Corporate Governance Leads - listed as mitigation.
2. Head of Psychology now in post and shown as mitigation. 3) Actions also updated as follows: - Work is ongoing to address the continuity of the other interim roles within the senior leadership team; Delivery of Targeted Intervention Framework outcomes for Mental Health. This work is now in progress and maturing with the Targeted Intervention Evidence Group scrutinising the evidence of accomplishment of the maturity matrix. It is anticipated that the target risk score will be achieved by the end of September 2022.

Executive Lead:	**Board / Committee:**	**Review Date: 29 September 2021**
Teresa Owen, Executive Director of Public Health	Quality, Safety and Experience Committee	

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 6: Integration and Improvement of Mental Health Services

Risk Reference: BAF21-08		Risk Rating	Impact		Likelihood		Score		Appetite	
Mental Health Service Delivery During Pandemic Management										
There is a risk to the safe and effective delivery of Mental Health & Learning Disability (MH&LD) services. This could be due to the consequences of the COVID-19 pandemic. This could lead to changing type and level of demand across the region, a lack of appropriate staff and resources, poorer outcomes for our population.		Inherent Risk	4		4		16		Low 1 - 6	
		Current Risk	3	↔	3	↔	9	↔		
		Target Risk	3		2		6			

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
MH&LD Covid19 Lead has been identified, and reports into the Divisional Governance meetings, Covid19 Divisional meetings and Covid19 Corporate meetings. Weekly Establishment Control meetings. Monthly operational accountability meetings.	1	1) MH&LD Covid19 Winter Plan discussed and agreed in both the Divisional and Corporate Clinical Advisory Group (CAG). 2) MH&LD Operational Covid19 Winter Plan fully implemented. (All patient transfers now progressed back to localities, although direct admission to Bryn Hesketh are being worked through due to outstanding estates works)	2	Review of 2021/22 Covid-19 winter plan underway.	30 November 2021
MH&LD Covid19 Winter Plan approved in both the Divisional Covid19 CAG meeting 3.11.20, and Corporate CAG meeting 6.11.20. Gaps in recruitment have been assessed and recruitment plan established as part of ESR.	1	MH&LD Engagement and Communication Plan in place to ensure effective and efficient communication across the MH&LD Division and also to all key stakeholders, both external and internal. This includes sharing the MH&LD Covid19 Winter plan. Monthly reporting against ESR and the divisional actions to scrutinise them through Senior Leadership Team (SLT).	2	Recruitment to vacancies identified as part of each area agreed establishment plan to be progressed. {Update: 13.10.21 Divisional vacancy monthly activity report continues to be discussed, monitored and reviewed at the Divisional Operational Leadership Meeting and Divisional workforce meetings. Alternative options for recruitment are being considered and implemented to enhance recruitment; for example, virtual recruitment drive.}	31 March 2022
Wellness, Work and Us Strategy launched in October 2020, to ensure staff are supported. Approved by the MH&LD Divisional Directors within the Divisional Business meeting September 2020.	1	1) Engagement sessions held across the MH&LD Division regarding the Wellness, Work and Us Strategies. Reviewed Year One priorities aligned to Covid19, ongoing implementation. 2)Approval by Corporate Business Continuity Lead for quality checking, and final sign of by the Divisional SLT at the appropriate Governance meeting of Business Continuity Plans and MH&LD Covid19 Action Cards. (East Business Continuity plan received Divisional sign off)	1	1) The year 1 priorities of the Wellness, Work and Us Strategies are being progressed. 2) A review of the covid19 action cards is underway	30 November 2021

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Business Impact Analysis, Business Continuity Plans and MH&LD Covid19 Action Cards implemented November 2020.	1	1) Support being delivered by Corporate Business Continuity Lead to quality check the MH&LD Business Continuity Plans. 2)Revisit and assess gaps in recruitment processes to support additional staff requirements. 3)Heddfan Establishment review undertaken and discussed in Gold Command meeting, 5.2.21	2	Having assessed the gaps in the recruitment processes it has been agreed that a full establishment review should be undertaken to clarify future needs and resource requirements. {Update 13.10.21 - All documents have been submitted to BCU Business Continuity department. Divisional vacancy monthly activity report continues to be discussed, monitored and reviewed at the Divisional Operational Leadership Meeting and Divisional workforce meetings. Establishment review has commenced across all inpatient units.}	30 September 2021 31 March 2022
MH&LD Divisional PPE Task and Finish Group in place, reporting into MH&LD Divisional daily SITREP call, MH&LD Covid19 Briefing meeting and Corporate PPE Task and Finish Group.	2	1) Monitoring and reviewing PPE availability, MH&LD Divisional plan developed and monitored to ensure all staff are appropriately FIT testing as part of key mitigation, feeds into Corporate PPE Task and Finish Group. Also reports to the Corporate FIT testing Steering Group. 2) Process to ensure continuous mapping of staff to enable redeployment decisions.	2	1) Monitoring and review continues with daily PPE stock levels and fit testing staff numbers included on the daily SITREP. Divisional representation continues to attend the Corporate PPE Task and Finish Group and Corporate FIT testing Steering Group continues. 2) MH&LD staff escalation policy reaffirmed across the Division.	
Clinical Patient Pathway, approved by Clinical Advisory Group, monitored and reviewed by the MH&LD Clinical Pathway Group and changes made aligned to the Covid19 Winter Plan.	1	MH&LD SITREPS completed daily, with oversight by Covid MH&LD Lead. MH&LD SITREPS sent daily to Executive Nurse Director. Staffing pressures reviewed in daily SITREPS and Divisional Safety Huddle, any issue escalated to Corporate Staff Redeployment meeting.	1	Review of 2021/22 Covid-19 winter plan underway, which incorporates the clinical patient pathway.	
Covid 19 Training in place with compliance monitored and reviewed through Workforce Work stream.	2	The MH&LD Operational Leadership meeting in place currently meets weekly, reports into the Divisional SLT business meeting and continues to feed into EIMT corporate meeting.	2		
MH&LD Divisional Workforce meeting, currently meeting monthly to review workforce plan, reports into the DSLT business meetings.	1	1) MH&LD Covid-19 Command Structure SOP developed 21st December 2020. 2) MH&LD Covid-19 Command Structure Standard Operating Procedure (SOP) operationalised.	1		
Attend Anywhere in operation across the MH&LD Division to provide a virtual consultation platform to allow the continuation of appropriate services, approved by the Divisional Clinical Advisory Group and is part of the MH&LD Winter Plan.	1	Divisional prioritisation of IT equipment requirements completed and forwarded to IT.	1	1)This project was initially progressed as a proof of concept which has been beneficial and is therefore support by the Division for wider roll out - this project is also aligned to Information Management and Technology (IM&T) implementation. {Update 13.10.21 - Monitoring and review of Attend Anywhere utilisation taking place across divisions.}	31 December 2021

Review comments since last report: The controls, mitigations and timelines have been reviewed, and scores remain unchanged but some actions have been revised as follows: Key Controls - MH&LD Covid19 Lead has been identified & MH&LD Covid19 Winter Plan: A review of the 2021/22 Covid-19 Winter Plan is underway, and the target date for completing the action set at 30 November 2021. Divisional vacancy monthly activity report continues to be discussed, monitored and reviewed at the Operational Leadership meeting and Divisional workforce meetings. Alternative options for recruitment are being considered and implemented to enhance recruitment, for example, virtual recruitment drive. The target date for actualising this action has been extended to 31 March 2022, from 31 August 2021. Key Control - Wellness, Work and Us Strategy: The year 1 priorities of the Wellness, Work and Us Strategies are being progressed and a review of the Covid-19 action cards is underway. The target date for completing these actions have been set at 30 November 2021. Key Control - Business Impact Analysis: All documents have been submitted to the BCU business continuity department. Divisional vacancy monthly activity report continues to be discussed, monitored and reviewed at the Operational Leadership meeting and Divisional workforce meetings. Establishment review has commenced across all inpatient units. The target date has been extended to 31 March 2022 from 30 September 2021, given the length of time the establishment review will take to complete. Key Control - MH&LD Divisional PPE Task and Finish Group: Monitoring and review continues with daily PPE stock levels and fit testing staff numbers included on the daily SITREP. Divisional representation continues to attend the Corporate PPE Task and Finish Group and Corporate FIT testing Steering Group continues. MH&LD Staff escalation policy re-affirmed across the Division. Key Control - Clinical Patient Pathway: A review of 2021/22 Covid-19 winter plan underway, which incorporates the clinical patient pathway. Key Control - Covid 19 Training: The key mitigation has been revised to reflect that the MH&LD Operational Leadership meeting in place currently meets weekly, reports into the Divisional SLT business meeting and continues to feed into EIMT corporate meeting. 8th Key Control has been revised to reflect that the MH&LD Divisional Workforce meeting, currently meeting monthly (previously fortnightly) to review workforce plan, reports into the DSLT business meetings (previously reporting into the MH&LD Covid19 briefing meeting and the Divisional Governance meetings). Key Control: Attend Anywhere: Monitoring and review of Attend Anywhere utilisation is taking place across divisions.		
Executive Lead: Teresa Owen, Executive Director of Public Health	**Board / Committee:** Quality, Safety and Experience Committee	**Review Date:** 13 October 2021
Linked to Operational Corporate Risks:		

Board Assurance Framework 2021-22

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-09		Risk Rating	Impact		Likelihood		Score		Appetite	
Infection Prevention and Control										
There is a risk that Health Board may not be able to deliver appropriate care to patients and they may suffer harm due to healthcare associated infection. This may be caused by a failure to put in place systems, processes and practices that would prevent avoidable infection. The impact of this may increase morbidity and mortality, increase admissions and longer length of stay, increase treatment costs, reputational damage and loss of public confidence.		Inherent Risk	4		5		20		Low 1 - 6	
		Current Risk	4	↔	4	↔	16	↔		
		Target Risk	4		3		12			

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Leadership and Governance in place to support the infection prevention and control agenda throughout the health board. Delivering a zero tolerance approach to HCAI as culture.	2	Business case approved and recruitment commenced to increase IPC team/resource. Risk register monitored and escalated via Infection Prevention Steering Group (IPSG) and Patient Safety & Quality Group. Safe, clean care harm free programme commenced, Hospital and Area directors on steering group to oversee delivery. Re-launch of senior leadership walk rounds	2	Analysis to be undertaken to ensure that there is the right leadership in place across Directorates/Divisions/Teams who understand infection prevention and the appropriate escalation arrangements in place across the Health Board. Finalise recruitment to increase IPC Team resource. Engage clinical directors in IPC to be integral to clinical governance. Safe clean care programme support required to support and manage and assure delivery.[Update 27.7.21 - 3 posts agreed] Substantively recruit into the Director of Nursing IPC role and carry out a whole team review with a view to pulling together a new team structure by end December to be fit for present and future. Ensure harm free care is integral to accountability meetings within the Health Board.	31 December 2021 Complete 30 November 2021 31 December 2021

Buildings/Environment - to be adequate and fit for clinical purpose in reducing/preventing infection	2	Monitoring of performance and risk in place to Public Health Wales and Welsh Government guidance. Ensuring any refurbishment/new build has the right ventilation and 3.6m bed spacing. As part of Safe Clean Care, reviewing bed spacing with a view to having a risk assessed approach and to align with other improvement programmes e.g. urgent care and planned care	2	Identify decant facilities on all clinical sites to ensure an effective deep cleaning programme (Hydrogen Peroxide Vapour {HPV}) and rolling maintenance programme can be set up. {Update: 05.10.21 - The issue with securing routine decant facilities is significantly impacted by the high occupancy rate and the issues around patient flow.} Development of a real time information platform to focus improvement actions and highlight gaps. To build or purchase more isolation facilities to ensure all infected patients can be isolated within two hours. Estates is redoing there original work to understand compliance and gap to 3.6m bed spacing. Areas taking a risk assessed approach to bed spacing and aligning with wider transformation work. Safe Place (Safe Clean Care Harm Free work stream) SRO now Director of Regional Delivery to put in focus pace and grip into the work stream.	31 October 2021 31 October 2025 31 October 2021 Complete
Equipment - making sure we have the right equipment, adequately maintained and stored correctly in each of the clinical areas	1	Having a robust tracking system to monitor equipment and maintenance	1	There is no robust way of tracking all equipment e.g. mattresses for decontamination purposes - there is a 6 monthly mattress audit programme but this lacks tracking of decontaminated mattresses; there is lack of assurance in terms of knowing whether or not mattresses are in use that should have been taken out of circulation. An IT tracking system is required (a request is to be submitted to the Executive Team, to ask for reprioritisation as this is not currently part of IT priorities, potential expansion of iFIT technology. {Update: 05.10.21 - this has been added for consideration on next year's IT annual plan}.	tbc
Cleaning - appropriate resource adequately trained are required to minimised transmission risk from equipment / environment	1	An additional £2.4m for enhanced cleaning has been agreed by Welsh Government	1	Work needs to come to fruition, so that 'nurse cleaning duties' become simply 'cleaning duties' - to allow nurses to nurse, as opposed to spending their time on cleaning. Cleaning supervision plan to support development of new and existing workforce. {Update: 05.10.21 - The recruitment process started; however, this is a significant ask given the numbers to be recruited including supervisors and training requirement}.	30 April 2022
Maintenance of buildings and equipment - maintaining to an optimum level	1	Estates backlog maintenance programme (Cross-reference to Estates risk)	1	The significant backlog of maintenance will impact on the ability to deliver - date is dependent upon roll out of the Estates Strategy. {Update: 05.10.21 - The Infection Prevention Steering Group (IPSG) will be provided with an update on the backlog programme}.	Dependent upon roll out of Estates Strategy

IPC Training, mandatory and targeted with Supervision (competency sign off) Regular observation and feedback	1	IPSG monitoring compliance through assurance section of agenda. Align training and competence compliance to study leave/PDR for all staff groups.	1	IPC mandatory training compliance is low amongst medics, and there is a lack of medical engagement at IPSG meetings - this has been escalated to the Executive Medical Director and there will be further escalation to the Executive Director of Nursing & Midwifery. {Update: 05.10.21 - The IPC team is working with the HR training department on getting a definitive list on who is not trained, specifically for doctors as they have significantly low level mandatory training level}. Only 15 minutes allocated to IPC at junior doctor induction. This has been raised with Medical Director as to how to better train juniors. Low Anti Non Touch Technique (ANTT) in some areas and staff groups. Escalate through responsible directors for action via clinical leads. {Update: 05.10.21 - Work is ongoing with junior doctor colleagues on designing interactive training both for induction and ongoing training}. {Update: 05.10.21 - Developed and running regular IPC Champions training every Tuesday with the aim of every department having a trained IPC Champion working in those departments}.	31 March 2022
Behavioural change/ transformation - Ensure HB transformation programme adopt the Safe Clean Care-Harm Free principles to reduce and maintain improvements around zero tolerance approach to nosocomial infections	1	1) Every accountable area has an infection prevention 21/22 plan on a page and all have carried out 40 point self-assessments (2nd round in July 2021) - Safe Clean Care Harm Free programmes flow from this. 2) Work, policy and risk register review programmes in place. Microbiology and Antimicrobial stewardship activity overseen by Infection Prevention Sub Group (IPSG), Audit Committee/ Patient Safety & Quality Group and Quality and Safety Executive.	1	To develop the leadership (all levels) to influence culture and behaviours to ensure that infection prevention becomes habit. This is an integral part of the safe, clean care harm free programme. IT solution and information leadership required to ensure that the right data is captured which can then be transformed into intelligence, so that people delivering care can see that they are delivering safe practice (real time system) and supporting releasing time to care. Strengthening of effective reporting arrangements through outbreak control groups and IPSG Not having enough people with the right skill set to support the accountable areas undertake their service improvement and transformation programme around IPC. Working with the Transformation Team for ongoing mitigation.	31 March 2022

Policies, Audits, and observation - All IPC policies are in date and reviewed against Welsh Government guidance and best practice.	1	Learning from patient infection reviews, matrons' audits and senior leadership walk rounds to steer improvements. Major Outbreak policy (IPO5) currently in place for managing Covid 19 infections. Audits developed to assure policies are embedded in practice.	1	Not all aspects of the system are electronic - work is underway on this to have in place the capability for instantaneous results through eforms and Office 365 apps. The reviewed infection prevention policies require final agreement from the Clinical Policies and Procedures Group. There is a need to ensure that the most effective control measures are being monitored at a local level (LIPG/Outbreak Control Meetings) and assurance reporting to IPSG/QSE Committee.	31 December 2021 Complete Complete

Review comments since last report:
The controls, mitigations and timelines have been reviewed, and scores remain unchanged but some actions have been revised as follows:
Key Control - Leadership and Governance: 2nd gap/action: Recruitment to increase IPC team resource has been finalised. This action is marked as complete.
5th gap/action: This has been revised to include carrying out a whole team review with a view to pulling together a new team structure by end December to be fit for present and future.
Key Control - Buildings/Environment: 1st gap/action: Revised to note that the issue with securing routine decant facilities is significantly impacted by the high occupancy rate and the issues around patient flow.
4th gap/control: Estates have completed work on redoing the original work to understand compliance and gap to 3.6m bed spacing. This is now marked as complete.
Key Control - Equipment: This has been added for consideration on next year's IT annual plan.
Key Control - Cleaning: The recruitment process started; however, this is a significant ask given the numbers to be recruited including supervisors and training requirement.
Key Control - Maintenance: The Infection Prevention Steering Group (IPSG) will be provided with an update on the backlog programme.
Key Control - IPC Training: 1st gap/action: The IPC team is working with the HR training department on getting a definitive list on who is not trained, specifically for doctors as they have significantly low level mandatory training level.
2nd gap/action: Work is ongoing with junior doctor colleagues on designing interactive training both for induction and ongoing training.
3rd action added: Developed and running regular IPC Champions training every Tuesday with the aim of every department having a trained IPC Champion working in those departments.
Key Control - Behavioural change/ transformation: added a 4th gap/action - Not having enough people with the right skill set to support the accountable areas undertake their service improvement and transformation programme around IPC. Working with the Transformation Team for ongoing mitigation.
Key Control - Policies, Audits, and observation: The key control description '*Major Outbreak policy (IPO5) currently in place for managing Covid 19 infections*' has become a key mitigation; while the key mitigation '*All IPC policies are in date and reviewed against Welsh Government guidance and best practice*', has become the key control description.
2nd and 3rd gap/actions have been completed.

Executive Lead: Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	**Board / Committee:** Quality, Safety and Experience Committee	**Review Date: 05 October 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 2: Strengthen our Wellbeing focus

Risk Reference: BAF21-10		Risk Rating	Impact		Likelihood		Score		Appetite	
Listening and Learning										
There is a risk that adverse events occur, or re-occur, in the organisation due to: 1) Lack of a clear and easy mechanism for patients or staff to raise incidents or complaints, 2) lack of a clear, effective and transparent mechanism for reviewing, addressing, sharing learning and feedback from reviews/investigations, 3) lack of trust and confidence in the systems and process. These adverse events could result in avoidable harm to patients or staff, disruption to clinical and support services, avoidable costs and loss of public and stakeholder confidence.		Inherent Risk	5		5		25		Low 1 - 6	
		Current Risk	5	↔	4	↔	20	↔		
		Target Risk	5		2		10			

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Incident reporting and investigation procedure, systems and processes in place - includes lessons learning learned being shared and actions tracked with reporting to Patient Safety and Quality Group (PSQ) and Quality, Safety and Experience Committee (QSE).	2	Training programme implemented for staff involved in investigations and sharing of learning.	2	Implementation of new procedures and processes for incidents, complaints, claims, redress, safety alerts and inquests - new processes will focus on learning and improvement, with improved use of technology. This will address aspects 1, 2 and 3 of the risk.	Complete
Complaint reporting and investigation procedure, systems and processes in place - includes lessons learned being shared and actions tracked and fed back to patients, families and carers with reporting to PSQ and QSE.	2	Use of the Datix concerns management system to track events, investigations and actions with reporting to PSQ and QSE.	2	Implementation of the new Datix IQ Cloud system for incidents, complaints, redress, claims and mortality reviews - new system will improve the quality of information (including across Wales) and the ability to triangulate information better. This will address aspects 1, 2 and 3 of the risk.	01 April 2022
Safety alerts procedure, systems and processes (both national and local alerts) - includes actions being tracked and WG Compliance Returns completed with reporting to PSQ and QSE.	3	Reporting on patient safety and patient and carer experience to local, divisional and Health Board groups and committees.	2	Implementation of a new skills pathway and passport for those involved in investigations and sharing of learning. This will address aspects 2 and 3 of the risk.	30 September 2021

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Claims and redress investigation procedure, systems and processes - includes completion of Welsh Risk Pool (WRP) Learning from Events Reports evidencing learning which are reviewed by the WRP Committee with reporting to PSQ and QSE.	3	Dashboards and information available at local, divisional and Health Board level to provide oversight of quality and safety indicators.	2	Implementation of a new digital learning library to bring together the access, cascade, and sharing of lessons learned. This will address aspects 2 and 3 of the risk.	01 April 2022
Learning from deaths procedure, systems and processes including mortality reviews, inquest coordination and interaction with Medical Examiners in place with reporting to CEG and QSE.	2	Implementation of an organisation-wide integrated Quality Dashboard.		Implementation of safety culture initiatives including development of a human factors community of practice, embedding of just culture principles into processes, embedding of Safety II considerations, learning from excellence reporting, annual safety culture survey, and safety culture promotion initiatives. This will address aspects 1, 2 and 3 of the risk.	31 March 2022
Local and organisation-wide safety culture and quality improvement initiatives based on identified themes, trends and areas of concern with reporting to PSQ and QSE.	2			Implementation of a new Quality Strategy (developed with patients, partners and staff) containing organisational improvement priorities and enabling measures aligned to the organisational strategy. This will address aspects 2 and 3 of the risk.	31 March 2022
		Implementation completed, of a new Speak out Safely process for staff to raise concerns . This addresses aspects 1, 2 and 3 of the overall risk.			

Review comments since last report:
Target action dates have been reviewed and updated as appropriate, acknowledging the delay in roll out of the new Datix system and postponing the full implementation until the spring thus avoiding roll out during the height of winter pressures. The delay in the Lessons Learnt Library is to align with the launch of the new Intranet. The target risk score is aimed for 31 March 2023 reflecting that in addition to system and process improvements, culture improvement is a key component.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	**27 September 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-12		Risk Rating	Impact		Likelihood		Score		Appetite	
Security Services										
There is a risk that the Health Board does not provide effective security services across the organisation. This is due to lack of formal arrangements in place to protect premises and people in relation to CCTV, Security Contract issues (personnel), lone working, lock down systems, access control and training that provides assurance that Security is effectively managed. This could lead to a breach in the Health Board's statutory security duties.		Inherent Risk	5		4		20		Low 1 - 6	
		Current Risk	5	↔	4	↔	20	↔		
		Target Risk	5		2		10			

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
1)There is Security provision at the three main hospital sites with 24/7 Security staff present. The Field Hospitals have adequate external security contract in place and reviewed to support the change of use of the sites until the end of March 2022 to ensure appropriate to needs of staff, landlord and patients. The external contractor is responsible for Patient Safety & Visitors and Estates Building Management. This has been increased to support Covid safe environments. 2) New Security Contractor appointed from 1.4.21 who will undertake enhanced DBS assessments of all security staff on the DGH sites.	1	Staff Training (which is V&A, module c and module d (breakaway and restrictive physical intervention) is in place in certain service areas. Risk Assessments on some areas looking at physical security. V&A Case Manager to support staff when taking criminal action against assailant. Additional Bank staff employed to support Covid vaccination centre work and security review. Business case to identify minimum standard approach now approved for one year.	2	1) A review of Security was undertaken in August 2019 and identified a number of shortfalls in the systems management and staffing of the current security provision for BCUHB. Limited capacity within the H&S Team to implement safe system of work. Clarity on roles required to describe an effectively managed security contract and safe systems of work in areas such as lone working, restraint training, lockdown and CCTV. Resources to facilitate and support V&A Security are looking at being secured, with recruitment of Bank/Agency staff until permanent post agreed. 2) Ligature assessments require additional support to ensure safe systems of working are in place in all service areas in Mental Health and Community/Acute areas. 3) Security Contractor to be extended to 1.4.22 (subject to Executive sign off) 4) HSE currently investigating suicide in Mental Health which may result in a prosecution or improvement notice which will need to be addressed. 5) HSE planned inspection regarding the prevention of V&A on 16th November.	31 December 2021 31 December 2021 31 December 2021

Specific restraint training is provided in specific areas such as mental health. General Violence and Aggression (V&A) training is provided by the Manual Handling Team.	1	Data capture and reporting systems for V&A. A 0.8 WTE V&A Case Manager is in post to support staff when criminal action is taken. The Obligatory Response to Crime has had a combined training event with North Wales Police. A plan is in place to review V&A training and with funding, can be implemented.	1	The lack of Policies staffing and structures poses a significant risk to staff, patients and visitors from V&A cases and security related activity. To control the risks a full review of Security services including, training particularly in restraint and restrictive practices is required. To ensure appropriate care, this particular aspect is delivered by competent staff. A full Security review was undertaken in September 2019 and previous reviews in 2017 by Professor Lepping and to date none of the recommendations have been implemented due to lack of appropriate resourcing. There is a lack of compliance with the NHS Wales Security Management Framework (NHS in Wales 2005) and Obligatory Response to Violence etc. [Update 1.7.21 - currently, V&A training is at 41% compliance.]	31 December 2021
There are some up to date maintained CCTV systems in place. Staff in some areas have had training on use and licencing requirements. IG aware of issues in relation to data and management of CCTV.	1	There is a system for gathering data when an incident occurs if the equipment is working effectively. A task and finish group has been established to review the current systems with a view to working up a scheme to centralise the CCTV system and improve current compliance.	2	There is a lack of a structured approach to CCTV management and control. The systems are different in many service areas. A central Policy is being developed but requires significant investment to centrally control all systems. This is likely to result in a breach of the Data Protection Act if not appropriately managed. There is often limited maintenance on CCTV systems. A full review of all systems is required. Estates have committed to upgrade CCTV systems in a number of premises.	30 November 2021

Review comments since last report: Scoring has been reviewed and remains currently at 20 due to the ongoing security risk including a HSE investigation into a suicide and planned formal inspection on 16 November 2021. Timelines for action have been extended. Business case to identify minimum standard approach now approved for one year. The Risk Lead considers the date by which it is anticipated that the target risk score will be achieved will be March 2022. It is acknowledged that the target risk score is higher than the risk appetite due to the complexity of services including Mental Health, Community Services and Emergency Department and Prison.

Executive Lead: Sue Green, Executive Director of Workforce and Organisational Development	**Board / Committee:** Quality, Safety and Experience Committee	**Review Date:** **29 September 2021**
Linked to Operational Corporate Risks:		

Board Assurance Framework 2021/22

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-13		Risk Rating	Impact		Likelihood		Score		Appetite
Health and Safety									
There is a risk that the Health Board fails in its statutory duty to provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation that could result in avoidable harm or loss.		Inherent Risk	5		4		20		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	5		2		10		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Health and Safety short courses for managers and staff, and mandatory e-learning are in place, with regular monitoring reported to Strategic H&S group.	1	Competence in training in service areas has been reviewed. Plan in place through business case (subject to approval) to establish robust Safety Competence and leadership training programme. There is a three year strategy that requires implementing to support the Strategic Objectives of BCUHB.	2	1)The gap analysis of 31 pieces of legislation,117 site specific inspections including Acute, Mental Health Community Services GP and Wrexham HMP identified significant areas of none compliance. The OHS team continues to have significant support from our trade union partners. Further evaluation of H&S systems has been led by Internal Audit. A clear plan and framework for action to firstly identify hazards and place suitable controls in place has been developed. Covid support has significantly effected the delivery of the action plan. 2) IOSH Managing Safely and Leading Safely Modules for Senior Leadership to be implemented following business case approval. 3) Estates Business Case requires approval to ensure that the structural elements of the gap analysis are effectively implemented. 4) Manual handling training compliance is not in line with the All Wales Passport. There are insufficient trainers and training rooms to be able to train all new staff (approximately 800) at this time. Business case approved but staffing and venues are still problematic.	31 December 2022 31 December 2021 31 December 2021 31 March 2022
Policies and Sub groups have been established including Asbestos, Water Safety, Fire Electrical Safety etc. to monitor and report into the Strategic Occupational Health & Safety Group and escalate via Quarterly Reports to QSE.	1	Clearly identified objectives for the Annual plan to achieve and transfer of risk ownership for a number of high level risks to E/F as duty holder for asbestos, legionella, contractor management and control, Electricity and Fire.	1	1) Clearly identified issues escalated to Board via business cases have been reviewed but require approval for the Estates element. (H&S Business case has been approved). There remain gaps in Fire safety for a number of premises including YG -work is ongoing to obtain funding from Welsh Government 2) HSE are scrutinising work activity in many areas, planned Health Board inspection for Violence and Aggression and Manual Handling is likely to require additional actions. 3)Actions arising from the Legionella review to be implemented. 4) Improvement Notices served in respect of Adult In-patient falls on 16th June - actions to be addressed. New Falls Policy requires approval and awaiting feedback from HSE regarding response.	31 December 2021 31 December 2021 31 March 2022 31 December 2021

Lessons Learnt analysis from COVID reported to Executive Team, through Covid Group and with action to progressed to appropriate Executives. Clear strategy from Board to deal with PPE and suitable control measures to minimise risk of transmission of Covid through risk assessment, safe distancing advice, FAQ's, ICT Audits, guidance and standard operating procedures.	2	RIDDOR reporting in place with robust timeline and tracking through outbreak groups of Datix 72 hour reviews in excess of 820 RIDDOR investigations have been undertaken since April 2020. PPE steering group has weekly meetings and a 'triple A' assurance report is provided to QSG and key issues escalated via QSE. Over 200+ site safety visits undertaken by the H&S Team to review Covid safe environments. Action cards in place to ensure movement of staff effectively managed during outbreak. Robust fit testing programme now in place and the business case for the fit testing co-ordination team has been approved for two years. There has been significant investment with fit testing equipment with an alternative respirator agreed by the Executive Team.	3	There will be a requirement to release fit testers and staff to comply with legal compliance required within all service areas. Agreed escalation process in relation to a lack of fit testers being released from their substantive roles to be reviewed again at Executive Level. Full time fit testing staff are required as the current arrangement is predicated on temporary staffing.	30 November 2022
Executive Team understand the range and types of risks identified through Annual Report and Gap analysis. Gaps in safety including areas of inefficiency to be addressed. Internal Audit have reviewed structure of meetings and Governance procedures.	1	Strategic OHS Group established to monitor performance and workshop with OD support has looked at leadership styles and developing a positive culture with partners from finance, procurement, Estates and Facilities and Occupational Health.	2	Robust action plan with clear objectives for Team difficult to deal with all elements of legislative compliance with limited capacity. Action: Recommending specialist support to review key areas of risk and attendance at operational groups to further understand significant risks. Specific reports are now being produced but will require robust implementation via appropriate Groups.	31 December 2021

Review comments since last report: The controls, mitigations and timelines have been reviewed, and scores remain unchanged but action timelines have been revised. IOSH Managing Safely and Leading Safely Modules for Senior Leadership to be implemented following business case approval. Estates Business Case requires approval to ensure that the structural elements of the gap analysis are effectively implemented. Manual handling training compliance is not in line with the All Wales Passport. There are insufficient trainers and training rooms to be able to train all new staff (approximately 800) at this time. Business case approved but staffing and venues are still problematic. Clearly identified issues escalated to Board via business cases have been reviewed but require approval for the Estates element. (H&S Business case has been approved). There remain gaps in Fire safety for a number of premises including YG -work is ongoing to obtain funding from Welsh Government. HSE are scrutinising work activity in many areas, planned Health Board inspection for Violence and Aggression and Manual Handling is likely to require additional actions. There will be a requirement to release fit testers and staff to comply with legal compliance required within all service areas. Agreed escalation process in relation to a lack of fit testers being released from their substantive roles to be reviewed again at Executive Level. Full time fit testing staff are required as the current arrangement is predicated on temporary staffing. Mitigation updated to reflect that a robust fit testing programme is now in place and the business case for the fit testing co-ordination team has been approved for two years.
There has been significant investment with fit testing equipment with an alternative respirator agreed by the Executive Team. Specific reports are now being produced but will require robust implementation via appropriate Groups. Improvement Notices served in respect of Adult In-patient falls on 16th June - actions to be addressed. New Falls Policy requires approval and awaiting feedback from HSE regarding response. It is anticipated that the Target Risk Score will be achieved by 31 December 2022.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	29 September 2021

Linked to Operational Corporate Risks:

CRR20-01 - Asbestos Management and Control
CRR20-02 - Contractor Management and Control
CRR20-03 - Legionella Management and Control
CRR20-04 - Non-Compliance of Fire Safety Systems

Strategic Priority 1: Covid 19 response

Risk Reference: BAF21-14		Risk Rating	Impact		Likelihood		Score		Appetite	
Pandemic Exposure										
There is risk that patients, staff or visitors are exposed to COVID-19 due to inadequate/inappropriate resources, lack of compliance with prevention/protection measures across all settings, lack of understanding, skills, ownership of responsibilities, lack of systems and/or capacity and/or capability to identify, analyse, adapt, address immediate themes arising from intelligence both internal and external in a dynamic way. This could impact or effect avoidable harm caused to our patients, staff, visitors, increase in demand/length of stay/risk to other patients, reduction in availability of staff to support the delivery of safe care and services. This could led to prosecution for breach of statutory/legal duty and reputational damage to trust and confidence.		Inherent Risk	4		5		20		Low 1 - 6	
		Current Risk	3	↔	5	↔	15	↔		
		Target Risk	3		4		12			

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Elimination (physically removing the hazard): Covid-19 vaccine programme in place. Visitors undertaking lateral flow test before visiting. Front line staff and staff that come into contact with them undertaking routine lateral flow tests.	2	Ensuring all staff, visitors and patients are double vaccinated to reduce transmission of infection in our care giving settings.	2	Getting access to data is problematic because of how data is collated e.g. people using their personal email addresses rather than their work email addresses. Need to look at a local method for understanding who is not vaccinated and ensure appropriate risk mitigation is in place to reduce risk of potential transmission to other staff and patients. Lateral flow testing has now come in-house so managers can see how many test kits are being handed to staff. Random quality assurance for staff around lateral flow to take place by managers, alongside spot checks in technique to assure test performing quality.	30 October 2021
Substitution (replacing the hazard): A review of all buildings has taken place against new regulations/ guidance in relation to what the clinical environment should look like with regard to infection prevention, with a schedule of improvements identified. Enough isolation rooms with ensuite facilities in place to house all infected and potential infected patient. One way control through the buildings. Routine and deep cleaning in place to reduce/eliminate bioburden.	1	Review of ventilation has taken place. Ventilation and Environmental groups reporting into Infection Prevention Sub Group (IPSG) and Patient Safety & Quality Group (PSQG) with governance structure in place. Implementation of segregation and screening to clinical areas to reduce risk of transmission	1	1) Review and risk assess the improvement plans in order to address the environmental considerations necessary to meet new guidance in relation to the built environment. Some buildings are a risk due to infrastructure (dialysis and community hospitals). Improvement plans in place via Planning and Estates, approved by Board and currently with Welsh Government awaiting approval. 2) To build or purchase more isolation facilities to ensure all infected patients can be isolated within two hours. 3b) All modernisations or new builds to have single rooms and where this is not achievable beds achieve ISBN guidance (3.6m bed spacing). 4) Safe clean care programme has a front door improvement project running. 3) C4C audits to be further acted upon in particular the estates elements as is an infection and reputational risk.	Complete 31 December 2025 31 December 2021 31 December 2021

Engineering (reducing potential transmission): Reducing footfall in clinical settings, working from home where possible and self-isolation requirements in place. Risk assessed visitation, Flow through our buildings. Change facilities for all hospital based staff.	2	Managerial staff working from home where possible/peripatetic working. Risk assessed visitation to our care facilities. Clear signage to areas and footfall managed by local lead.	1	1) Need to understand impact of amended WG guidance (AUG21) around self isolation and potential risk of transmission to venerable staff and patients. 2) Spot checks to be developed as part of the ward accreditation programme to test robustness of visiting risk assessments and compliance. 3) Self isolation guidance has been updated to reflect Government guideline, but this potentially puts staff and patients at risk. This has been mitigated with the guidance around FFP3 mask and strongly recommended this happens in outbreak areas.	
Administrative (change the way that work is performed): Virtual ward/board rounds and visiting, Safe break improvements. Staff and patient moments reduced	1	Virtual visiting is preferred option for visiting. IPADs available for patients use. Board rounds being reviews as part of the unscheduled care transformation programme. Wandering patient project (SCC-HF Safe Action project)	1	1) Need to link in with Unscheduled Care Programme to ensure board and ward round improvements focus also on less footfall and more virtual interfaces. 2) STREAM to be operationalised throughout acute care to support virtual board and ward rounds - options appraisal developed by IT. {Update: 05.10.21 - The target date extended to 31 March 2023, given this is a major IT project. This is now being considered by the Director of Digital to take forward and a draft business case is being developed.}	31 March 2022 31 March 2023
PPE: Adequate PPE stocks in place and maintained. Monitoring and management in place to check sufficient availability	1	PPE Steering Group (PPESG) and reporting into IPSG and PSQG with governance structure in place. In addition the formation of the Safe Clean Care Harm Free Group which now reports to Quality, Safety and Experience (QSE) Committee.	2	Continuous PPE supply is secure. Still remain an issue with masks being upgraded / discontinued which then means all staff need to be re-fit tested on new masks. PPE meetings stood down from weekly to fortnightly now because of more secure position. {Update: 05.10.21 - Whilst the risk has been lowered, the mitigation is completely out of BCU's control.}	Complete
PPE: Fit testing in place to ensure the right mask to prevent avoidable infection.	1	Fit testing programme, Accreditation training and business case in place to increase assurance monitored by PPESG. Any escalations sent through to This is monitored via IPSG and OH&SG.	2	Trainers to be part of the local workforce. To ensure fit testing becomes business as usual and is kept under continuous review by the Health & Safety Group. {Update: 05.10.21 - The fit testing programme has been funded by EIMT business case in August 2021. This will ensure a programme of systematic testing of staff and fit testing is recorded on ESR. However, this does not include temporary staff and local management make the decision to test their fit testing before starting work.}	31 March 2022

Clear **Leadership & Governance** in place to support delivery of the clinical and admin improvements required to lower the risk score through embedding mitigating actions.	1	Safe Clean Care Harm Free reports through PSQB to QSE. All accountable areas have 2020/21 plans on a page they delivering against. All accountable areas have undertaken their second HARMS self assessment with underpinning assurance and where appropriate improvement actions managed through Local Infection Prevention Groups (LIPG) through to IPSG to QSE.	1	Recruit to key posts to support delivery out in the accountable areas of their Safe Clean Care Harm Free Infection Prevention plans on a page 2021/22. Ensure accountable areas are represented at the SCC-HF steering group meetings, to drive focus, pace and grip. Ensure standardised agendas at LIPGs to align to assurances sort by IPSG.	31 December 2021

Review comments since last report:
The controls, mitigations and timelines have been reviewed, and scores remain unchanged but some actions have been revised as follows:
Key Control - Elimination: It is proposed that the target date be changed and discussion to be had around how controls could be further strengthened.
Key Control - Substitution (replacing the hazard): 1st gap/action: actions on Improvement plans are now complete.
Key Control - Engineering (reducing potential transmission): 2nd key mitigation - *Ten day self isolation period when come into contact with a positive case where no PPE was worn e.g. outside work, breaks etc.* has been removed to adhere to Government guideline.
3rd gap/action added: Self isolation guidance has been updated to reflect Government guideline, but this potentially puts staff and patients at risk. This has been mitigated with the guidance around FFP3 mask and strongly recommended this happens in outbreak areas.
Key Control - Administrative: Target date for the 1st gap/action has been included as 31 March 2022. The target date for the 2nd gap/action has been extended from 31 March 2021 to 31 March 2023, given this is a major IT project. This is now being considered by the Director of Digital to take forward and a draft business case is being developed.
Key Control - PPE: Adequate PPE stocks: This gap/action is now complete. However, whilst the risk has been lowered, the mitigation is completely out of BCU's control.
Key Control - PPE: Fit testing: The fit testing programme has been funded by EIMT business case in August 2021. This will ensure a programme of systematic testing of staff and fit testing is recorded on ESR. However, this does not include temporary staff and local management make the decision to test their fit testing before starting work. The target date has been extended to March 2022 to receive assurance that the agreed business case has been operationalised.
Key Control - Leadership & Governance: The target date has been extended to 31 December 2021 from 31 October 2021, as no internal candidates were sourced.

Executive Lead: Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	**Board / Committee:** Quality, Safety and Experience Committee	**Review Date:** **05 October 2021**

Linked to Operational Corporate Risks:		

Board Assurance Framework 2021/22

Strategic Priority 1: Covid 19 response

Risk Reference: BAF21-19		Risk Rating	Impact		Likelihood		Score		Appetite	
Impact of COVID-19										
There is a risk that the ongoing Covid-19 pandemic will lead to the HB being overwhelmed and unable to respond to Covid healthcare needs and/or carry out its core functions due to the spread and impact of Covid-19 in North Wales. This could lead to reduced staff numbers available for work, increased demand on services (including acute, community, mental health and primary care), and suspension of planned services. This could negatively affect patient safety and quality of care, patient outcomes; delivery of the mass vaccination programme and TTP; and the Health Board's ability to deliver its plans and corporate priorities.		Inherent Risk	5		4		20		Low 1 - 6	
		Current Risk	4	↔	4	↑	16	↑		
		Target Risk	4		2		8			

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Divisional operational management teams' Covid response arrangements are in place. Additional workstreams established including Operational Hub. Any issues requiring escalation are reported into Executive Team or the Executive Incident Management Team (EIMT) as appropriate. EIMT is currently meeting 3 times a week and Cabinet has been reconvened	2	Contingency and escalation plans are in place and operational measures taken to support the response to Covid-19 including amended care pathways; provision of PPE; remote or prioritised assessment pathways; prioritisation of treatment; escalation plans and surge capacity. Surge plans/winter resilience plans are being updated and will be tracked against modelling predictions. Revised modelling is being used to inform capacity and re-escalation plans.	2	1) Review of surge plans against WG options framework for escalation. 2) Development of proposals for redeployment of staff, extended capacity and other escalation options under the framework	31 October 2021 31 October 2021
Covid-19 response programmes established to plan and deliver specific targeted response including Test, Trace and Protect programme; Vaccination Delivery Programme; PPE group; Operational Delivery Group for outbreak management; Ysbyty Enfys Assurance Group now stood down but reporting continues through EIMT for significant decisions.	2	1)Detailed programme plans in place for each programme area; performance indicators identified to enable monitoring and evaluation; governance structures in place to enable oversight and decision-making. 2) Strengthening of reporting processes into and from EIMT and/or Executive Team in place. 3) Establishment of clear regularised reporting structures around established workstreams.	2	1) Prevention and response plan priorities and actions reviewed again in light of revised Coronavirus Control Plan produced by WG, working with partners 2) Vaccination booster programme underway, requires review of capacity to ensure completion consistent with WG timeline	31 October 2021 30 November 2021
Clinical Pathways Group established to scrutinise clinical response to the pandemic and approve amended pathways and reporting into the Clinical Effectiveness Sub-Group.	2	1) Clinical approval for service delivery proposals; approved pathways published on the BCU intranet; reporting to Executive Team and EIMT. 2) Programme and links into ET/EIMT reviewed.	2	Clinical strategy work to facilitate development of Clinical Senate	30 November 2021

Coronavirus Co-ordination Unit established to support programme reporting and strategic co-ordination, working closely with the Business Intelligence Unit (BIU) and Covid Intelligence Hub to ensure timely and accurate analysis of data and modelling of trajectories.	2	Covid dashboards to facilitate up to date review of performance; weekly reporting to executive team and IMs; monitoring of reporting to WG including SitReps, outbreak reporting, unscheduled care and hoc reports. Dashboard now consistently linked for BIU users. Mechanisms in place for ongoing surveillance, analysis and modelling after current pandemic peak.	2	1) Ensure readiness for further escalation as required in the event of further waves of Covid pandemic, in line with national modelling and revised regional projections (latest update received 18.10.21).	30 November 2021
Executive Incident Management Team has been established and is meeting as required, with formal reporting to the Board regularly and updates as appropriate.	2	Recording of actions and decisions via daily updates to logs; regular briefing to IMs via Board briefings; escalation of matters requiring Board approval. Frequency increased to 3 times weekly and Cabinet re-established.	2	Ongoing work to ensure all records captured and indexed. Archivist team being established and preparation for public inquiry underway	31 March 2022
North Wales LRF Strategic Co-ordinating Group has stood down. Recovery Co-ordinating Group remains in place and is continuing surveillance and managing recovery. SCG will be reconvened as and when required.	3	Risk assessment, escalation of sub-regional and regional issues, whole system response; and reporting to WG on an escalation basis. Mechanisms in place through RCG for ongoing collaborative arrangements for monitoring transition into recovery. Split agenda for RCG encompasses whole system pressures	3	1) Prevention response plan to set out remobilisation processes	[next review point 31 October]

Review comments since last report: Controls, mitigations, actions and timeframes have been reviewed and updated to reflect the current position on the pandemic. The current risk score *relating to the impact of Covid* has been increased in light of ongoing high levels of community transmission, although this needs to be balanced against the effect of the vaccination booster programme and the evidence of reduced levels of severe disease and hospitalisation. Demand on healthcare from Covid is stabilising, and the risk to staffing levels due to isolation not increasing as absence rates appears to be stabilising (alongside revised guidance on isolation for vaccinated individuals.) The Prevention & Response Plan is being reviewed with partners, noting that there are gaps in capacity across all partners organisations to respond to potential rising community transmission and associated increases in testing and tracing. The Risk Lead is considering the date when it is anticipated that the target risk score will be achieved.		
Executive Lead: Gill Harris, Deputy Chief Executive and Executive Director of Nursing and Midwifery	**Board / Committee:** Quality, Safety and Experience Committee	**Review Date: 15 October 2021**
Linked to Operational Corporate Risks:		

Appendix 2 – Full list of BAF risks with nominated Committee, Executive Lead and Risk Lead

BAF ref	BAF Risk	Exec Owner/ Risk Lead	Assurance Committee	Risk Score	Target Risk Score
BAF21-01	Emergency Care	Gill Harris, Meinir Williams	QSE	16	12
BAF21-02	Sustainable key health services	Teresa Owen Gwyneth Page	PPPH	15	10
BAF21-03	Primary Care sustainable health services	Chris Stockport, Clare Darlington	PPPH	20	12
BAF21-04	Timely access to planned care	Gill Harris Andrew Kent	PFIG & QSE	20	12
BAF21-05	Mental Health-effective stakeholder relationships	Teresa Owen, Amanda Lonsdale	PPPH	9	4
BAF21-06	Safe and effective Mental Health delivery	Teresa Owen, Mike Smith	QSE	20	9
BAF21-07	Mental Health leadership model	Teresa Owen, Carole Evanson	PPPH	15	8
BAF21-08	Mental Health service delivery during pandemic	Teresa Owen, Carole Evanson	QSE	9	6
BAF21-09	Infection Prevention and Control	Gill Harris, Sally Batley	QSE	20	15
BAF21-10	Listening and Learning	Gill Harris, Matt Joyes	QSE	20	10
BAF21-11	Culture; staff engagement	Sue Green, Ellen Greer	PPPH	16	12
BAF21-12	Security Services	Sue Green, Peter Bohan	QSE	20	10

BAF ref	BAF Risk	Exec Owner/ Risk Lead	Assurance Committee	Risk Score	Target Risk Score
BAF21-13	Health & Safety	Sue Green, Peter Bohan	QSE	**20**	**10**
BAF21-14	Pandemic exposure	Gill Harris, Sally Batley	QSE	**20**	**15**
BAF21-15	Value Based Improvement Programme	Sue Hill, Geoff Lang	PFIG	**12**	**8**
BAF21-16	Digital estate and assets	Chris Stockport, Phil Corrin	PPPH	**20**	**12**
BAF21-17	Estates and assets development	Sue Hill, Rod Taylor	PFIG	**9**	**6**
BAF21-18	Workforce optimisation	Sue Green, Nick Graham	PPPH	**16**	**12**
BAF21-19	Impact of Covid-19	Gill Harris, Sally Baxter	QSE	**12**	**8**
BAF21-20	Development of an Integrated Medium Term Plan (IMTP) 2022/25	Chris Stockport, Sue Hill, Sue Green, John Darlington	PPPH	**12**	**6**
BAF21-21	Estates and assets	Sue Hill, Neil Bradshaw	PFIG	**15**	**10**

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience (QSE) Committee 2nd November 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Corporate Risk Register Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Simon Evans-Evans, Interim Director of Governance
Awdur yr Adroddiad Report Author:	Justine Parry, Assistant Director: Information Governance and Risk
Craffu blaenorol: Prior Scrutiny:	Risk Management Group on the 11th October 2021 Executive Team on the 20th October 2021
Atodiadau Appendices:	Appendix 1 – QSE Corporate Tier 1 Operational Risk Report Appendix 2 – Full list of Corporate Risks

Argymhelliad / Recommendation:

That the Committee:-

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

CRR20-01: Asbestos Management and Control

a) **Note** the Risk Management Group (RMG) recognise the progress in implementing actions including the identification of weaknesses in the asbestos management survey which has been mitigated with the annual re-inspection programme. The Estates and Facilities (E&F) team are continuing to work through the actions identified within the Corporate Health and Safety Gap Analysis Action Plan.
b) **Note** the change in the Executive Director oversight of Estates and Facilities to the Executive Director of Finance.
c) **Note** the applied reduction in the current risk score following approval at the Committee on the 7th September 2021.

CRR20-02: Contractor Management and Control

a) **Note** the RMG recognise the progress in implementing actions in line with the identified timeframes which remain on track.
b) **Note** the change in the Executive Director oversight of Estates and Facilities to the Executive Director of Finance.
c) **Note** the applied reduction in the current risk score following approval at the Committee on the 7th September 2021.
d) **Note** the additional Action ID18688 to address the gaps identified in the Health and Safety Gap Analysis report.

CRR20-03: Legionella Management and Control

a) **Note** the RMG recognise the progress in implementing actions which includes the establishment and commenced meetings of the Water Safety Group.

b) **Note** the change in the Executive Director oversight of Estates and Facilities to the Executive Director of Finance.
c) **Note** the applied reduction in the current risk score following approval at the Committee on the 7th September 2021.
d) **Note** the additional Action ID19015 to address the gap identified and to further support risk mitigation.
e) **Note** the completion of the Action ID12269 advised by the RMG and approved by ET, so that it will be archived and removed from the next report, recognising that their implementation will be captured as part of the controls within the next iteration of the risk.

CRR20-04: Non-Compliance of Fire Safety Systems
a) **Note** the RMG recognise the progress in implementing actions which includes confirmation of receipt of monies from EFAB and Statutory compliance to commence with a programme of work to support the risk mitigation.
b) **Note** the change in the Executive Director oversight of Estates and Facilities to the Executive Director of Finance.
c) **Note** the applied reduction in the current risk score following approval at the Committee on the 7th September 2021.
d) **Note** the further extension to Action ID12279 due to the delay in the delivery of the manual handling training.
e) **Note** the completion of the Actions ID12554 and ID12555 advised by the RM and approved by ET, with evidence of the programme of audits in place and the review of unwanted fire alarm activations taking place, so that they will be archived and removed from the next report, recognising that their implementation will be captured as part of the controls within the next iteration of the risk.

CRR20-05: Timely access to care homes
a) **Note** the RMG recognise the progress in implementing standardised ways of working across North Wales to support the reduction in the gaps in controls.
b) **Approve** the ET request to extend the target risk due date following the continued waves of the pandemic and the requirement to continue to support the care sector.
c) **Note** the completion of the Action ID14943 advised by the RMG and approved by ET, as a standard revised rate for care homes has been agreed, so that it will be archived and removed from the next report, recognising that its implementation will be captured as part of the controls within the next iteration of the risk.
d) **Note** the additional Action ID18646 to address the gap identified and to further support risk mitigation.

CRR20-08: Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.
a) **Note** the RMG recognise the progress in implementing actions including Diabetic Retinopathy now in place across all 3 acute sites.
b) **Approve** the ET request to extend the target risk due date following the delay in approving the business case for outsourcing activity.

CRR21-13: Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)
a) **Note** the RMG recognise the progress in implementing actions including the implementation of the recruitment and retention strategy and plan, understanding that circumstances outside of the Health Boards controls could impact on the programme.

b) **Note** the additional controls added for the management of the pandemic nursing plan, nursing roster KPIs and Band 4 Nurse roles are now in place.
c) **Note** the extension to the due date for Action ID17509 and further extension to ID15635 to enable full completion of the actions.

CRR21-14: There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients
a) **Note** the inclusion of this risk onto the Corporate Risk Register following approval at the Committee on the 7th September 2021.
b) **Approve** the ET request to extend the target risk due date due to the national delay in the publication of the code of practice which will come into effect on the 1st April 2022.
c) **Note** the extension to the due date for Action ID15709 due to the national delay in the publication of the code of practice.
e) **Note** the additional Actions ID18983 and ID18984 to address the gaps identified and to further support risk mitigation.

CRR21-15: There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014
a) **Note** the inclusion of this risk onto the Corporate Risk Register following approval at the Committee on the 7th September 2021.
b) **Note** the RMG recognise the progress in the management of the risk including the updating of the gaps and the mitigations required to address those gaps.
c) **Note** the ET recognise and have agreed to the target risk score remaining outside of the Health Boards risk appetite given the multi-faceted arena the safeguarding agenda is.
d) **Note** following the initial review by RMG, revised timeframes to the Actions ID15701 and ID15702 have been implemented.

CRR21-16: Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients
a) **Note** the inclusion of this risk onto the Corporate Risk Register following approval at the Committee on the 7th September 2021.
b) **Note** the RMG recognise the progress in the management of the risk including the increased controls put in place, understanding the reduction in capacity has impacted on the ability to reduce the current risk score. Mitigations are being put in place to address this gap in capacity.
c) **Note** the extension to the due date for Action ID17978, ID17979 and ID17980 to allow time for implementation following the length of time taken to sign the contracts.
d) **Note** the completion of the Action ID17594 advised by the RMG and approved by ET, so that it be archived and removed from the next report, recognising that the implementation will be captured as part of the controls within the next iteration of the risk.
e) **Note** the additional Actions ID18859 and ID18860 to address the gaps identified and to further support risk mitigation.

CRR21-17: The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours
a) **Note** the inclusion of this risk onto the Corporate Risk Register following approval at the Committee on the 7th September 2021.
b) **Approve** the ET request to extend the target risk due date to allow completion of all actions, recognising there will be a phased reduction in the likelihood of the risk with the completion of earlier identified actions.

c) **Note** the RMG recognise the progress in the management of the risk including the review of ligature points on Paediatric Wards, the standard operating procedures under review before further implementation and the updated mitigations to address the gaps identified.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

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

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

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

Cefndir / Background:

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

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

Following the inclusion of the 4 new risks onto the Corporate Risk Register in September 2021, a further risk is being developed in line with the QSE previous meeting recommendation and it is anticipated this will presented during the January 2022 for escalation approval**.** This risk is in relation to the Health Boards resilience to uncertainty, unknowns and potential unchartered territory which could be caused by a number of converging and novel factors. The risk will be assigned to the Executive Director of Primary and Community Services as it is linked to business continuity and emergency planning.

Summary Table of the Full Corporate Tier 1 Risk Report:
Current Tier 1 Risks for the Quality, Safety and Experience/Performance Committee oversight (full details and progress can be found in Appendix 1):

Risk Title	Inherent risk rating	Current risk rating	Target risk rating	Movement*
CURRENT RISKS – appendix 1				
CRR20-01 - Asbestos Management and Control	20	15	8	Decreased
CRR20-02 - Contractor Management and Control	20	15	8	Decreased
CRR20-03 – Legionella Management and Control	20	16	8	Decreased
CRR20-04 - Non-Compliance of Fire Safety Systems	20	16	8	Decreased
CRR20-05 – Timely access to Care Homes	25	20	6	Unchanged
CRR20-08 – Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients	25	20	6	Unchanged
CRR21-13 - Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	20	16	6	Unchanged
CRR21-14 - There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	25	20	6	New Risk, will be presented to the Board in January 2022
CRR21-15 – There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014.	20	16	12	New Risk, will be presented to the Board in January 2022
Risk ID 3893 – Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients.	20	16	4	New Risk, will be presented to the Board in

				January 2022
CRR21-17 - The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.	20	16	8	New Risk, will be presented to the Board in January 2022

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

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

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

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

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

Opsiynau a ystyriwyd / Options considered

Continuing with Corporate Risk Register.

Goblygiadau Ariannol / Financial Implications

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

Dadansoddiad Risk / Risk Analysis

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

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

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

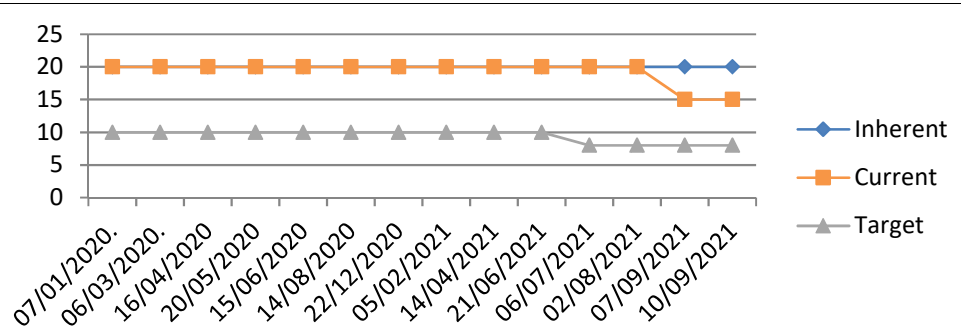
Asesiad Effaith / Impact Assessment

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

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

CRR20-01	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 10 September 2021
	Risk: Asbestos Management and Control	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 31 March 2022

There is a significant risk that BCUHB is non-compliant with the Asbestos at Work Regulations 2012. This is due to the evidence that not all surveys have been completed and re-surveys are a copy of previous years surveys. There are actions outstanding in some areas from surveys. This may lead to the risk of contractors, staff and others being exposed to asbestos, and may result in death from mesothelioma or long term ill health conditions, claims, HSE enforcement action including fines, prosecution and reputation damage to BCUHB.



	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 2021	Decreased (from 20 to 15)		

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 our annual re-inspection programme is in place. 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.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee. 4. Internal Audit review undertaken against the gap analysis.

Gaps in Controls/mitigations
1. We are unable to achieve compliance with awareness and training as not everyone is able to undertake the training within a specified timescale.

Progress since last submission
1. Following approval at the QSE Committee Meeting on the 7th September 2021, the agreed reduction in the current scoring from 20 to 15 has been applied to the risk. 2. Following a change in the Executive Director's portfolios, the risk has been updated to reflect this change. 3. Controls and gaps in controls have been reviewed and updated to reflect the current position. 4. Further work is continuing to provide evidence to align the controls and the gaps as identified in the Health and Safety gap analysis. 5. Weakness in the asbestos management survey has been mitigated with the annual re-inspection programme.

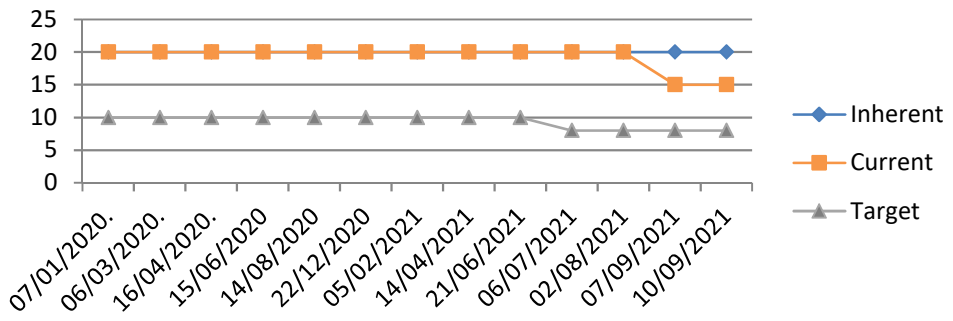
Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Strengthen our wellbeing focus	BAF21-13 BAF21-17

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12243	Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	This action will help us to identify the areas of asbestos and thus better mitigate and manage any potential impact by enabling to a web supported system to access records remotely.	On track
	12248	Update intranet pages and raise awareness with staff who may be affected by asbestos.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Creating staff awareness of the presence of asbestos thus reducing any potential impact.	On track

	18298	To develop and implement a Management Action Plan in response to the Internal Audit report.	Mr Rod Taylor, Director of Estates & Facilities	31/12/2021	The Management Action Plan will support current mitigation and management of the risk.	On track
	18686	Ensure 100% compliance with asbestos awareness training for Operational Estates maintenance staff.	Mr Arwel Hughes, Head Of Operational Estates - Interim	31/03/2022	Ensure compliance with training legislation and help to reach the target risk score.	On track

CRR20-02	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 10 September 2021
	Risk: Contractor Management and Control	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 30 September 2022

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



	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 2021	Decreased (from 20 to 15)		

Controls in place	**Assurances**
1. Control of contractors procedure in place. 2. Induction process being delivered to new contractors. 3. Permit to work paper systems in place across the Health Board. 4. Pre-contract meetings in place. 5. Externally appointed CDMC Coordinator (Construction, Design and Management Regulations) in place. 6. Procurement through NHS Shared Services Procurement market test and ensure contractor compliance obligation.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

Gaps in Controls/mitigations
1. Lack of ongoing programme of training in line with requirements in legislation. 2. It is recognised that the existing estates management capacity is often exceeded by the number of projects and capital works that is in progress and is therefore is a limiting factor.

Progress since last submission
1. Following approval at the QSE Committee Meeting on the 7th September 2021, the agreed reduction in the current scoring from 20 to 15 has been applied to the risk. 2. Controls and gaps in controls have been reviewed and updated to reflect the current position. 3. Further actions have been identified to address the gaps identified in the Health and Safety Gap analysis report, which will support the reduction in the current risk score. 4. Action dates have been extended following previous Executive Team agreement and noted at QSE on the 7th September 2021. 5. Following a change in the Executive Director portfolios, the risk has been updated to reflect this change.

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 H&S Management within H&S Policy).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for additional staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the Operational Estates geographical areas to manage COSHH and Inspection process to ensure compliance.	On Track

	12254	Identify current tender process & evaluation of contractors, particularly for smaller contracts consider Contractor Health and Safety Scheme on all contractors. This will ensure minimum H&S are implemented and externally checked prior to coming top site.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance for contractor's appointment criteria. The process and system will be a Health Board wide management system. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	On Track
	12255	Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	On Track
	12256	Identify the current system for signing in / out and/or monitoring of contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE data base.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	On Track
	12257	Identify level of Local Induction and who carry it out and to what standard.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management	On Track

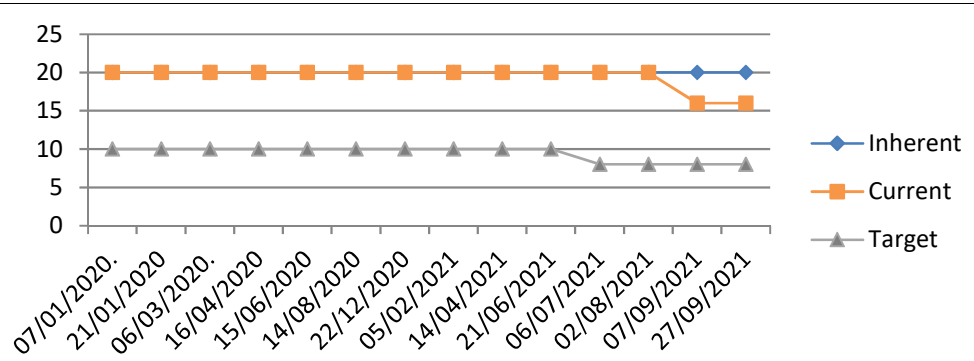
					of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	
	12258	Identify responsible person to review RA's and signs off Method Statements (RAMS), skills, knowledge and understanding to be competent to assess documents (Pathology, Radiology, IT etc.).	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	On Track
	12259	Identify the current Permit To Work processes to determine whether is it fit for purpose and implemented on a pan BCUHB basis.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	A Permit to Work system will be adopted as part of implementation of SHE software. Original action due date was	On Track

					30/09/2022. Approved reduction at QSE 07/09/2021.	
	12260	Lack of consistency and standardisation in implementation of contractor management procedure picked up in H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/05/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	On Track
	12552	Induction process to be completed by all contractors who have not yet already undertaken.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for addition staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the	On Track

					Operational Estates geographical areas to manage COSHH and Inspection process to ensure compliance.	
	18688	An annual review of business as usual capacity to be developed to ensure estates project management capacity is not exceeded.	Mr Arwel Hughes, Head Of Operational Estates - Interim	31/03/2022	Create assurance that there is sufficient estates management capacity and technology to ensure that projects can be delivered safely.	On Track

CRR20-03	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 27 September 2021
	Risk: Legionella Management and Control.	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 30 September 2022

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



	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 2021	Decreased (from 20 to 16)		

Controls in place	**Assurances**
1. Legionella and Water Safety Policy in place. 2. Risk assessment undertaken by clear water. 3. High risk engineering work completed in line with clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonis. 6. Authorising Engineer water safety in place who provides annual report. 7. Annual Review of the H&S Self Assessments undertaken by the Corporate H&S Team. 8. Water safety Group has been established to better provide monitoring, oversight and escalation. 9. Internal audit of compliance checks for water safety management regularly undertaken.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Experience Committee.

Gaps in Controls/mitigations

1. There is a weakness that little used outlets are not reported to Estates for management and control. e.g. we can have a ward shower temporarily used as a store, therefore it isn`t part of Estate flushing programme.
2. There is a weakness that alterations to pipe works are not undertaken with consent from local Estate Water Management Team.
3. BCU wide Water Safety Plan is currently being written, which will provide legal requirement under L8 for processes and controls for water safety systems.

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

Progress since last submission
1. Following approval at the QSE Committee Meeting on the 7th September 2021, the agreed reduction in the current scoring from 20 to 16 has been applied to the risk. 2. Following a change in the Executive Director's portfolios, the risk has been updated to reflect this change. 3. Risk reviewed following concerns by the corporate Health and Safety Team in relation to the reduction of the risk score from 20 to 16. Estates and Facilities Team agreed that the score should remain at 16 taking into account current control measures in place. 4. Gaps in controls updated to align with current position of the risk. 5. Action ID 12269 – Proposal to close this action as the Water Safety Group is now in place. 6. Additional action identified following a review of gaps in controls to secure funding and appointment of additional posts.

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

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

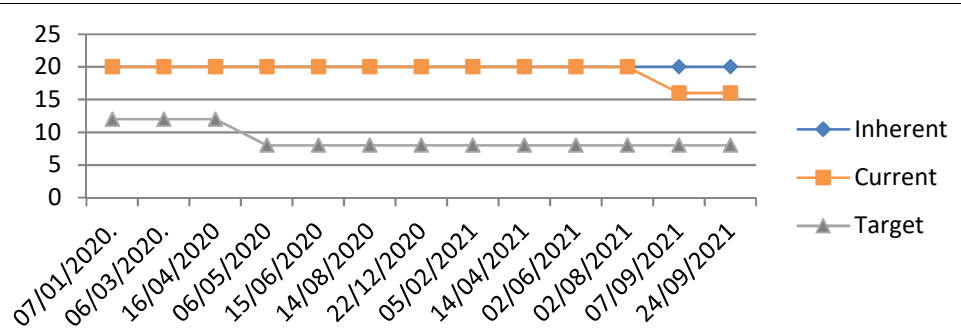
	12263	Departments to have information on all outlets and deadlegs, identification of high risk areas within their services to ensure they can be effectively managed.	Mr Rod Taylor, Director of Estates & Facilities	30/06/2022	All water outlets within managed departments have outlets run as part of the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

	12268	BCUHB Policy and Procedure in place and ratified, along with any department-level templates for SOPs and check sheets.	Mr Rod Taylor, Director of Estates & Facilities	30/11/2021	A policy for water safety management is currently in place – A consultant has been appointed to review current procedural documents for each area with the objective to develop one policy document. As part of the water safety plan infection prevention will need to be integrated within key sections of the plan.	On Track
	12269	Water Safety Group provides assurance that the Policy is being effectively implemented across all sites, this requires appropriate clinical and microbiology support to be effective.	Mr Rod Taylor, Director of Estates & Facilities	29/10/2021	ACTION CLOSED - 27/09/2021 Water Safety Group provides assurance that the Policy is being effectively implemented across all sites; this requires appropriate clinical and microbiology support to be effective. The Water Safety Groups reports issues of significance and assurance to the Infection Prevention Sub-Group (IPSG) and Strategic Occupational Health and Safety Group (SOH&SG).	Completed
	12270	Lack of consistency and standardisation in the implementation of the Legionella and Water Safety Policy picked up in the H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	Independent Consultant appointed to review the current procedural documents for each area with the objective to develop one policy document.	On Track

	19015	Secure funding and appointment of 3x band 7 Senior estates officers for water safety.	Mr Rod Taylor, Director of Estates & Facilities	31/12/2021	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.	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:** 24 September 2021
	Risk: Non-Compliance of Fire Safety Systems	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 30 September 2022

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



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2021	Decreased (from 20 to 16)		

Controls in place	**Assurances**
1. Fire risk assessments in place. 2. Evacuation routes Identified and evaluation drills established and implemented. 3. Fire Safety Policy established and implemented. 4. Fire Engineer regularly monitor Fire Safety Systems. 5. Fire Safety Mandatory Training and Awareness session regularly delivered to BCUH Staff. 6. Fire Warden Mandatory Training established and being delivered to Nominated Fire Warden.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Committee.

Gaps in Controls/mitigations
1. Insufficient revenue funding to maintain compliance with fire equipment and infrastructure. 2. Insufficient capital to upgrade fire detection and compartmentalisation of the fire safety infrastructure.

Progress since last submission
1. Following approval at the QSE Committee Meeting on the 7th September 2021, the agreed reduction in the current scoring from 20 to 16 has been applied to the risk. 2. Following a change in the Executive Director's portfolios, the risk has been updated to reflect this change. 3. Funding has been received from EFAB and statutory compliance monies to commence a programme of works. 4. Action dates have been amended following previous Executive Team agreement and noted at QSE on the 7th September 2021. 5. Action ID12279 – Proposal for a further extension to this action to 31/03/2022 due to the delay in the delivery of the manual handling training. Further discussions are progressing with the manual handling leads. 6. Action ID12554 – Proposal to close this action with evidence of audits captured within the programme of activity. 7. Action ID12555 – Proposal to close this action with evidence of reporting being provided to the Fire Safety Management Group.

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

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12273	Review Internal Audit Fire findings and ensure all actions are taken.	Mr Rod Taylor, Director of Estates & Facilities	31/12/2021	Governance actions completed and operational elements are captured within the gap analysis areas below. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	On Track
	12274	Identify how actions identified in the site FRA are escalated to senior staff and effectively implemented.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Escalation through Hospital Management Teams, Area Teams and MH&LD management teams with site responsible persons has been completed. Assurance on	On Track

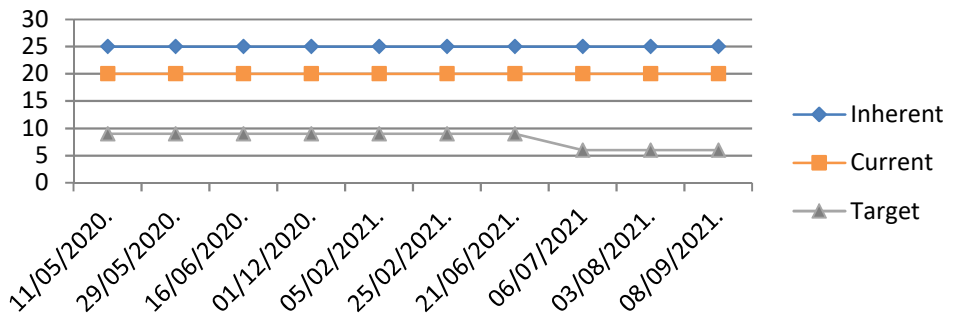
					implementation of actions outstanding. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	
	12275	Identify how site specific fire information and training is conducted and recorded.	Mr Rod Taylor, Director of Estates & Facilities	30/06/2022	Database located within the fire safety files, managed and updated by the fire safety trainer. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	On Track
	12276	Consider how bariatric evacuation training is undertaken and define current plans for evacuation and how this is achieved.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Work in progress. To be included in site specific manual and training developed with Manual Handling team.	On Track
	12279	AlbaMat training - is required in all service areas a specific training package is required with Fire and Manual Handling Team involved.	Mr Rod Taylor, Director of Estates & Facilities	30/11/2021	Albac mat training is undertaken as part of the induction programme for clinical staff and as part of the refresher-training programme delivered by the Manual Handling team. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021. Request extension until 31/03/2022 to enable completion of action, due to the delay in Manual Handling training within BCU, further	Delay

					work ongoing with Manual Handling leads.	
	12554	Commission independent shared services audits.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	ACTION CLOSED – 27/09/2021 Independent, Shared Services (Specialist Estates Services) audits commissioned on an annual basis to ensure the appropriate fire safety measures, process and procedures are in place within Acute and Community hospital sites The Health Board has now in place a programme of independent fire safety audits undertaken annually by the HB's appointed authorizing engineer - fire safety. Sites are selected based on risk and operational activity.	Completed
	12555	Information from unwanted fire alarms and actual fires is collated and reviewed as part of the fire risk assessment process.	Mr Rod Taylor, Director of Estates & Facilities	29/04/2022	ACTION CLOSED - 24/09/2021 Unwanted Fire signals (Uwfs) and fire safety data collated within an All-Wales management system and annual report collated and published. Details shared with the SOH&SG and escalated to QSE as necessary. Information reviewed as part of the annual Fire Risk	Completed

					Assessment process and appropriate action taken. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021. Report on fire alarm activations is presented at each Fire Safety Management Meeting.	
	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.	On Track

CRR20-05	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 11 May 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 08 September 2021
	Risk: Timely access to care homes	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 31 December 2021

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	3	2	6
Risk Appetite	Low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2021	unchanged		

Controls in place	**Assurances**
1. Multi-agency care home cell established as part of the emergency planning arrangements. 2. PPE distribution system operational including identification and support for residents with aerosol generating procedures. 3. Testing for residents and staff in place aligned with national guidance. 4. Unified “One contact" data gathering from care homes established with 6 Local Authorities. 5. Systems for Access to specialist advice via Public Health Wales and the Environmental Health Teams in place to manage isolation and outbreaks. 6. Personalised care and support plans promoted led by specialist palliative care team. 7. New arrangements in place for the timely provision of pharmacy and medication support at the end of life. 8. Remote consulting offered by general practice. 9. Home first bureaus established and embedded across the 3 area teams to facilitate sensitive and collaborative decision making on hospital discharge, transfer between care homes and admissions from home. 10. Regular fortnightly formal communication channels with care homes at a local level and across BCU.	1. Oversight via the Care Home Cell which includes representatives from Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW). 2. Oversight via Gold and Silver Strategic Emergency Planning. 3. Oversight as part of the Local Resilience Forum via SCG. 4. Oversight by the Recovery Group.

11. North Wales care home escalation and support tool that complements national work programmes has been implemented, monitored as part of the North Wales care homes single action plan at RPB. 12. Communication with care homes at a local level and across North Wales as part of the North Wales care homes single action plan. 13. MDT Care Home group meeting daily Monday to Friday, for issue resolution for period of enhanced second covid wave pressures. 14. Re-establishment of the North Wales Silver Health and Social care group reporting into the Strategic Control group, to identify where joint responses are required and shared learning. 15. Contribution to the incident management teams in outbreaks/incidents within care homes.	

Gaps in Controls/mitigations
1. It remains unclear who is leading on outbreaks in Independent Hospitals which are mainly MH hospitals. 2. There is a massive shortage in accessing domiciliary care support. 3. There is a real issue sorting out staff for Agency last minute cancellation when a home turns red or has a positive case. 4. Changes in Government Strategy is affecting the Nursing Homes. 5. Lack of standardised reporting across North Wales for cause/delay in discharge for MFD patients.

Progress since last submission
1. Proposal put forward to move the target risk due date from 31/12/2021 to 30/06/2022 due to continued waves in the pandemic and the requirement to support the care sector. 2. Controls in place reviewed and updated to align with current position. 3. Gaps in controls have been reduced with the implementation of standardised ways of working across North Wales eg. BCU chairing MDT meetings and implementation of standardised risk assessments. 4. Care homes cell has been reviewed and membership extended.

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

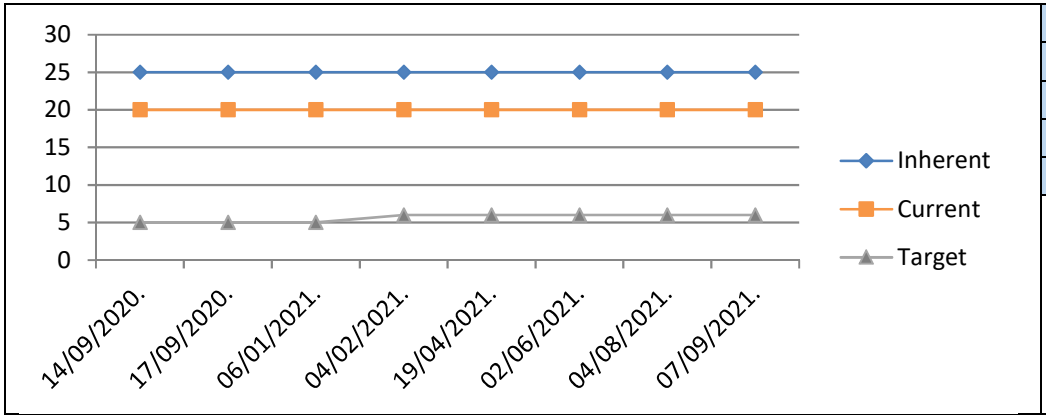
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	14943	Deliver a revised financial support package for care homes.	Kathryn Titchen, Commissioning Manager CHC	02/08/2021	ACTION CLOSED 04/08/2021 This action will support access to care homes with a standardised rate agreed for care homes.	Completed
	14949	Development of resources support capacity and demand for care homes.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	28/02/2022	This will help eradicate delays in discharge through better co-ordination. Draft framework is in place and we have setup 6 different work streams to implement the various strands of the Quality Assurance Framework. Extension to the original action due date from 30/06/2021, approved at QSE 07/09/2021.	On Track
	18024	To work with LAs to review domiciliary care resource across North Wales.	Ms Jane Trowman, Care Home Programme Lead	28/02/2022	It will improve patient flow by enabling patients to be discharged to their own homes.	On Track
	18025	Working with the North Wales Regional Workforce Board to develop an improvement recruitment package for Independent Providers.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	31/12/2021	It will prevent admissions from Care Homes which have no staff and improve patient flow to enable discharge.	On Track

	18646	MFD - Work with local authorities and care provides to implement an agreed action plan	Ms Jane Trowman, Care Home Programme Lead	31/12/2021	Improved flow and discharge of patients in a more timely manner, and improve the quality of care to patients.	On Track

CRR20-08	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 14 September 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 07 September 2021
	Risk: Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 28 February 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	5	4	20
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 2021	unchanged		

Controls in place	**Assurances**
1. Reviewing list of patients affected to get fast-track or book those who may deteriorate to clinics. 2. Cataract - All cataracts have been stratified in order of visual impairment, to deal with the most clinically pressing cases first. 3. Once surgery resumes across all sites patients who are already clinically prioritised may be shared across all three units in North Wales to ensure equity of access as part of the 'Once for North Wales' process. 4. More clinic slots are being made available to accommodate clinically pressing patients. 5. Diabetic retinopathy now in place across all 3 sites.	1. Risk is regularly reviewed at local Quality and Safety meetings. 2. Risk reviewed at monthly Eye Care Collaborative group. 3. Monthly reports to WG against KPI's for eye care measure and KQI's. 4. All Wales and MIAA audits have taken place. In addition, two clinical condition audits are undertaken annually by Welsh Government.

Gaps in Controls/mitigations
1. They are continuing to stratify patients into R1, R2 and R3 to enable prioritisation of permanent sight lost. However, further table-top risk stratification is challenged by reduced OBD (Office Based Decision) making by clinicians as a consequence of their return to expanded clinical activities. 2. Surgery has recommenced but the Pan-BCU cataract PTL (to reduce inequality) has yet to be operationalised. 3. Diabetic retinopathy in place in two of the three Sites with West Site still to achieve flow to Primary Care. 4. Current partnership pathways which mitigate waiting times and reduce capacity during Covid-19 are reliant upon an assigned clinical condition, however, a significant number of patients do not have a clinical condition logged on the system (Central 2290; East 3600 and West 910). 5. Guidance for number of cataracts being undertaken per list is currently set to 6-8, the health board is running at 3.6-4, differences in national standards between numbers of cataract procedures per list.

Progress since last submission
1. Following a review of the Target Risk Score, Target Risk Date, the outstanding actions to be implemented and the delay in receiving the Business Case Approval, a request to extend the target risk date to the 30/06/2022 has been put forward to allow the achievement of the actions to support the reduction in the risk score. 2. Approval from the Health Board to outsource cataract services has been received and work has commenced. 3. Controls have been updated to include that Diabetic Retinopathy is now in place across all 3 sites. 4. Gaps in controls have been reviewed and updated with the risk lead to reflect the current position.

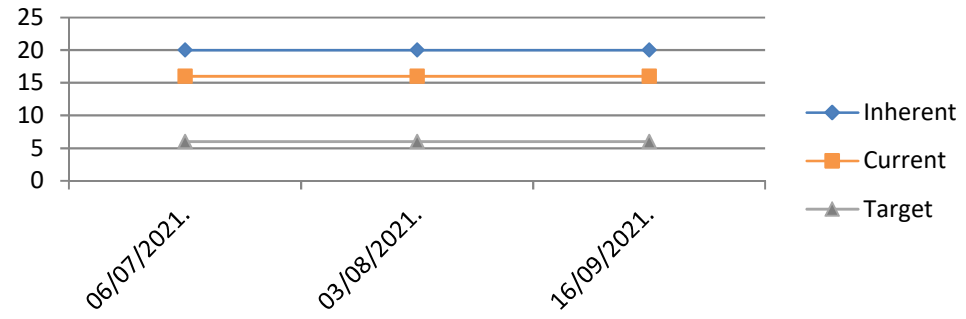
Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Recovering access to timely planned care pathways	BAF21-02 BAF21-04

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
	14908	The retinal cameras have been procured as part of a larger equipment replacement scheme and are expected to be commissioned soon. Date awaited from internal sources.	SINGARAM, Mr SRINIVAS - Specialty Doctor	31/12/2021	This action will enable the service to effectively mitigate and manage this risk so as to achieve its target score.	On Track
	15662	Proliferative diabetic retinopathy – Pan BCUHB pathway has been initiated to get optometry review of the backlog. Referrals being sent out from secondary care to primary care optometrists and are at various stages of progression but positive progress.	SINGARAM, Mr SRINIVAS - Specialty Doctor	31/12/2021	This action will enable the service to appropriately mitigate and manage this risk in attaining its target score.	On Track

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:** 16 September 2021
	Risk: Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 30 December 2022

There is a risk to the provision of high quality safe and effective nursing care due to the number of nursing vacancies across the Health Board. This may be caused by the increasing age profile within the nursing workforce, difficulties with recruitment and retention of nursing staff across the Health Board, geographical challenge and competition with other hospitals across the borders. There is also the precarious position of Bank & Agency staffing in terms of continuity of supply and the impact this has on skill mix and patient experience. This has been further exacerbated by the impact on the resilience of the workforce due to the ongoing Covid 19 pandemic.

This could lead to negative impact on the safe delivery of highly quality, timely patient-centred care and enhanced experience, financial loss due to reduction in business/operational activities and potential reputational damage to the Health Board.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	3	2	6
Risk Appetite	moderate level		9-12
Movement in Current Risk Rating Since last presented to the Board in July 2021	Unchanged		

Controls in place	**Assurances**
1. Safe Care supports the daily review of staffing in Acute and Community Areas across the Health Board to ensure safe deployment in line with existing Safe Staffing Act. 2. Double sign off of nursing rosters to ensure effective deployment. 3. Nurse staffing policy outlines standards and escalation. 4. Safe staffing legislation being extended into Paediatric inpatient areas from Q3 2021. 5. District Nursing principle compliance review undertaken bi annually in line with AW approach. 6. Biannual staffing Inpatient reviews - reviewing establishments and association of harms with reports to QSE/Board. 7. Workforce recruitment and retention strategy in place. 8. Recruitment and Retention operational group in situ with HB wide representation. 9. Targeted Recruitment Campaign for Band 5 nurses developed and rolled out.	1. Risk is regularly reviewed and monitored at the Site Quality and Safety meeting. 2. Bi-annual nurse staffing review undertaken that is overseen by Quality, Safety and Experience Committee as the designated committee, as well as the approval of the Nurse Staffing policy. 3. Risk is regularly reviewed and monitored at the Senior Nursing Meeting.

10. Annual Commissioning requirements calculated triangulating service development / staffing review and national planning information. 11. International Nurse recruitment programme in place informed by data analysis. 12. Clinical Fellows for Nursing programme being rolled out. 13. ADN appointment to lead and support nurse recruitment. 14. Workforce/Service planning process to triangulate requirements. 15. Introduction of new roles to support e.g. Band 4 roles across the HB where applicable. 16. Daily redeployment meeting with Senior Nursing Leadership chair during pandemic surge. Currently twice weekly. 17. MDT staffing support across the Health Board during surge due to inability to respond to demand. 18. Objective setting via the PADR process to ensure staff are working to 'top of license' and have opportunity. 19. Pandemic surge plan approved by Executive Director of Nursing and Midwifery, the plan has been implemented within the Health Board. 20. Workforce nursing utilisation dashboard developed and introduced to senior nursing teams to optimize nurse staffing rostas. 21. Band 4 roles review completed with actions identified to progress identified roles through to fast track nursing studies resulting in band 5 positions going forwards.	4. Welsh Government oversight of nurse staffing as well as tri-annual summary submission.

Gaps in Controls/mitigations
1. There remains some variability in adherence to the Rostering Policy in relation to application of rotas, approval and KPIs. e.g. Annual Leave. 2. There are some instances of reliance on paper-based rotas rather than electronic rotas which lead to manual checking of staffing on a daily basis which wastes time and is less efficient. 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. 4. Whilst the recruitment and retention strategy and plan are in place, there are extenuating circumstances outside of the Health Board's control which could impact on the programme.

Progress since last submission
1. Controls in place and Gaps in controls have been updated to reflect the current situation in relation to the recruitment and retention strategy and plan. 2. Additional control added for the management of the pandemic nursing plan. 3. Additional control added as a result of the closure of actions relating to nursing roster KPI's and nurse band 4 roles. 4. New actions identified as a result of closed actions relating to nursing roster KPI's and nurse band 4 roles. 5. Action ID 17509 - request an extension to the due date of the action to 30/11/2021 to enable full completion of the action. 6. Action ID 15635 - request an further extension to the due date of the action to 30/11/2021 to enable full completion of the action.

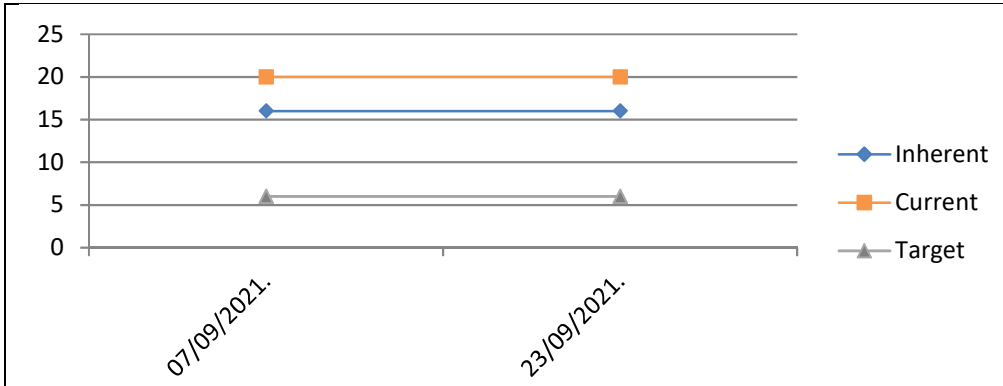
Links to	
Strategic Priorities	**Principal Risks**
Effective alignment of our people (key enabler) Strengthen our wellbeing focus	BAF21-02 BAF21-09 BAF21-11 BAF21-18

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	30/09/2021	This action will assist to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise. This will increase the ability to expedite recruitment and increase volume. The individual benefits and KPIs of the business case are linked to the relevant sections of our corporate risk register. Request extension until 30/11/2021 to enable completion of action.	Delay
	17433	Introduction of leadership development programmes commencing with Matrons which will extend to include Ward Managers, Heads of Nursing and subsequently aspirant programmes.	Mrs Joy Lloyd, Senior OD Manager	31/03/2022	This action will support retention with providing developing opportunities but also aid delivery of the Quality & Safety strategy within the Nursing workforce.	On Track

	17508	Development of collaborative Career Clinics supported by Workforce & Organisational Development.	Mrs Anne-Marie Rowlands, Associate Director Professional Regulation	31/08/2021	ACTION CLOSED - 31/08/2021 This action will continue to further develop career pathway opportunities and aid stability within the current workforce	Completed
	17509	Exploration of the Global Learning Programme.	Mrs Alison Griffiths, Associate Director of Nursing Workforce	31/08/2021	The Global Learners Programme offers an exciting 3 year work-based educational opportunity for overseas nurses to work in the NHS This action will embed global skills, learning and innovation into the organisation and further strengthen workforce development Request extension until 30/11/2021 to enable completion of action.	Delay
	18834	Introduce targeted monitoring across rosters, through KPI management to reduce agency expenditure and maximise substantive staff usage.	Mr Nick Graham, Workforce Optimisation Advisor	31/12/2021	Effective utilisation of substantive staff.	On Track
	18835	Support and progress existing band 4 roles through to fast track nurse training and support and progress band 2/3 nursing roles into future band 4 roles for succession planning.	Mrs Alison Griffiths, Associate Director of Nursing Workforce	30/12/2022	This action will enable the Health Board to be in a position to grow our own nursing workforce which will reduce overall vacancy rates and provide continued long term sustainable workforce.	On Track

CRR21-14	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 20 August 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 23 September 2021
	Risk: There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 01 April 2022

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



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	5	20
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. Formal reporting and escalation of activity, mandatory compliance and exception reports are reported to the Mental Health Act Committee, Patient Safety Quality Group and Safeguarding Forums in line with the Safeguarding Governance and Reporting Framework. 2. Audit findings and data are monitored and escalated following the Safeguarding Governance Reporting Framework. 3. BCUHB mandatory training is in place for MHLD and key departments and is included within the mandatory adult at risk level 2 and 3 training. This increases compliance with process and legislation and supports the reduction of unlawful detention. 4. The revised DoLS Procedure [SOP] is in place and it provides a clear process and guidance to reduce legal challenge [21a]. 5. DoLS COVID 19 Interim Guidance and Flow Chart is in place. This supports interim arrangements during reduced face to face contact.	1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group. 2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings. 3. The risk is reviewed and scrutinised at the Executive Business Meeting. 4. This risk is regularly monitored and reviewed by participation in the safeguarding ward accreditation audit and analysis. 5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding

	Adults Board to scrutinise safeguarding mortality reviews.

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

Progress since last submission
1. Following approval at the QSE Committee on the 7th September 2021, this risk has been escalated onto the Tier 1 Corporate Risk Register. 2. Proposal put forward to extend the target risk due date due from 01/04/2022 to 31/10/2022, due to the delay in publication of the code of practice which will come into effect on the 01/04/2022. This is a national delay in the publication which inhibits the Helath Boards ability to implement improvement/change. Whilst this proposal has been put forward, it is expected that once the code of practice has been published incremental reductions in the risk score should be achieved. 3. Following feedback from Risk Management Group on the achievement of the actions, extensions to action due dates have been implemented. 4. Action ID15709 - Further proposal to extend action to the 31/12/2021 due to the delay of the publication of the code of practice. 5. New actions identified to support the achievement of the target risk score once the code of practice has been published.

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

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	15704	The Business Case to support the structure will be presented to the Executive Team in October 2021.	Miss Andrea Davies, Personal Assistant	31/10/2021	Additional resource will enable implementation of the SSW[W] Act and will reduce risk.	On Track
	15705	The National Task and Finish Group Finish Group will support the implementation of the [LPS] legislation and Code of Practice ensuring National consistency for NHS organisations.	Miss Andrea Davies, Personal Assistant	31/12/2021	The National Task and Finish Group will develop indicators specific to the NHS which will reduce unlawful detention and risk.	On Track
	15706	LPS Training and guidance documentation and review of the DoLS forms has been agreed to be reviewed and developed by a leading Barrister and is supported by an agreed memorandum of understanding.	Miss Andrea Davies, Personal Assistant	31/10/2021	An informed workforce will comply with revised legislation which will reduce unlawful detention and risk	On Track
	15707	Finance to be secured due to cost pressures for S12 Dr activity, external BIA assessments and CoP activity. (To be included within the Business Case to the Executive Team in October 2021).	Miss Andrea Davies, Personal Assistant	31/10/2021	Additional resource will enable the implementation of the SSW[W] Act and compliance with the MCA and the new Mental Capacity [Amendment] Act 2019 and will reduce risk.	On Track

	15708	The DoLS Governance arrangements and reporting structures of BIA's are to be reviewed to ensure improved reporting and escalation of non compliance with legislation for the both the Managing Authority and Supervisory Body.	Miss Andrea Davies, Personal Assistant	31/10/2021	The Memorandum of Understanding provides step by step guidance which will reduce error and improve quality and reduce unlawful detention.	On Track
	15709	The BCUHB LPS Implementation Task and Finish Group will be implemented and will support the transition of DoLS as guided by the new LPS legislation.	Miss Andrea Davies, Personal Assistant	31/10/2021	Additional resource will enable the implementation of the SSW[W] Act and Mental Capacity [Amendment] Act 2019 and will reduce unlawful detention and risk. Requesting extension of due date to 31/12/2021 to complete action and implement task and finish group due to delay in publication of the code of practice	Delay
	18117	Recruitment to new posts required due to implementation of LPS.	Michelle Denwood, Associate Director Safeguarding	01/04/2022	Additional resource will ensure the legal requirements of LPS will be implemented and will reduce the number of unlawful detentions.	On Track
	18118	Implement and Monitor a Court of Protection Engagement and Procedure SoP for DoLS / LPS.	Michelle Denwood, Associate Director Safeguarding	31/10/2021	The pathway will reduce delay, improve communication and reinforce organisational accountability. This will improve activity with the COP and meet the needs and safeguards of service users.	On Track

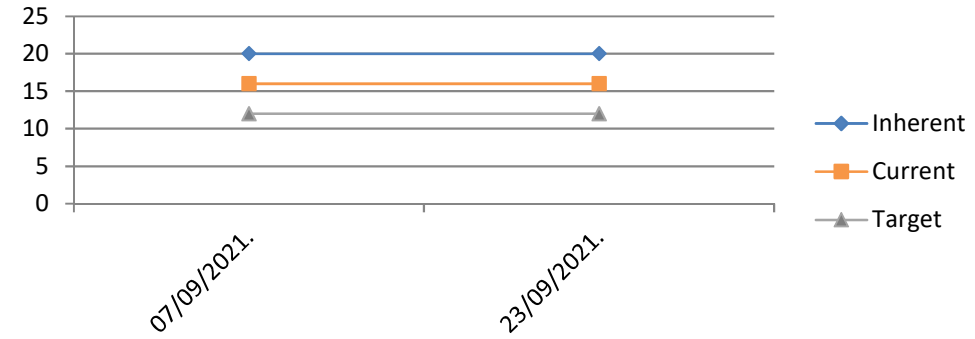
	18983	Implement changes in line with publication of new code of practice which will include revised job descriptions, training packages, audits, supervision, and strengthened court of protection activity.	Michelle Denwood, Associate Director Safeguarding	31/10/2022	Reduce the risk by improving education and implementation of legislation which will reduce unlawful detention.	On Track
	18984	Review of all policies, procedures and guidance in line with publication of the new code of practice.	Michelle Denwood, Associate Director Safeguarding	31/10/2022	BCU will be compliant with legislation and provide guidance to service users.	On Track

CRR21-15	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 21 December 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 23 September 2021
	Risk: There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 01 April 2022

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

This may be caused by a failure to engage and implement appropriate safeguarding arrangements, develop an engaged and educated workforce and provide sufficient resource to manage the demand and complexity of the portfolio.

This could lead to harm to persons at risk of harm to which BCUHB has an duty of care, potential financial claims, poor patient experience and reputational damage to the Health Board.



	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 – New Risk not presented to Board	New Risk		

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

4. The Children's Division BCUHB are managing the recruitment process for the replacement of the Named Doctor. Interim arrangements are in place and all statutory safeguarding meetings are attended by a Doctor.	safeguarding ward accreditation audit and analysis. 5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Adults Board / Children's Board to scrutinise safeguarding mortality reviews.

Gaps in Controls/mitigations

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

Progress since last submission

1. Following approval at the QSE Committee on the 7th September 2021, this risk has been escalated onto the Tier 1 Corporate Risk Register.
2. Following a review at the Risk Management Group it was recognised that the target risk score will remain outside of the risk appetite for the Health Board. The safeguarding agenda and the multi-faceted arena is/can be outside of the HB's control. We require multi agency engagement with both research and national recognition which places safeguarding as a high risk due to the subjective nature and catastrophic outcome of abuse and harm.
3. Gaps and mitigations have been reviewed and updated to strengthen the identification of the gap and mitigations in place to support the gaps.
4. Following feedback from RMG on the achievement of the actions, extensions to action due dates have been implemented.

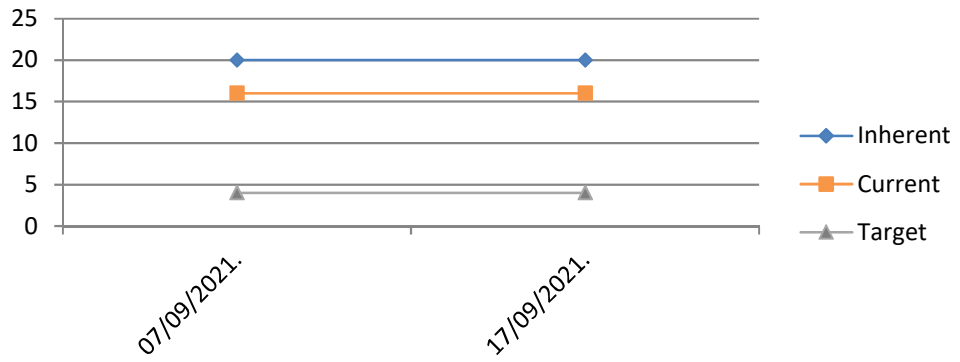
Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

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

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

CRR21-16	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 22 April 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 17 September 2021
	Risk: Non compliant with manual handling training resulting in enforcement action and potential injury to staff and patients	**Date of Committee Review:** 07 September 2021
		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, HSE enforcement action (current related Improvement Notice for Patient Falls) and reputational damage.
This may be caused by staff being unable to attend Manual Handling training due to a lack of dedicated training facilities, particulary in the West region, reduction in class sizes due to COVID-19 restrictions and insufficient numbers of trained staff.
This could lead to an impact on compliance as set at an All Wales level and requires BCUHB to have a compliance of 85% for Patient handling refresher and 100% prior to new starters / students undertaking patient handling duties.



	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 – New Risk not presented to Board	New Risk		

Controls in place	Assurances
1. An additional trainer has recruited via Bank and is in place to provide additional training sessions. 2. A blended approach has been put in place for inanimate load handling, to increase training compliance for those that do not require the practical element of module B of the passport. 3. Recommenced face to face training to improve compliance took place in July 2021 and will continue where appropriate and safe to do so. 4. ESR bookings for courses for staff to self-book onto sessions, right up to the day of courses is now available. 5. Risk assessments and SOP in place for training rooms. 6. Additional rooms secured and funding agreed to allow the additional training to take place.	1. Regular oversight and review by the Occupational H&S team 2. Reviewed at the Strategic Occupational Health and Safety Group and agreement to escalate at the SOHS Group. 3. Risk Management Group oversight. 4. Local Partnership Forum

Gaps in Controls/mitigations
1. Additional trainer is currently working through bank and they are not contractually obliged to attend for work. This is a weakness for the provision of training, as may result in reduced capacity if no hours worked. 2. Training particularly in the West region has been impacted by a lack of training venues. The last dedicated training space in Llandudno Hospital has now been be recalled for use, rendering it unavailable for training/office use for both trainers. 3. The All Wales Passport sets minimum standards for training, with module B of inanimate load requiring practical training. The current blended approach does not allow for module B practical to be covered, but does cover all other elements required for module A & B from the Passport. 4. Numbers reduced due to social distancing requires increased classes to be offered and ensure the numbers of staff requiring training can attend. This is difficult to achieve without training rooms and additional trainers. 5. ESR systems not easy to use. Staff often ring trainers or email for help to book onto courses. ESR contact emails not always up to date, unable to contact attendees booked of changes to session booked or cancelled courses. 6. Review the rate of DNA's and evaluation of causes of none attendance is a gap in the system. This will be undertaken by the new band 6 roles, when in post. 7. Patient Handling refresher and orientation training should be delivered by clinically trained staff to comply with the MH Passport Scheme. The business case has been agreed for two years but this remains a gap in the controls until recruitment has been agreed. Current compliance for Patient Handling refresher is now at 57%. 8. Reduction in capacity within the team to deliver the training requirement, 3x staff members on long terms sickness leave. Currently recruiting an internal trainer via secondment and trainer/advisor rolls from external for an additional 6 members of staff.

Progress since last submission
1. Following approval at the QSE Committee on the 7th September 2021, this risk has been escalated onto the Tier 1 Corporate Risk Register. 2. Controls strengthened to take into account agile working requirements in training and compliance with COVID requirements. 3. Gaps updated to include the reduction in capacity and the mitigating actions put in place. 4. Proposal to extend 3 action due dates due to time required for implementation following the length in time taken to sign contracts. 5. Additional actions also identified to support the achievement of the target risk score. 6. Proposal to reduce the likelihood score from a 4 to a 3 was discussed, and until the policy and plan has been implemented it is recommended that the likelihood score should remain at 4.

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	17594	Insufficient training rooms.	Ms Jillian B-J Hughes, Manual Handling Manager	30/09/2021	ACTION CLOSED - 19/07/2021 1. The additional rooms will allow the manual handling department to provide mandatory training for staff and increase compliance for manual handling to the targeted 85% required. 2. Having clinical band 6 trainers will provide BCUHB with the correct level of qualified staff as per the All Wales Passport for people handling, along with the minimum standard on ratio of trainers to attendee for classes. 5. Completing a training needs analysis to target areas that would benefit from training first. Those that have high Datix reports with training issues in inanimate load handling, or areas with patients that may require more assistance with people handling. These areas targeted to provide training earlier should result in reduced Datix, reduced potential injuries and possible work related sickness from a musculoskeletal injury.	Completed
	17978	Renting of temporary training rooms in West, Central & East. SBAR has been approved for 2 year leases on the premises, awaiting contracts to be finalised.	Ms Jillian B-J Hughes, Manual Handling Manager	31/08/2021	Request extension until 30/11/2021 to enable completion of action due to timings to sign terms and contracts. Having additional rooms to provide manual handling training for staff will reduce risk mitigation by allowing an increasing the number of courses that	Delay

					can be delivered, increase the number of staff trained and increase compliance for BCUHB.	
	17979	Additional trainers sought, to be clinically trained as per the standards set within the All Wales Manual Handling Passport and Information Scheme that BCUHB have signed up to provide.	Ms Jillian B-J Hughes, Manual Handling Manager	31/08/2021	Request extension until 30/11/2021 to enable completion of action and appoint to additional posts. Additional trainers to provide training to the standard set within the Passport for clinical qualifications. Having increased number of trainers allows for increasing classes that can be offered, increase attendance and compliance for BCUHB.	Delay
	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.	Ms Jillian B-J Hughes, Manual Handling Manager	29/10/2021	Request extension until 31/12/2021 to enable completion of action, training needs analysis will be completed following appointments to new posts due to current capacity within the team. 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.	Delay
	18859	Finalise approve and implement MH policy and plan.	Ms Jillian B-J Hughes, Manual Handling Manager	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.	On Track

	18860	ESR to be reviewed to include manual handling 1A and 1B training courses for inanimate load level 1.	Ms Jillian B-J Hughes, Manual Handling Manager	31/03/2022	Support the risk and allow correct compliance and correct level of training, reducing the risk of injury for those attending class for a competency assessment.	On Track

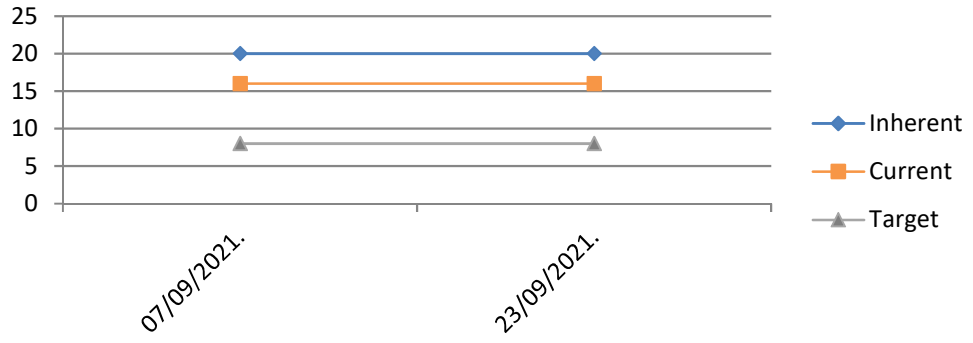
CRR21-17	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 26 July 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 23 September 2021
	Risk: The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 31 March 2022

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

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

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

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



	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. Local individual risk assessment undertaken by nursing staff as part of the Paediatric admission process. 2. CAMHS practitioners provide 7 day service and support to the paediatric wards for a limited number of hours (i.e. 9-5pm, 7 days a week). 3. Paediatricians attend the s136 suites for children under the age of 16 years to undertake a holistic medical assessment. 4. CAMHS Psychiatry provide a 7 day service for S136 assessments between 9am to 5pm for young people up to their 18th birthday and out of hours telephone on-call rota. 5. CAMHS provide support to the s136 suites for young people under 16 years or those with complex needs where possible. 6. Collaborative/partnership working with Local Authority in finding placements for young people waiting on Paediatric wards. 7. Safeguarding discharge SOP for young people in place. 8. Daily SITREP reporting between Paediatrics and CAMHS. 9. Analysis of intelligence from related incidents in generating organisational learning, awareness and fostering improvements.	1. A scoping exercise or SBAR of CAMHS Unscheduled/Crisis Care has been completed. 2. Related CAMHS risks are now regularly reviewed, scrutinised and discussed within a Pan-BCU approach. 3. Risk also regularly discussed at the Area - Quality and safety group. 4. Risk, controls and actions in place have been sufficiently shared with key stakeholders, i.e. the Local Authority and Police. 5. Pre Jet Meeting with WG, joint with MH division on a quarterly basis.

Gaps in Controls/mitigations
1. Inability to meet growing demand in crisis presentations due to availability, staff shortages and availability of appropriately trained staff, which has been exacerbated by the lockdown arising from Covid-19. Currently working with recruitment agency and established multi disciplinary team is already in place. 2. Lack of suitable LA placements or shared safe environments within which young people can be assessed or discharged to. 3. Lack of agreed criteria, threshold and standardisation for reporting related incidents.

Progress since last submission
1. Following approval at the QSE Committee on the 7th September 2021, this risk has been escalated onto the Tier 1 Corporate Risk Register. 2. Proposal to extend the target due date to 31/10/2022, to allow completion of all actions, whilst recognising there will be a phased reduction in the likelihood of the risk with the completion of earlier identified actions. 3. Working with lead officers to review the ligature points on Paediatric Wards and ensure appropriate environmental risk assessments are completed. 4. Currently reviewing SCH03 SOP under review (admission of young people with self harming behaviours) to ensure clear escalation process. 5. Working to finalise CAMHS pan BCU governance approach to link into area and children's services governance groups. 6. Strengthened assurance to include pre Jet Meetings with WG. 7. Gaps updated to be clear on the actual gap and mitigation in place.

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

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	17956	Multi-agency plan and policy for underpinning a robust Multi-agency Crisis Intervention pathway to be developed.	Marilyn Wells, Head of Nursing	31/10/2022	This will enable us to divert young people at the front door and support their needs in different ways	On Track
	17957	To use a collaborative multi agency partnership approach in addressing the needs of young people accessing CAMHS.	Marilyn Wells, Head of Nursing	31/10/2022	This will enable us to meet the needs of young people before crisis occur as most of their needs are pyscho-social and not just MH.	On Track
	17961	Targeted ligature assessments to be undertaken on Paediatric wards to identify ligature points to support existing preventative measures already in place.	Mr Martin McSpadden, Head of Nursing, Children's Acute and Community Services	29/10/2021	Ensure a safe environment by identifying all ligature points on the ward.	On Track
	17962	To recruit additional staff/agency to support individual young people as required.	Marilyn Wells, Head of Nursing	31/03/2022	It will support timely access to support and treatment in relation to the demand that has been experienced. The increase in workforce will enable us to provide more out-of-hour response.	On Track

	17963	Task and Finish Group to review SCH03 policy and update policy around care of young people at high risk of harm.	Marilyn Wells, Head of Nursing	30/12/2021	This will enable us to have a pathway in place and enable timely assessments without necessarily needing admissions.	On Track
	17964	Training and awareness raising for relevant professionals in supporting and assisting young people in crisis. For example: Paediatric staff/ A&E staff, Local Authority and North Wales Police.	Marilyn Wells, Head of Nursing	31/03/2022	Create awareness and develop skill in assessment and improve staff morale.	On Track
	18334	Identification and development of suitable shared (non hospital) environment for comprehensive assessment of needs and development of a plan to address needs across agencies.	Marilyn Wells, Head of Nursing	31/10/2022	Provision of an age appropriate environment that provides an appropriate alternative to hospital.	On Track

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

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

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

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 2nd November 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quality and Performance (QAP) Report to 30th September 2021
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Hill, Executive Director of Finance
Awdur yr Adroddiad Report Author:	Mrs Kamala Williams, Interim Director of Performance Mr Ed Williams, Head of Performance Assurance
Craffu blaenorol: Prior Scrutiny:	The data and information in this report has been scrutinised by the Interim Director of Performance
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

Members of the Quality, Safety and Experience Committee are requested to scrutinise the report and advise any areas to be escalated for consideration by the Board.

Please tick as appropriate

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

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:

Delivery Measures

This report includes key indicators from the NHS Wales Delivery Framework 2020-21. The Executive Summary is included within the Report.

The NHS Wales Delivery Framework for 2021-22 was formally published on 1st October 2021 and the Quality and Performance Report will include key performance and quality measures from December 2021.

Cefndir / Background:

This report outlines performance against the key performance and quality measures identified as a priority for the Health Board and reported to the Quality, Safety and Experience Committee.

The Executive Summary pages of the QAP Report sets out performance against the key measures contained within the 2020/21 Welsh Government National Delivery Framework.

The National Delivery Measures are derived from the Framework and are aligned to the Quadruple Aims set out in 'A Healthier Wales', Welsh Government's long term plan for health and social care.

Asesiad / Assessment & Analysis

Strategy Implications
The National Delivery Measures align to the National Delivery Framework, which supports 'A Healthier Wales' and the Health Board's Annual Plan.

Options considered
Not Applicable

Financial Implications
The delivery of the measures contained within the Health Board's Annual Plan will have direct and indirect impact on the financial position of the Board.

Risk Analysis
The COVID-19 pandemic has produced a number of direct and indirect risks to the delivery of care across the healthcare system.

Legal and Compliance
This report will be available to the public once published for Quality, Safety & Experience Committee

Impact Assessment
The Report has not been Equality Impact Assessed


GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board
Quality and Performance Report
Quality, Safety & Experience Committee
Performance to 30th September 2021
Presented on 2nd November 2021

About this Report

Welsh Government has advised Health Boards to continue to monitor performance in line with the measures included in the 2020-21 NHS Wales Delivery Framework until such time as the NHS Wales Delivery Framework for 2021-22 is formally published. The NHS Wales Delivery Framework for 2021-22 was formally published on the 1st October 2021. Key measures will be included in the Quality & Performance Reports from November 2021.

Report Structure

The format of the report reflects the latest published National Delivery Framework which relates to 2020-21 and aligns to the quadruple aims contained within the statutory framework of 'A Healthier Wales'.

The report is structured so that measures complementary to one another are grouped together. Narratives on the 'group' of measures are provided, as opposed to looking at measures in isolation.

This report contains data showing the impact of the pandemic on referrals, planned care activity and waiting lists.

Performance Monitoring

Performance is measured via the trend over the previous 6 months and not against the previous month in isolation. The trend is represented by RAG arrows as shown below.

- ↑ Performance has improved over the last 6 months
- ↓ Performance has got worse over the last 6 months
- → Performance remains the same

Ongoing development of the Report

The Quality & Performance Report for this Committee, together with the sister report for Finance & Performance Committee and for the Health Board are in the process of being redesigned.

The Integrated Quality & Performance Report will take a proactive approach towards providing assurance. It is supported by a set of frameworks and methodologies that will provide objective and replicable levels of assurance on content.

Executive Summary

The Committee is asked to note the following:

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

The seasonal flu vaccination campaign for 2021-22 was launched on the 4th October 2021. The progress of the campaign will be included in the next report.

Quadruple Aim 2: Infection Prevention
Over the past 12 months, the cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population, including E.Coli and C.Difficile has increased at an all Wales level.

The infection prevention and control teams continue to work on reducing the number of infections alongside their work on COVID-19.

Quadruple Aim 2: Mental Health
For Children's & Adolescent Mental Health Services (CAMHS) performance remains poor against the targets for the rate of children assessed within 28 days of referral, at 23.60%, and starting therapy within 28 days of assessment at 16.40%.

Although improved, Performance against the 26 Week target or children awaiting neurodevelopment assessment remains poor at 30.34%, compared to 32.79% reported previously. September performance figures are starting to show the impact of increased referrals to our external supplier; increased capacity from July with a 6 week lead in time to assessment. We expect the waiting list to start to reduce month on month by the end of October with the trend set to continue to end March 2022.

For adult mental health services, performance remains on an improvement trajectory in August, with percentage adults assessed within 28 days of referral at 66.6%. Although it has fallen slightly, the number of patients starting therapy within 28 days of assessment remains above the 80% target at 80.10%.

There has been a consistent and significant improvement in the percentage rate of adults waiting less than 26 weeks to start psychological therapy and at 87.1% in October 2021 continues to exceed the 80% target rate. This is a significant and sustained improvement from a low of 20.1% in September 2020.

The number of patients experiencing delayed transfer of care (DToC) within our mental health has increased slightly at 17 in September 2021 (compared to 16 reported previously), the length of stays has also increased to 817 (compared to 580 reported previously). The service is working to resolve issues that lead to DToC and it is expected that the number and length of DToC's will fall over the coming months.

Quadruple Aim 3: Quality & Safety
Two new Never Events were reported in Quarter 2 of 2021/22 (both occurred in August 2021), compared to three Never Events reported in Quarter 1 of 2021/22.

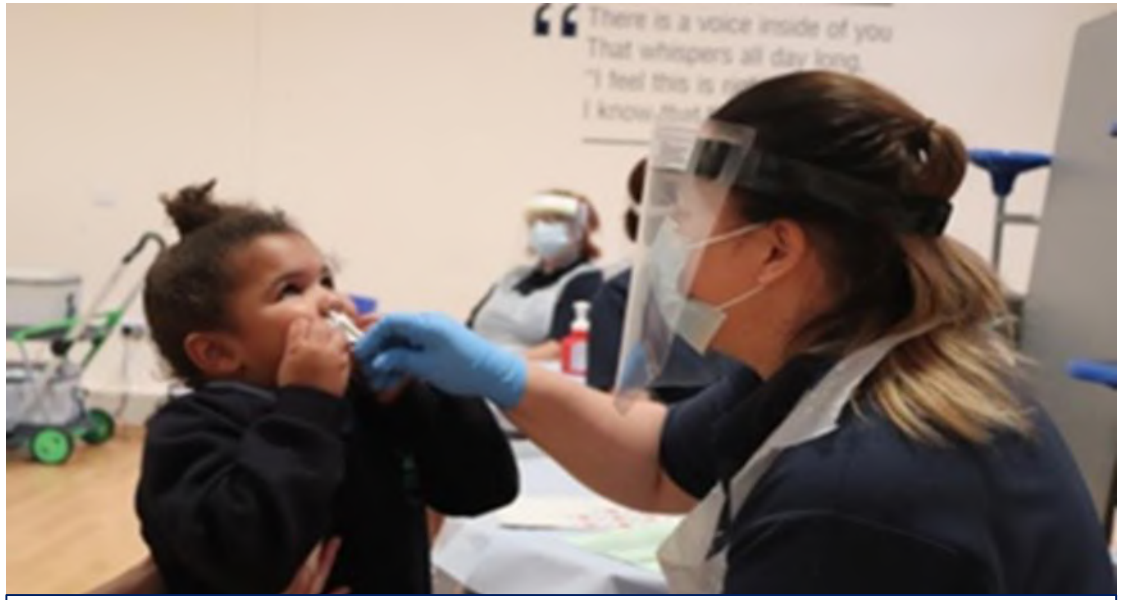
The percentage closure rate of complaints managed under PTR < 30 working days (target 75%) – 65.93% September 2021. Whilst not reaching the set target the process is currently stable and delivering at around 62% compliance for the last 7 months. This is a sustained improvement compared to previous years, where performance has been as low as 30%. This reflects the learning from incidents and focus upon timely responses.

Quadruple Aim 4: Mortality and Timely Interventions
Crude Mortality (under 75 years old) has decreased to 0.93%. The mortality rate for BCU is lower than the Wales average of 1.13%. As BCU has not been an outlier for mortality for at least 24 months, it is suggested that there is no longer a need to provide an exception report on this.

Concern remains with regards the recording and monitoring of provision of Sepsis Six bundles both for our Inpatients and within our Emergency Departments. The Office of the Medical Director is currently reviewing this. Reporting of both Inpatient and Emergency Department data and reporting has recommenced as of September 2021 although figures should be viewed with caution at this time.

Performance management
The Quality & Performance Report is currently being redesigned with a view to presenting a new Integrated Quality & Performance Report to the Health Board and its committees in December 2021 for approval before implementation in April 2022.

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



People will take more responsibility, not only for their own health and well-being but also for their family and for the people they care for, perhaps even for their friends and neighbours. There will be a whole system approach to health and social care, in which services are only one element of supporting people to have better health and well-being throughout their whole lives. It will be a 'wellness' system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

Measures

Period	Measure	Target	Actual	Trend
Q1 21/22	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1*	>= 95%	94.90%	↓
Q1 21/22	Percentage of children who received 2 doses of the MMR vaccine by age 5*	>= 95%	94.10%	↑
Q1 21/22	Percentage of adult smokers who make a quit attempt via smoking cessation services**	>= 5%	1.20%	↓
Aug 21	Percentage of health board residents in receipt of secondary mental health services who have a valid Care and Treatment Plan (aged under 18 years)***	>= 90%	97.30%	↑
Aug 21	Percentage of health board residents in receipt of secondary mental health services who have a valid Care and Treatment Plan (aged 18 years & over)***	>= 90%	90.80%	↑

* 12 Month Trend

** Performance compared to same quarter previous year

*** Reported 1 month in arrears

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

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

Measures

Period	Measure	Target	Actual	Trend
Aug 21	Percentage of mental health (CAMHS) assessments undertaken within 28 days of referral*	>= 80%	23.60%	↓
Aug 21	Percentage of therapeutic interventions (CAMHS) within 28 days of assessment*	>= 80%	16.40%	↓
Aug 21	Percentage of mental health (Adult) assessments undertaken within 28 days of referral*	>= 80%	66.60%	↑
Aug 21	Percentage of therapeutic interventions (Adult) within 28 days of assessment*	>= 80%	80.10%	↑
Aug 21	Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy	>= 80%	87.10%	↑

** Reported 1 month in arrears*

Quadruple Aim 2: Infection Control Measures

Period	Measure	Target	Actual
Sep 21	Cumulative rate of laboratory confirmed E-Coli cases per 100,000 population	<= 67	66.36
Sep 21	Cumulative number of laboratory confirmed E-Coli cases	N/A	234
Sep 21	Cumulative rate of laboratory confirmed S.Aureus cases per 100,000 population	<= 20	25.81
Sep 21	Cumulative number of laboratory confirmed S.Aureus cases	N/A	159
Sep 21	Cumulative number of laboratory confirmed C.Difficile cases	N/A	125

Period	Measure	Target	Actual
Sep 21	Cumulative rate of laboratory confirmed C.Difficile cases per 100,000 population	N/A	35.45
Sep 21	Cumulative numberof laboratory confirmed MRSA cases	0	4
Sep 21	Cumulative number of laboratory confirmed MSSA cases	<= 40	87
Sep 21	Cumulative number of laboratory confirmed Klebsiela cases	<= 38	73
Sep 21	Cumulative number of laboratory confirmed Aeruginsoa cases	<= 10	22

Targets received from Welsh Government – October 2021

Comparison Charts to all Health Boards in Wales – October 2021

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

Quadruple Aim 2: Infection Prevention

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

- In comparison with other Welsh Health Boards we are not an outlier for any of the 6 Healthcare Acquired Infections (HCAI). As the biggest health board our position is either 3rd or 4th when looking at the data for April to September 2021.
- We are improving and transforming what we do to reduce the risk of infections so we should see ourselves move over to the left more in these charts (previous page) over the coming months as the improvements lead to even more harm free behavioural change.

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

- Strengthened leadership and assurance in Infection Prevention & Control (IPC) particularly nursing and management.
- Safe Clean Care Harm Free transformation/improvement programme beginning to change behaviour in the organisation.
    - Visitors lateral flow pilots a success develop to roll out across health board.
    - COVID-19/Flu testing in Emergency Departments (EDs) now rolling to paediatrics.
    - Leadership walk-around restarted and making an impact.
    - Walking with purpose Bevan Exemplar.
- International IPC week this week programme of education and awareness to embed learning and skills.
- IPC big conversation recorded and available to watch on SCC-HF intranet page to support staff.
- Quarter 3 Safe, Clean Care - Harm Free (SCC-HF) self assessments submitted and going through table top confirm and support meetings highlighting good progress towards a zero tolerance approach to (HCAIs).

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

Performance will improve over the coming months as the changes and improvements we have put in place lead to more harm free behavioural change.

What are the risks/ mitigations to delivery?

We need the following to reduce the risk of not continuing to deliver improved performance

- increased patient flow through the health board to decrease the risk of low infection transmission.
- prudent antimicrobial prescribing and learning from Post Infection Reviews (PIRs) to change behaviour.
- estate that is fit for present and future clinical care provision.
- skilled staff in substantive posts with the space to recruit/train rapidly.

Quadruple Aim 2: Neurodevelopment and Children & Adolescent Mental Health Services

Frequency	Measure	Target	Actual	Trend
Sep 21	Percentage of children and young people waiting less than 26 weeks for neurodevelopment assessment	>= 80%	30.34%	
Aug 21	Percentage of mental health (CAMHS) assessments undertaken within 28 days of referral*	>= 80%	23.60%	
Aug 21	Percentage of therapeutic interventions (CAMHS) within 28 days of assessment*	>= 80%	16.40%	

* Reported 1 month in arrears

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

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

- Increased Demand - there has been an increase by 9% in total referrals since April 21, compared to 2019/20 pre-pandemic levels.
- Deterioration in core capacity for routine assessments and therapy available is multifaceted, in part related to pandemic social distancing requirements and changes in practice associated with the pandemic. We have also diverted some capacity to provide greater Crisis capacity noting the increased Crisis demand nationally.
- Complexity of referrals has also increased and affected new to review ratios by 30% when compared to 2019/20.

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

- A full tender exercise is underway for additional external capacity, which is expected to be completed by December 2021.
- A regional CAMHS performance group has been established under Targeted Intervention (TI) arrangements to address performance against the trajectory and to ensure that each team is delivering on expected outputs and recovery planning implemented at al early stage where applicable.
- Local capacity planning is being improved with supplemented training being provided to new colleagues in senior roles. Training Programme for all staff groups under development in conjunction with Health Education & Improvement Wales (HEIW).
- A Performance Management Framework is being implemented and adopted with increased clarity of KPIs, responsibilities and accountability.
- There are some concerns regarding data quality of waiting lists, particularly with East area data, resulting in a waiting list validation exercise being undertaken.
- Use of the Choice and Partnership Approach (CAPA) framework continues to be a priority, with engagement in a further CAPA workshop arranged by the CAPA founder in October.
- Given observations that some health boards are reporting better performance against Mental Health Measure (MHM) targets across Wales, service leads are meeting with colleagues in Aneurin Bevan, Cwm Taf Morgannwg, and Swansea Bay Health Boards to share best practice.

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

- During Q3 and Q4 it is anticipated that there will be an improvement during 21/22, with a view to further improvement in line with target of 80% of patients having waited under 28 days during 2022/23. This is based upon trajectories that assume that the demand continues at expected levels, which will be continually reviewed.

What are the risks to this timeline?

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

What are the mitigations in place for those risks?

- Workforce plan and development of recruitment strategy with support from Just-R recruitment agency.
- Performance management framework and escalation through TI Access Work Stream and CAMHS Strategic Improvement and Development Group.
- Weekly capacity and demand meetings held across each team to monitor and manage flow.

Quadruple Aim 2: Neurodevelopment (ND)

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

- Current waiting list is 2,544; an increase of 4.4% (107 children) since the last report and 15.3% (338 children) since April 21. Longest wait is at 208 weeks; this case is booked for September, after previously declining external provider offers.
- Currently there are 1292 children who have waited over 1 year, and 1703 who have waited longer than 26 weeks. In August 21 BCUHB was shown at 26.8% compliance with Welsh Government (WG) target compared to an all Wales compliance of 32.6%. The Waiting List (WL) validation exercise continues and results should be reflected in the October data.
- Internal activity remains below planned trajectory, which is a theme consistent with other health boards due to change in practices due to COVID-19. Internal trajectories are currently being reviewed in light of this. Dedicated management time is being considered to review the Neurodevelopment (ND) service requirements going forward.
- Accepted referrals remain in line with pre pandemic levels (100-120 per month)

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

- Our planned activity from our external provider increased in July to 100 cases per month. This higher level of activity will begin to be shown in WL numbers from September onwards (the contract gives 6 weeks to begin assessment from receipt).
- Confirmation received from finance regarding allocation of the recovery funding and slippage to support external supplier contracts.
- Agreement to establish dedicated managerial and operational capacity to complete outstanding work on activity, waiting list validation and establish links with other Health Boards whose internal activity has recovered. Led by the Regional Neurodevelopment Steering Group.
- Identify at Local authority team level ways to work together to support families.
- Continue contributing to the Welsh Government ND work streams, (ND Clinical Work stream, Interventions and Digital platform) which are due to report mid to late 2022.

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

- Historical Waiting list will start to fall from September and continue to fall until March 2022, due to increased external provider activity of approximately 100 per month.
- Establish dedicated management operational time by end of October.
- Regional Waiting list validation exercise continues to be scoped/agreed, in the meantime some local validation of waiting lists is taking place.
- Production of initial business case to establish a sustainable service able to meet all elements of neurodevelopment service, prevention, assessment and intervention by December.

What are the risks to this timeline?

- Current service lacks the capacity and size to meet all elements of Neurodevelopment/Neurodiversity Service: Prevention, assessment and intervention.
- Capacity within current teams to support the historical waiting list recovery whilst addressing current demand within service
- Lack of progress in identification of dedicated management time to support service development
- Mixed engagement from local authorities and other Health Board.

What are the mitigations in place for those risks?

- Overview and reporting of Regional Neurodevelopment Steering Group (RNDSG) and successor group to report directly to Area Directors/ Executive Director.

Quadruple Aim 2: Adult Mental Health Measures

Frequency	Measure	Target	Actual	Trend
Aug 21	Percentage of mental health (Adult) assessments undertaken within 28 days of referral**	>= 80%	66.60%	↑
Aug 21	Percentage of therapeutic interventions (Adult) within 28 days of assessment**	>= 80%	80.10%	↑
Sep 21	Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy	>= 80%	87.10%	↑
Sep 21	Total Number of mental health delayed transfer of care (DToC) patients	Reduction	17	↓
Sep 21	Total Number of mental health delayed transfer of care (DToC) bed days	Reduction	817	↓

*** Reported 1 month in arrears*

Quadruple Aim 2: Adult Mental Health Delayed Transfers of Care

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

- Since February 2021 (32 patients and 2,956 bed days) the Mental Health & Learning Disabilities (MH&LD) Delayed Transfers of Care (DToC) performance has improved significantly
- The reasons for delays are commissioning gaps which are being progressed.

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

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

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

- Weekly scrutiny and escalation to SLT in place
- Current DToC figures for August 2021 is 15 patients and 770 days (a reduction from approximately 3,000 bed days per month prior to February 2021)
- Action Plan developed aligned to recommendations of the DToC review, updates provided monthly at Operational Leadership meeting and assurance report presented monthly at Divisional Senior Leadership Team (DSLT).
- Commissioning gaps being considered in future plans and division participating in All Wales Stranded Patients work programme.

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

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

Quadruple Aim 2: Adult Psychological Therapy

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

Issues Affecting Performance

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

Actions

- Welsh Government (WG) funding and recruitment of small increase in Adult Mental Health (AMH) secondary care psychology specialist resource was targeted at waiting times/demand hotspots.
- Sustained stepped care pathway work over last 3 years resulted in incremental improvements re: target compliance.
- The set up and roll out of the AMH Psychology Stepped Care Initiative increased psychological therapies provision from the Multidisciplinary Team (MDT) workforce across multiple services (as per Matrics Cymru) through a rolling supervision & training programme.
- This initiative also developed and delivered increased direct provision of evidence based psychological therapy group interventions across Primary Care Mental Health (PCMH) and Community Mental Health Teams (CMHT) pan BCUHB.
- During the COVID-19 pandemic this initiative developed and increased availability of digital resources and adaptations, making these accessible to mental health MDT clinicians pan BCUHB Mental Health & Learning Disabilities (MH&LD) services to support increased access and delivery of Cognitive Behavioural therapy (CBT), Dialectical Behavioural Therapy (DBT), and Coping Skills via group and individual input.
- Two rounds of external support have been organised to address the Wrexham legacy waiting list, now cleared.
- Recruitment and retention support for psychology staff resource in Community Mental Health Teams (CMHTs), Inpatient Services, Perinatal Services.
- North Wales Traumatic Stress Initiative Consultant Lead Psychologist recruited, due in post December.
- Funding for dedicated psychology resource embedded in Primary Care Mental Health (PCMH) achieved to further develop PTs in PCMH and outreach across stepped care mental health services, recruitment underway.
- Early Intervention Psychosis (EIP) Strategic and Clinical Lead Psychologist recruitment recruited, due in post December to support Psychological Therapists (PTs) development in EIP services pan BCUHB, alongside other EIP service aims.
- West (Arfon/ South Gwynedd) CMHT Band 7 recruitment successful, due in post October, will support West compliance.

Outcomes

- AMH secondary care specialist PTs compliance August 2021 is the highest since target was introduced.
- Long-term sustainability supported by increased psychological therapies competences and skills in the wider MDT workforce as per the stepped care model (Matrics Cymru) enabling wider service user access.

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

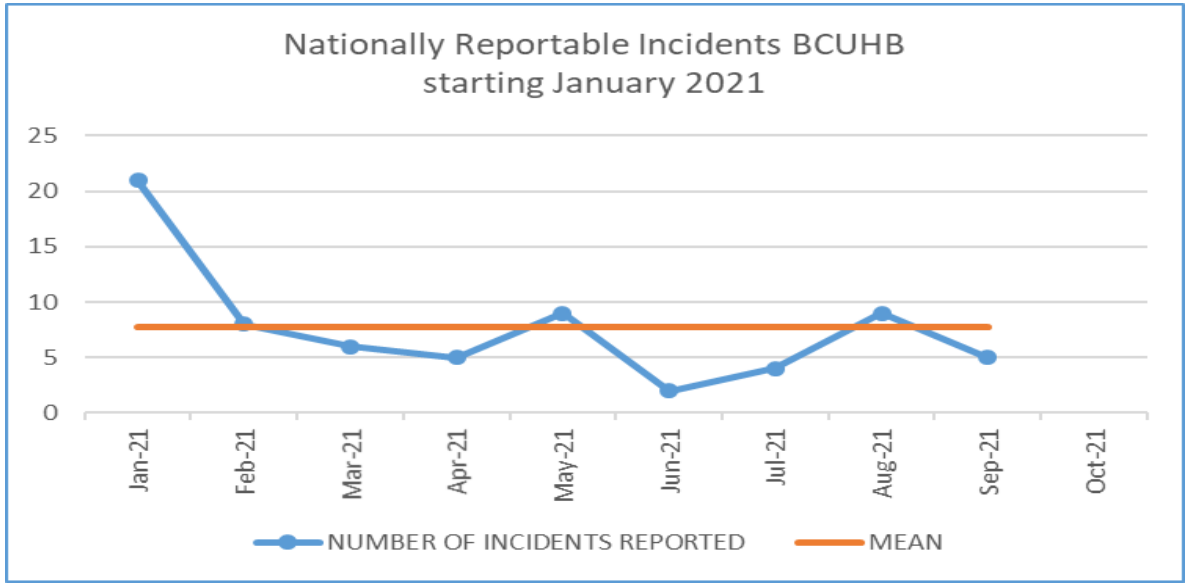
New models of care will involve a broad multi-disciplinary team approach where well-trained people work effectively together to meet the needs and preferences of individuals. Joint workforce planning will be in place with an emphasis on staff expanding generalist skills and working across professional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

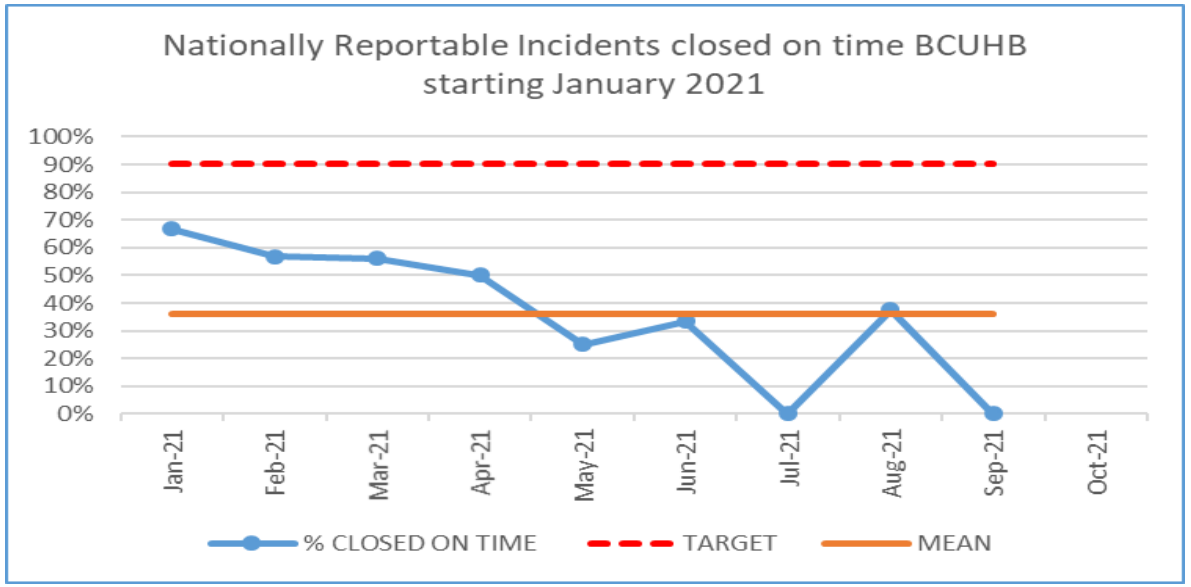
Measures

Period	Measure	Target	Actual	Trend
Q2 21/22	Percentage of complaints that have received a final reply (under Regulation 24) or an interim reply (under Regulation 26) up to and including 30 working days from the date the complaint was first received by the organisation	75%	65.93%	↑
Q2 21/22	Number New Never Events	0	2	↑
Oct 21	Doctor Appraisal / revalidation rate*	95%	80.69%	↓

Failure to complete an appraisal due to COVID-19 issues will be logged as an approved missed appraisal. Everyone who has not completed an appraisal so far in 2021 is entitled to an approved missed appraisal. The adjusted figures should read 100% for all areas.

Quadruple Aim 4: Incidents (Reportable)



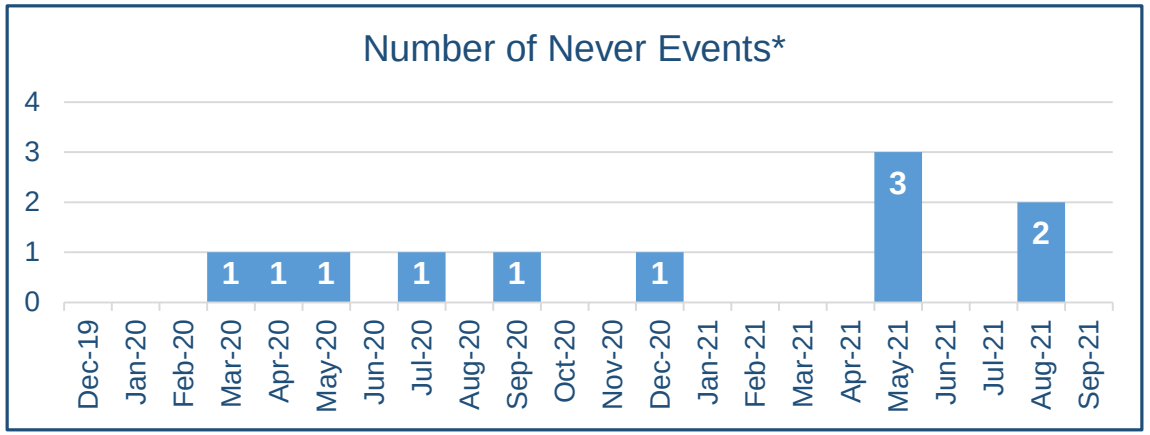


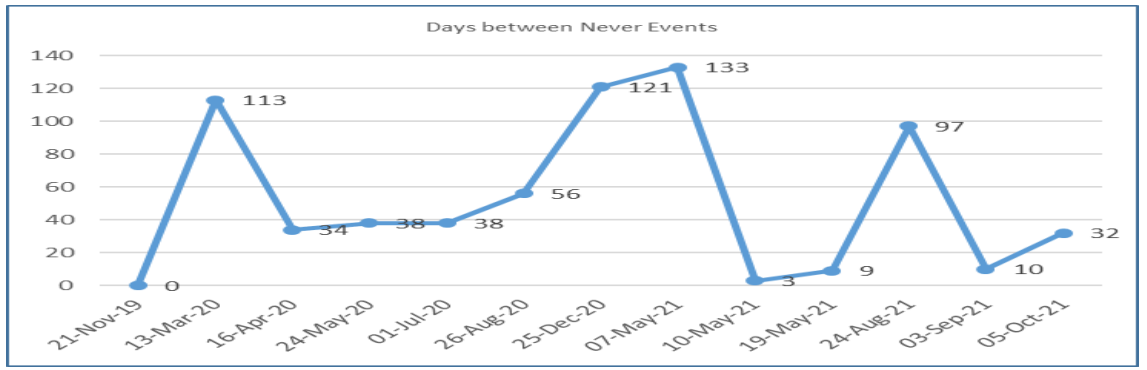
From 4th January 2021, in response to the increase in pressure on services, caused by the second wave of Covid-19, the Welsh Government reintroduced their reduced list of reportable serious incidents. Numbers of incidents reported subsequently fell again.

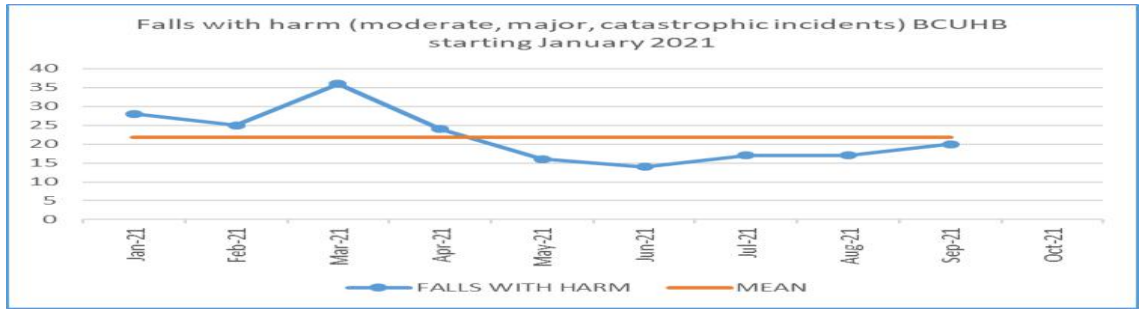
The continued low reporting levels from June 2021 however, are as a result of the changes in reporting criteria as detailed in Phase 1 of the NHS Wales National Reporting Policy, in particular the requirement to report only falls resulting in severe (i.e. permanent harm). Further detail is included in the Quality Highlight Report to QSE.

The percentage of nationally reportable incidents that have been closed on time has been below target for some time and noticeably poor since May 21. Reasons for specific incidents not closing on time in time period include: identification and capacity of investigators, a number of complex investigations, and quality issues that need addressing following review at the Incident Learning Panel.

Quadruple Aim 4: Never Events and Reportable Incidents







There have been 5 never events since April 2021

- Incorrectly prescription Methotrexate
- Chest drain- wrong side
- Ascetic drain inserted- wrong patient
- Nerve block- wrong side
- Retained object following surgery.

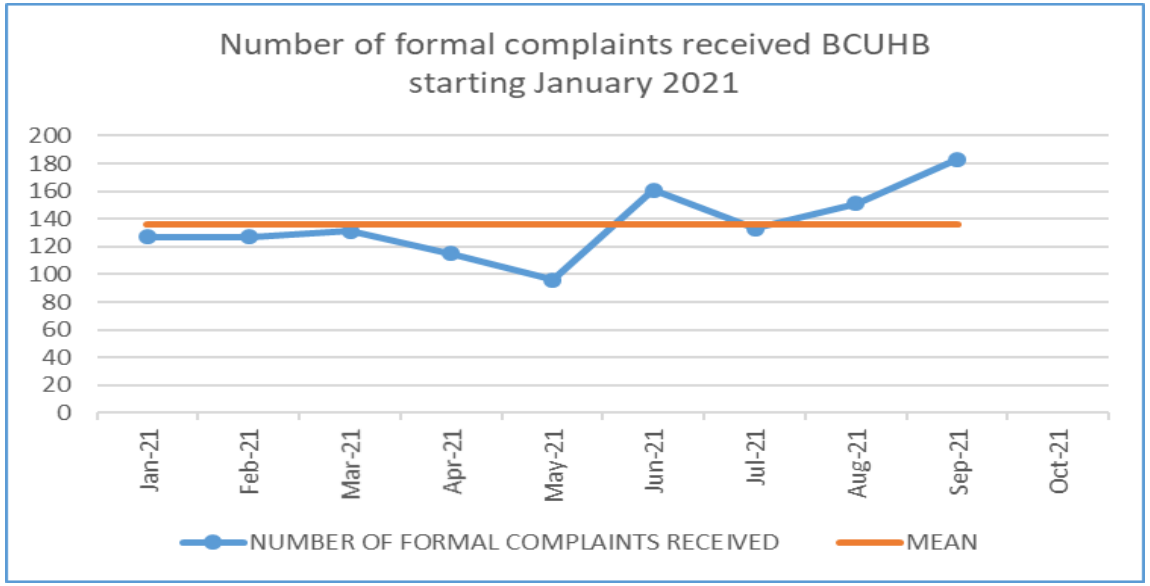
- The reduction in the days between Never Events may be indicative of the impact of the pandemic and associated human factors. There are work streams under development to address Never Events to include work around WHO checklist. Further detail on the Never Events is contained in the Quality Highlight Report to QSE.

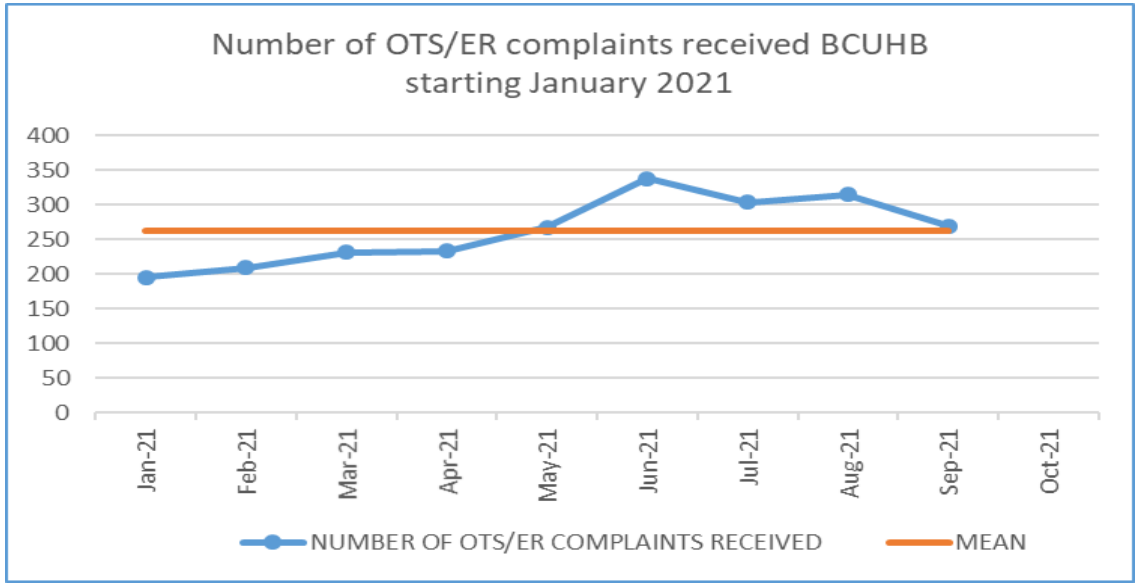
- The Number of falls with harm (categorised as moderate, major and catastrophic within the incident reporting system) has fallen although the last few months has shown a slight increase. There are a number of interventions taking place including a strategic falls group looking at training, reviewed policy and measurement.

- Since June 21, falls are only nationally reportable if death or severe harm has been caused by any action or inaction in the course of their care.

** Never Events in the Month they occurred as opposed to the month they were reported. The Days between Never Events graph shows the dates the never event was reported, not the day on which it occurred.*

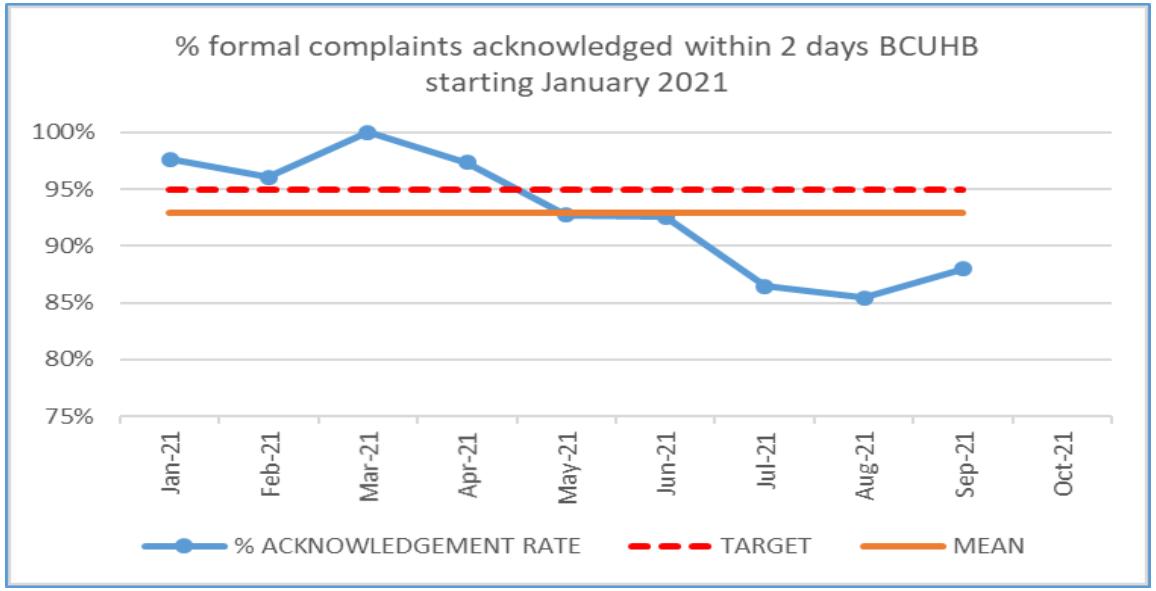
Quadruple Aim 4: Complaints

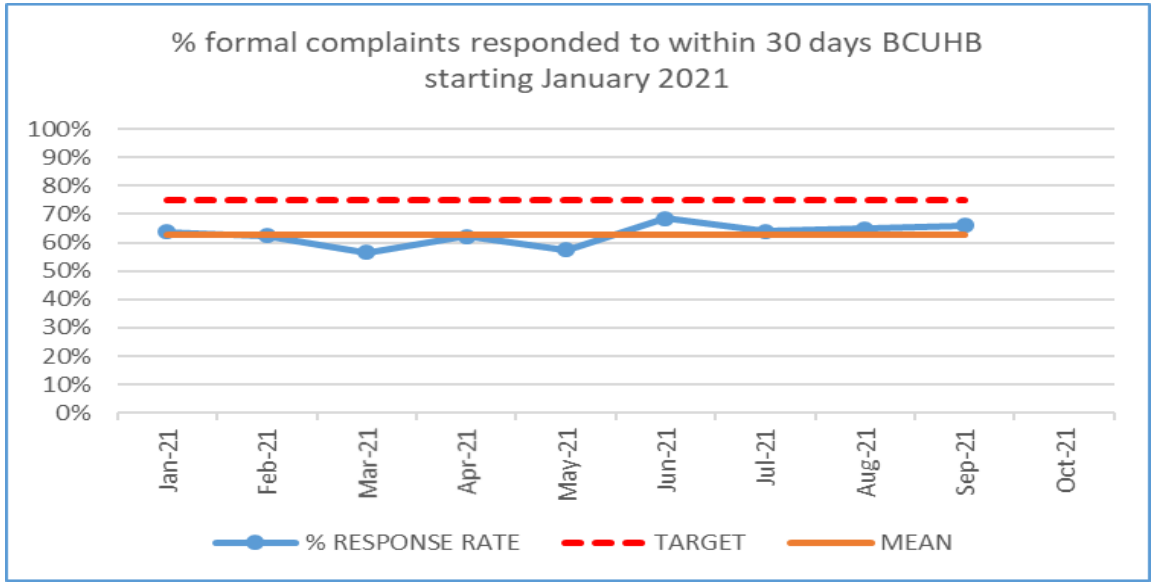




- There has been an increase in the number of Formal Complaints received, following a trend analysis many of these relate to secondary care waiting times and care delivery issues.
- A number of new Formal Complaints received are indirectly COVID-19 related, in light of the ongoing pressures our trajectory is a continued increase in complaints raised specifically in relation to waiting times and access.
- The number of Early Resolutions (ER) increased gradually from January to May with a significant increase in June, July and August. This demonstrates the proactive approach by the Complaints Team to resolve the complaints in a two day time frame (for those that do not allege harm), improving rapid resolution of concerns for patients and preventing them from becoming Formal Complaints.

Quadruple Aim 4: Complaints



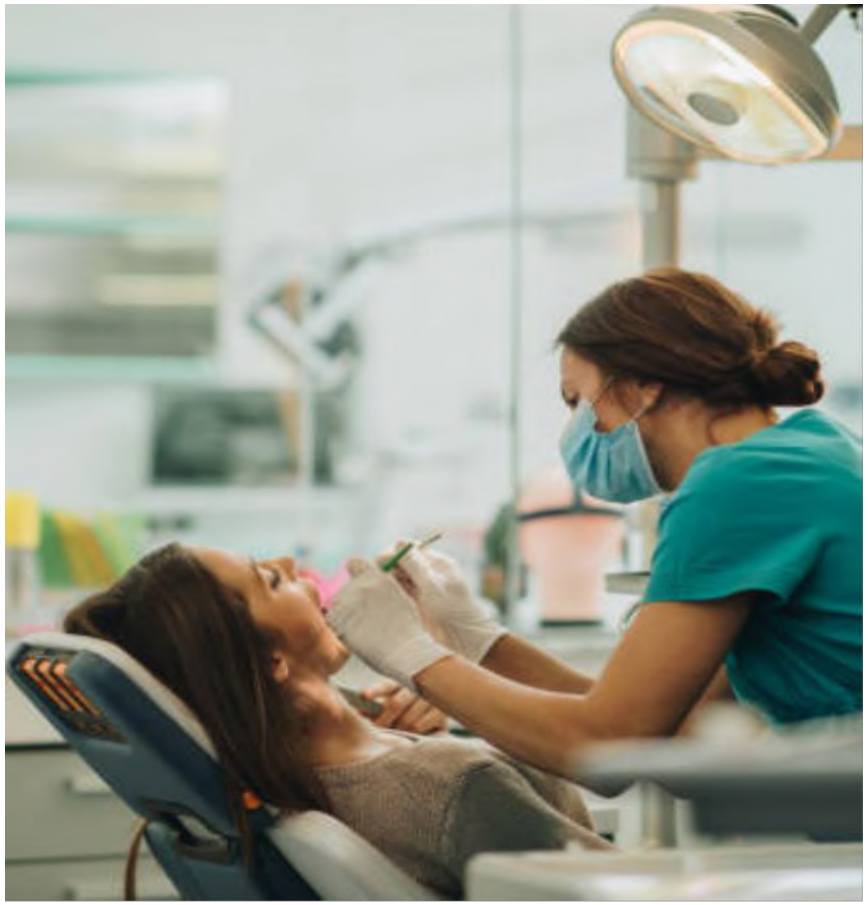


- There was a significant drop in the number of 2 day acknowledgements in July/August/September. This is largely due to a delay in sending complaints to the Complaints Team from services and departments, sickness absence and leave over the summer. A recovery plan is being put into place as detailed below.

- The 30 day performance target is above 2020 levels however at 65.93%, (129/226) it remains below the 75% target set by Welsh Government, this is due to number of factors including – increase in the volume of Formal Complaints received, third wave of the COVID-19 pandemic and the capacity within services to investigate complaints.

- A recovery plan is being put into place to improve complaint performance recognising the expected pressures over the coming winter. This includes further refining processes and additional resource.

Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation enabled by data and focussed on outcomes.



Measures

Period	Measure	Target	Actual	Trend
Aug 21	Crude hospital mortality rate (74 years of age or less)*	Reduction	0.93%	↑
Aug 21	Percentage of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening**	Improve	66.67%	↓
Aug21	Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening**	Improve	29.49%	↓
Jul 21	Percentage of patients (age 60 years and over) who presented with a hip fracture that received an orthogeriatrician assessment within 72 hours *	Improve	71.67%	↑
Sep21	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Improve	93.70%	↓

* Rolling 12 months reported 1 month in arrears

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

Quadruple Aim 4: Narrative - Mortality

The 12 month rolling crude mortality rate for ages 75 years and under is below the peer group (0.93% v 1.10% (Other Welsh HBs ex Powys) to August 2021). This has reduced during further as COVID infections have lessened and is similar to the previous year. The highest number of deaths was in those patients admitted with COVID-19 (113) , Sepsis (79) and pneumonia (72 – lobar and unspecified). The HB has the lowest mortality rate compared to the peer group.

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

- Crude mortality- overall (2.06% v 2.42%) this is similar to previous year.
- Mortality- sepsis (18.01% v 21.68%) remains below the peer; variation seen over the past year is common cause with mortality “as expected” overall.
- Mortality- cerebrovascular disease incl. stroke (12.34% v 17.7%) variation seen over the past year is common cause with mortality “as expected” overall.

Actions being taken

- A Clinical Mortality Lead (Dr Damian McKeon) has been appointed. He will lead the implementation of the Once for Wales National Mortality Framework and clearing the backlog of stage 2 reviews.
- The new DATIX module will be accessible form this month; however, training is required from the national team. The framework to be in place to maximise its use; however the early release does not have the ability to generate reports and so additional administrative support is needed. This is include in the business case for the clinical effectiveness department currently with the Exec Medical Director.

Timelines

- Clinical Mortality Lead - commences in post October 2021.
- The business case will need to be discussed with the Executive Team, once the Medical Director ahs agreed the content. (by end October 2021).
- Learning from Deaths Policy and process – this should be updated by March 2022 when the framework is in place.
- Option appraisal to clear the backlog will be developed by the end of November 2021.

Risk

- Lack of agreed mortality review process across all acute sites may result on the three areas working differently. Mitigation - all sites are using the same tools. Working towards delivering the national framework by Mar 2022 across all sites.

- Failure to complete mortality reviews in a timely way, means learning is not identified or shared and this could lead to patient harm and loss of organisational reputation. Site-based reporting has been put in place to ensure all sites are aware of the pending stage 2 reviews. Mitigation -Sites all have processes in place to complete reviews. Those reported through the Putting Things Right system or to the Coroner have a robust governance system to monitor action plans and share learning. A quarterly report is in place that highlights the concerns raised by the Medical Examiners Service to enable thematic review. Actions: an option appraisal to clear the backlog will be delivered by the end of November 2021.

Quadruple Aim 4: Narrative – Timely Interventions - Sepsis

Issues Affecting Performance

- Data collection remains a challenge on all sites as reported previously, Approximately, half the coded admissions are being reported, more from YG than other areas; inpatient data is very poorly captured .
- The current sepsis tool is not fit for purpose and has not been updated in line with changes elsewhere in the UK. This over diagnoses sepsis and results in the overprescribing of antibiotics which is under close investigation. Therefore sepsis is being diagnosed clinically, depending on the assessing team. .
- Long ambulance waits, delays in Emergency Dept. doctor reviews and sometimes lack of nurses contribute to delays in diagnosis and treatment in YG.
- The Symphony system in ED requires real time data entry; this is hampering time sensitive interventions as data tends to be entered retrospectively.

Actions and Outcomes

- All sites are aware of this issue and it has been escalated to Secondary Care division and corporate Clinical Effectiveness Group (CEG).
- Karen Mottart is working to co-ordinate a response between the sites and an update of the sepsis tool in line with current NICE guidance.
- YG ongoing unscheduled care improvement work stream will address some process delays. They are trying to identify additional staff to support data entry.
- YGC are is trialling an updated tool with good response in ED, to address data collection forms will be used until at transition to an electronic record. In the next month we will begin getting the next complete data set from ED. And will aim to roll out the tool to other wards.
- YWM has identified sepsis champions for all clinical areas that will start to support a programme led by Acute Intervention Team; sepsis bundle included in local teaching with additional targeted education focussing on new starters.
- Sepsis bundle to be included in the electronic nurse documentation.

Timeline for delivery of improvement

- New tool to be adopted by the end of the calendar year.

Risks and Mitigations

The risk is the organisation is not sighted on Sepsis 6 bundle compliance because of poor data capture. This has been escalated within sites, to Secondary Care Medical Director and CEG and corporate CEG. There is no mitigation in place, although clinical staff are aware of the requirement for this care to be delivered; training is in place in all EDs. At the current time mortality from sepsis is within expected limits and below the Welsh average peer group in the Comparative Healthcare Knowledge System (CHKS).

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

Quadruple Aim 4: Narrative – Timely Interventions – Orthogeriatrician Review

Ortho-geriatrician Review within 72 Hours

Issues Affecting Performance

- YG – The compliance in July 2021 was 63.6% . Lack of Ortho-Geriatric cover due to consultant shielding and sickness are a concern
- YGC - The compliance in July 2021 was 86.4%. There is a full time physician in this role and a dedicated Physicians Associate attached to Ortho-Geriatrics.
- YWM - overall orthogeriatric review within 72 hours for patients over the aged of 60 with NOF/proximal femoral fractures sits at 65% for the 12 month period to August 2021 (includes time period with no orthogeriatric cover because of COVID but this is reaching the end of its time lag). Monthly trend upwards (especially since additional consultant sessions since April 2021) with most recent monthly figure >80%. Risk remains that there is no formal cover plan in situ for leave etc.

Actions and Outcomes

- YG - Limited sessional cover secured for planned annual leave (10 sessions/year of Care of the Elderly COTE).
- YGC – no additional actions.
- YWM - no additional actions.

Timeline for delivery of improvement

There are no actions currently underway.

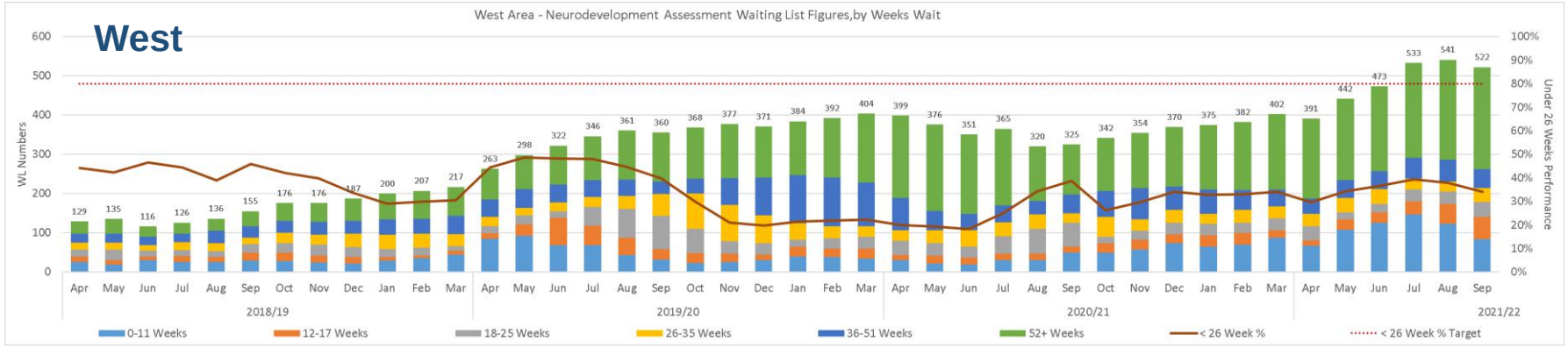
Risks and Mitigations

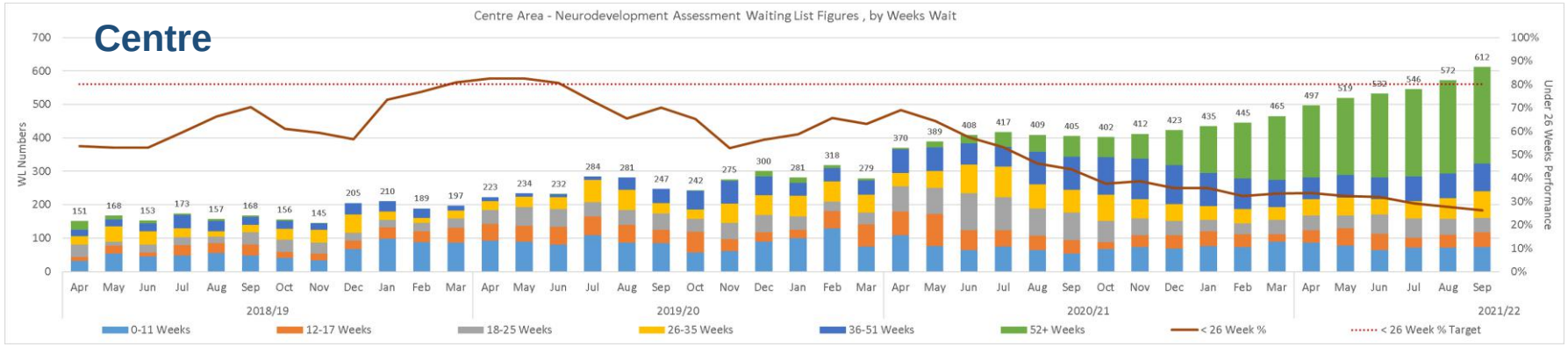
The risk is that patients' health is not maximised before surgery and comorbidities not managed well peri-operatively with the potential for avoidable morbidity and mortality. Performance has improved over the past 3 years across the Health Board with additional resources.

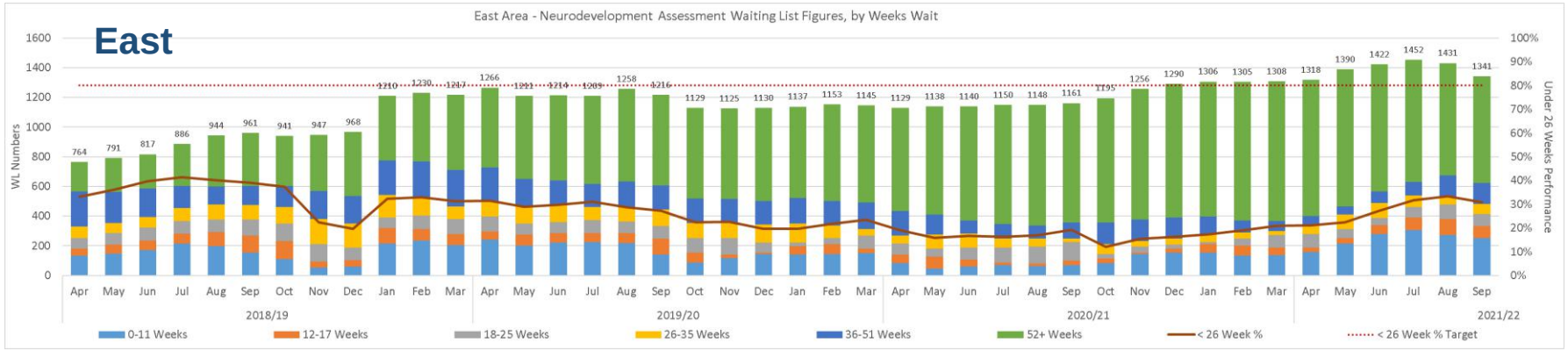
YG = Ysbyty Gwynedd YGC = Ysbyty Glan Clwyd YWM = Ysbyty Wrecsam Maelor

Additional Information

Quadruple Aim 2: Charts Neurodevelopment







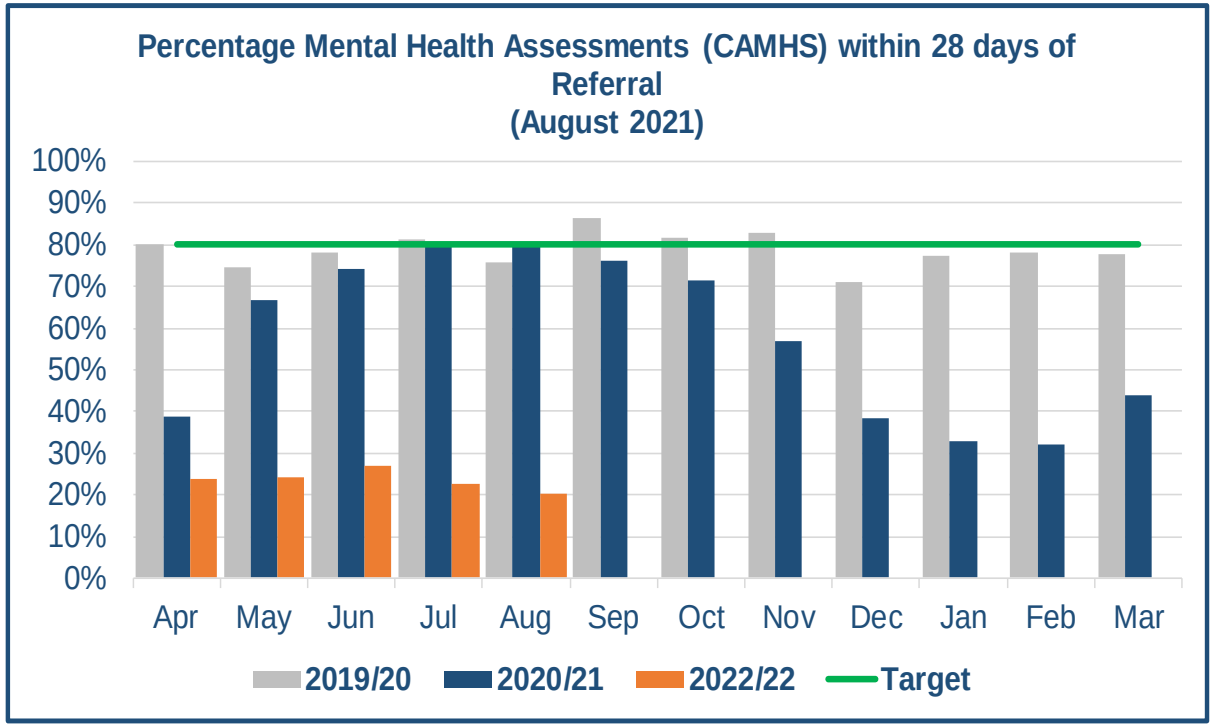
Note: Significant increase in number of patients waiting over 52 Weeks in all areas.

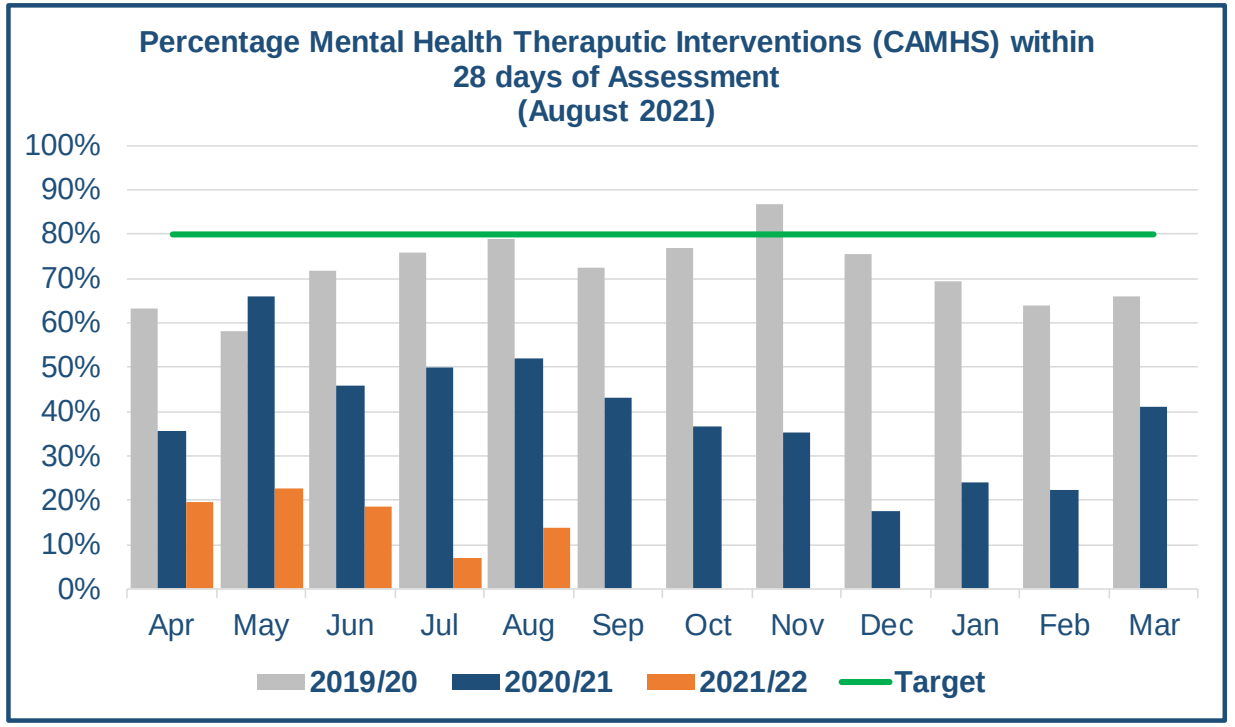
West and East have always had significant cohort of patients waiting over 52 weeks. However, in the Central Area, the increase in the number of patients waiting over 52 weeks coincides with the outbreak of the COVID-19 Pandemic.

As can bee seen in the graphs, East area has more patients waiting than West and Centre combined, and has always had a significantly higher number of patients waiting over 52 weeks.

In the East, between December 2018 and January 2019 there was a significant increase (almost double) in the number of patients waiting for a neurodevelopment assessment. The level of patients waiting has remained high ever since.

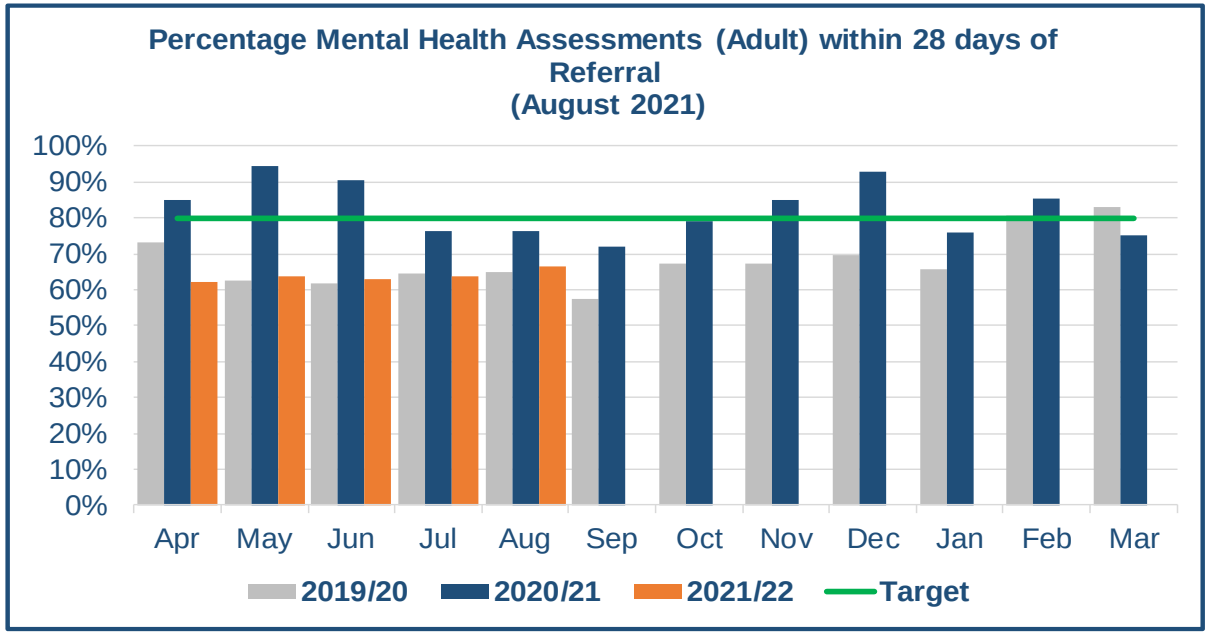
Quadruple Aim 2: Charts CAMHS

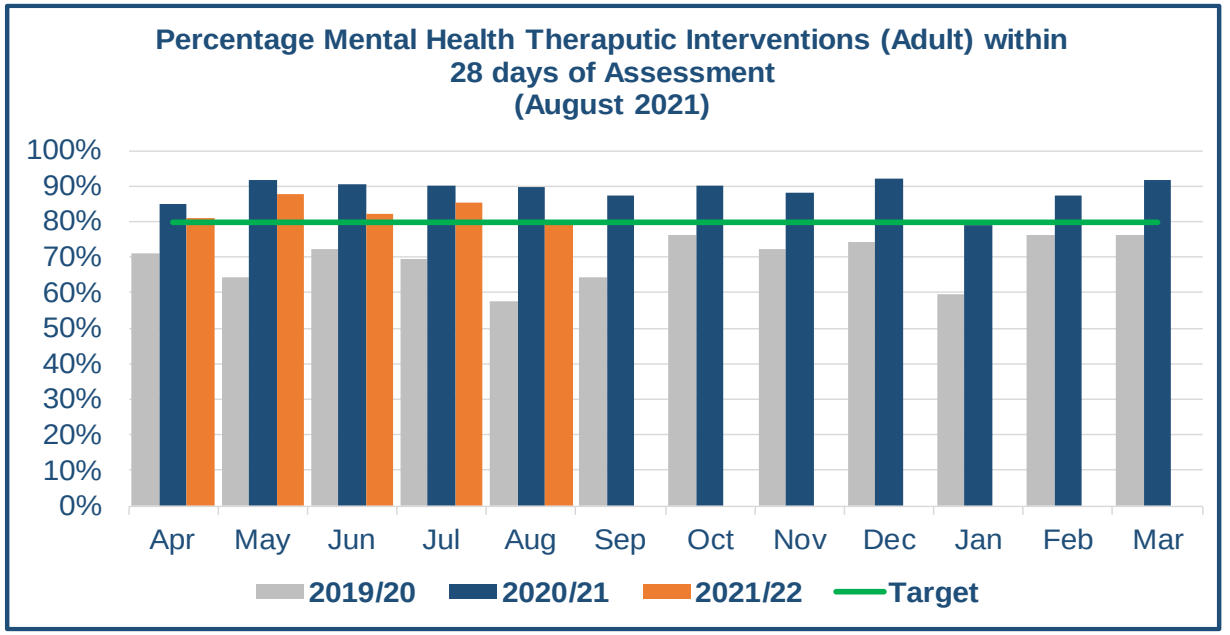




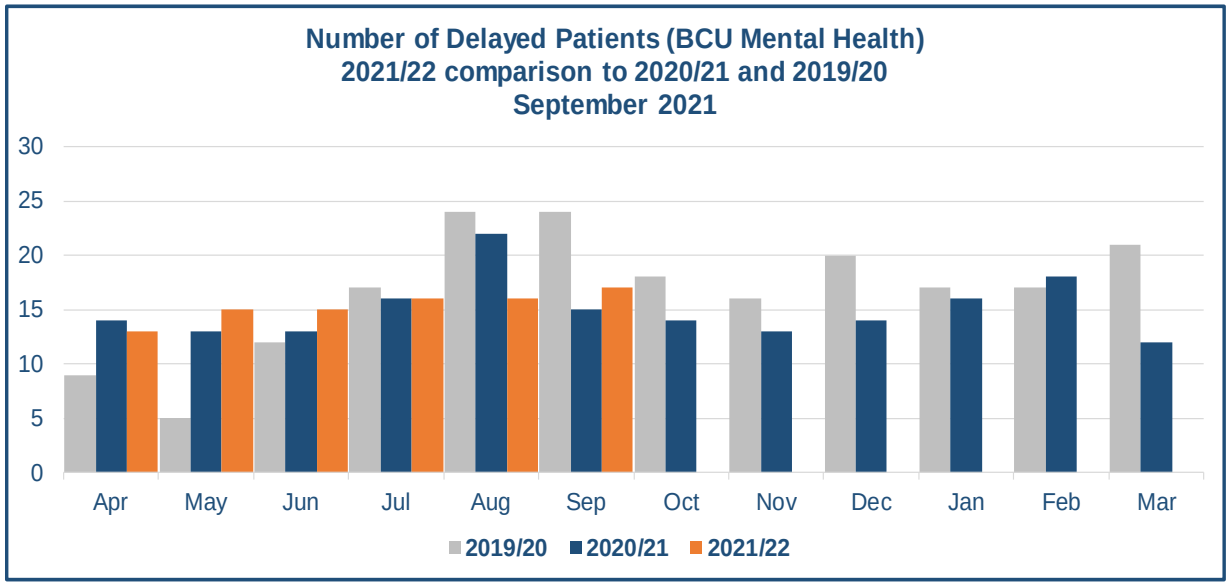
Data is reported 1 month in arrears

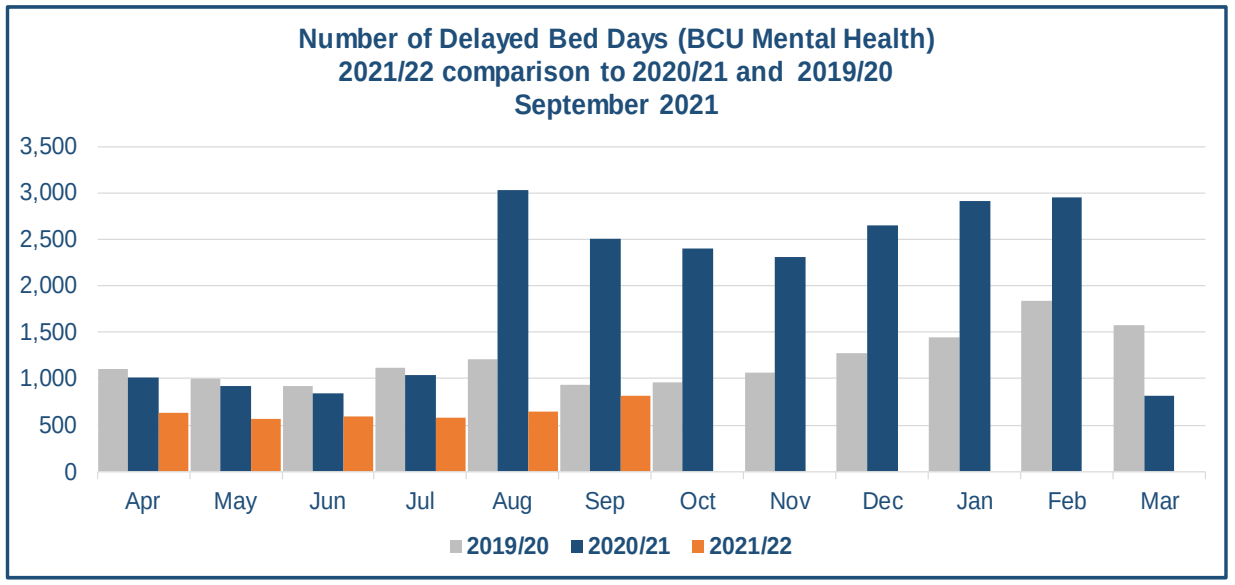
Quadruple Aim 2: Charts Adult Mental Health



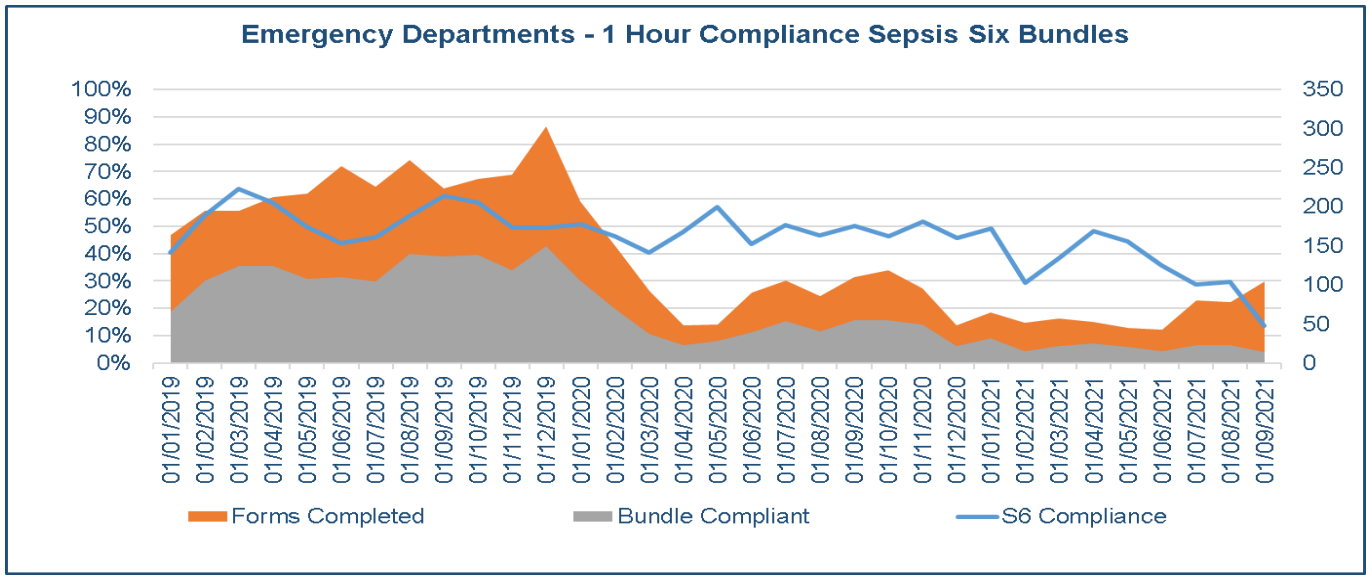


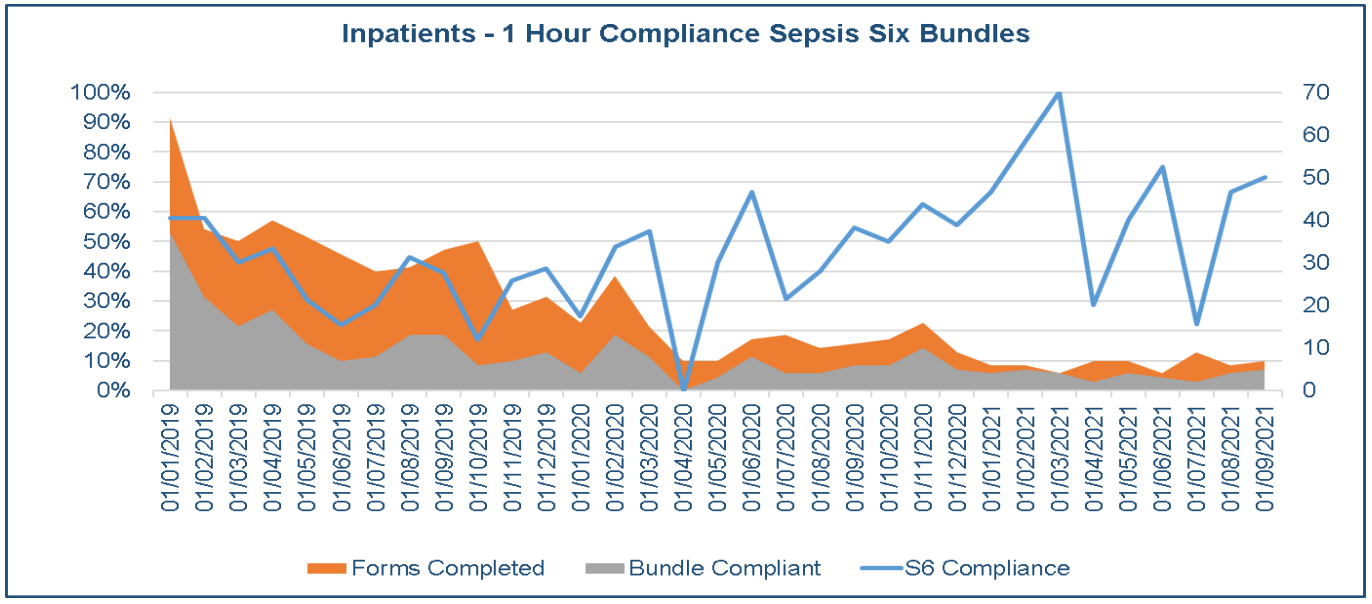
Quadruple Aim 2: Mental Health Delayed Transfers of Care





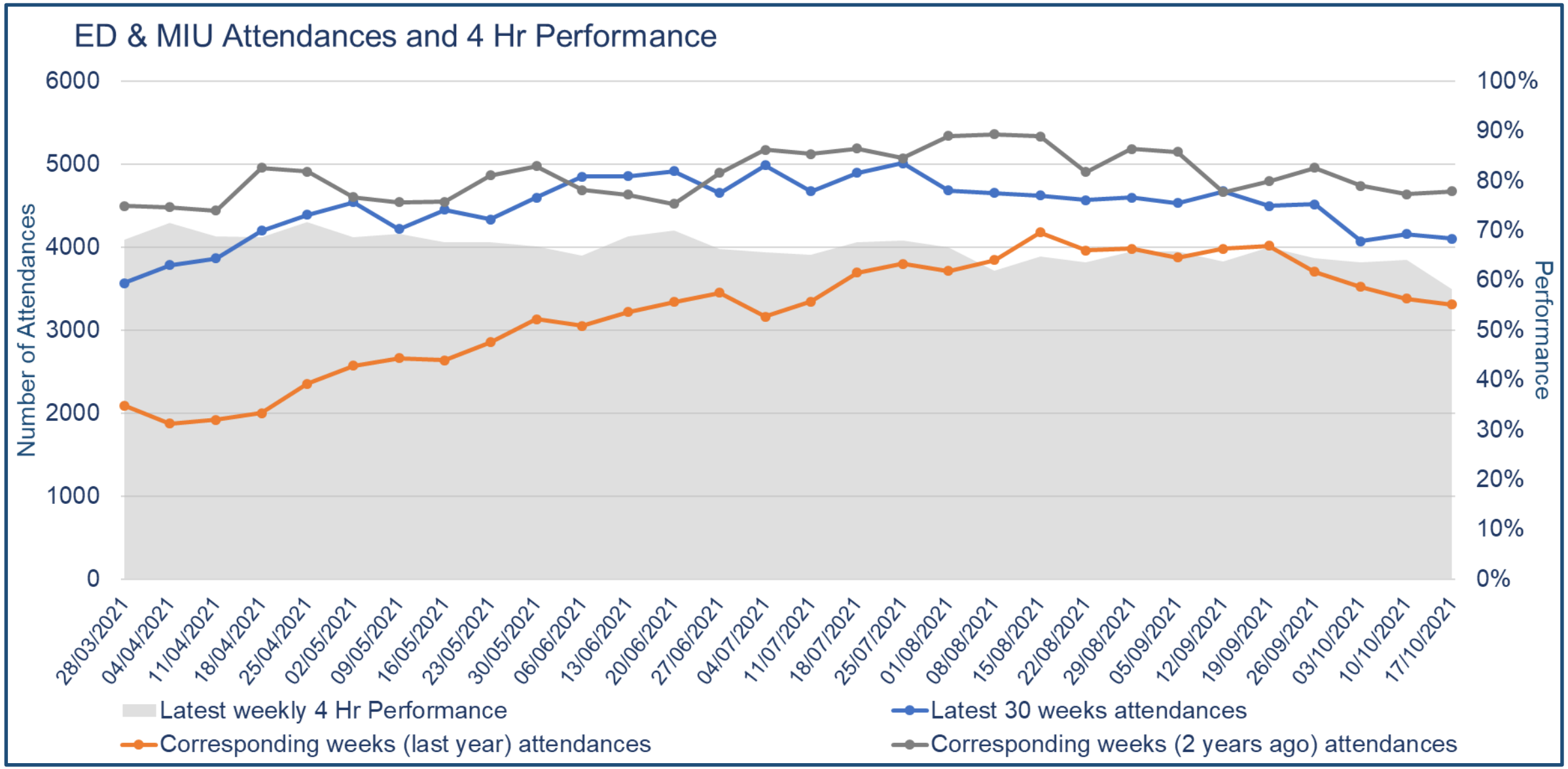
Quadruple Aim 4: Timely Interventions - Sepsis





Note: Significant decline in the number of forms being completed coinciding with the start of the COVID-19 Pandemic early in 2020. Hence, the percentage data presented should be viewed with caution.

Unscheduled Care Activity 4 Hour Wait Performance

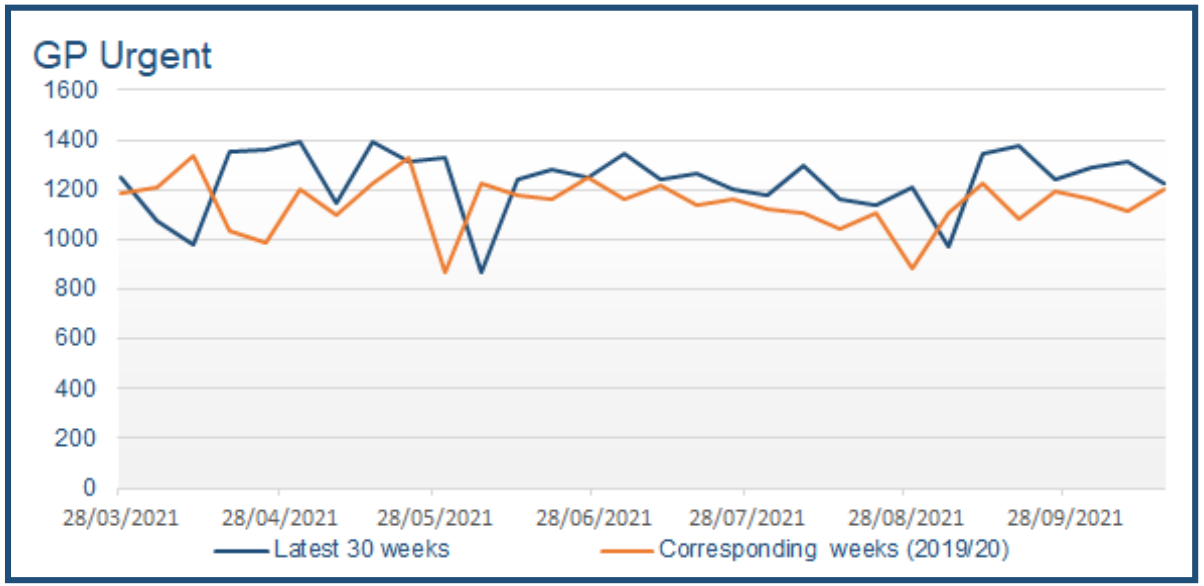


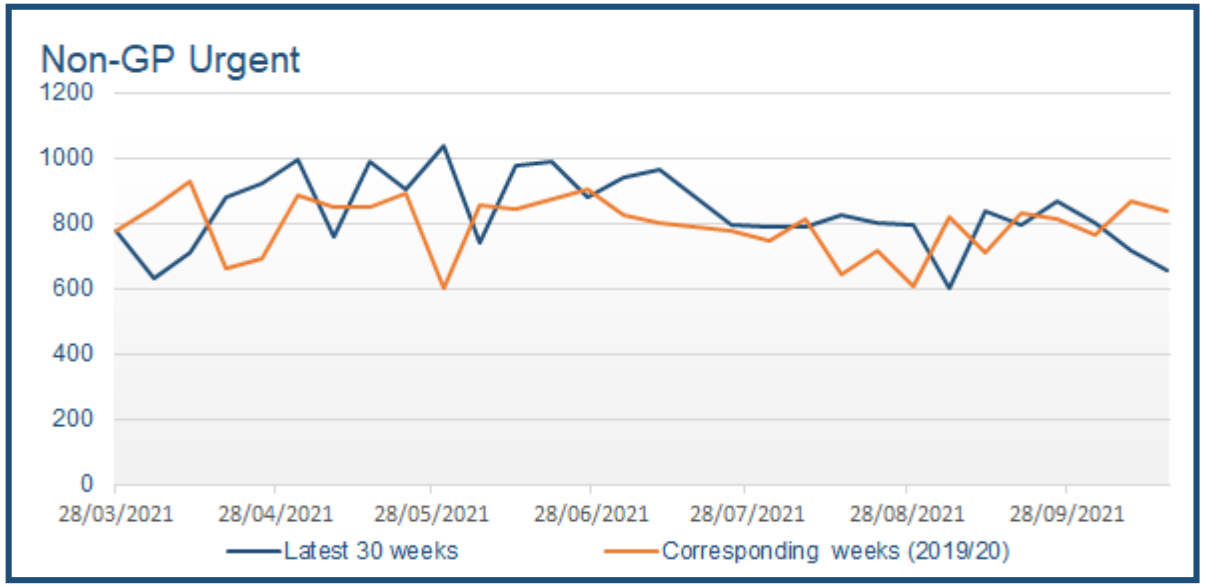
Unscheduled Care Performance

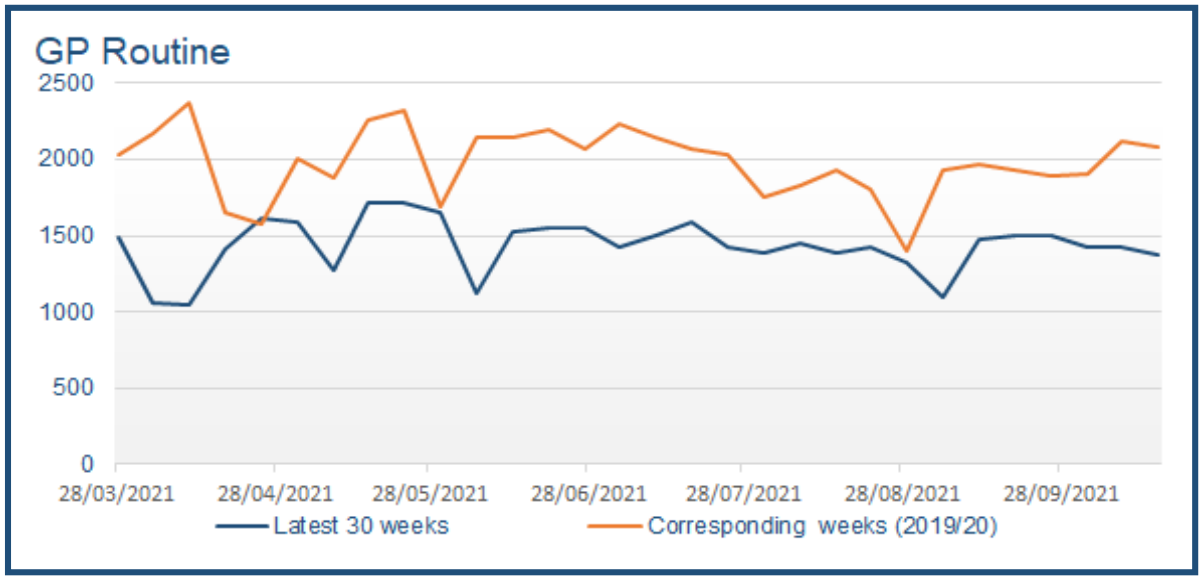
Position as at end of 17th October 2021	Jun 21	Jul 21	Aug 21	Sep 19	Sep 21	October 1st - 17th 2019	October 1st - 17th 2021
ED&MIU 4 Hour Performance*	67.32%	66.99%	64.52%	71.62%	64.96%	71.03%	**61.03%**
ED 4 Hour Performance	58.44%	57.26%	54.17%	60.03%	54.95%	60.04%	**52.33%**
ED 12 Hour Performance	2079	2385	2746	1977	2595	1015	**1477**
1 - 2 Hour Ambulance Handover	647	769	698	574	599	266	**371**
2 - 3 Hour Ambulance Handover	314	421	421	192	364	96	**208**
3 - 4 Hour Ambulance Handover	153	190	250	70	272	24	**140**
4 - 5 Hour Ambulance Handover	66	128	177	35	141	6	**81**
Over 5 Hour Ambulance Handover	42	94	189	24	234	10	**112**
Red 8 Minute	56.88%	50.96%	49.27%	69.37%	45.18%	70.37%	**48.32%**

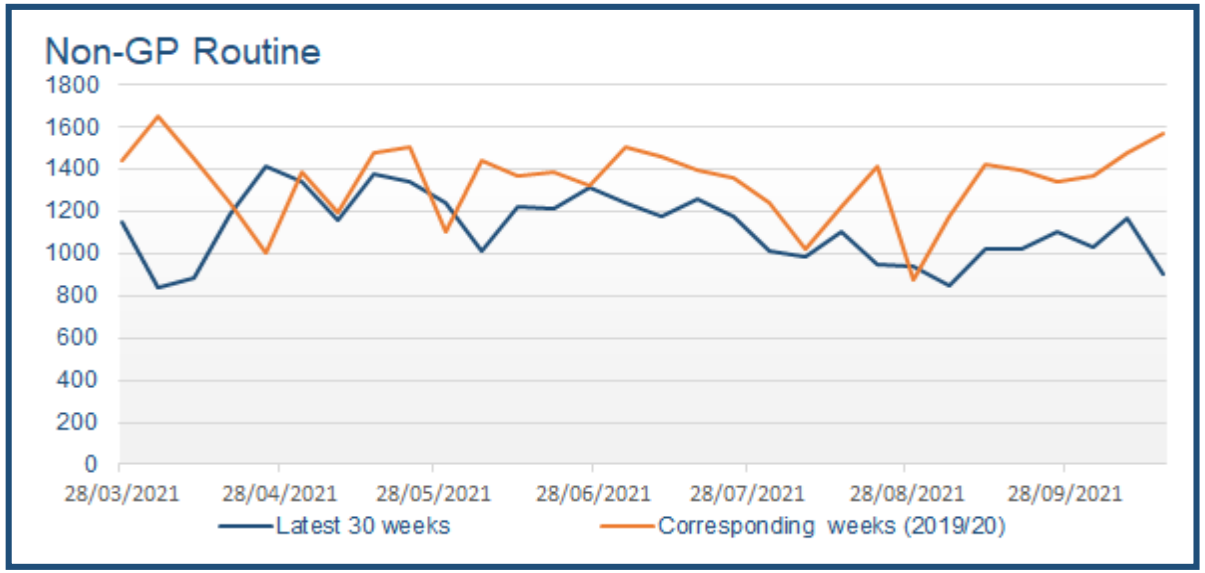
Red 8 Minute data is unvalidated and not for sharing outside this report.
*MIU figure refreshed resulting in variance to current IRIS view for September

Referral Rates



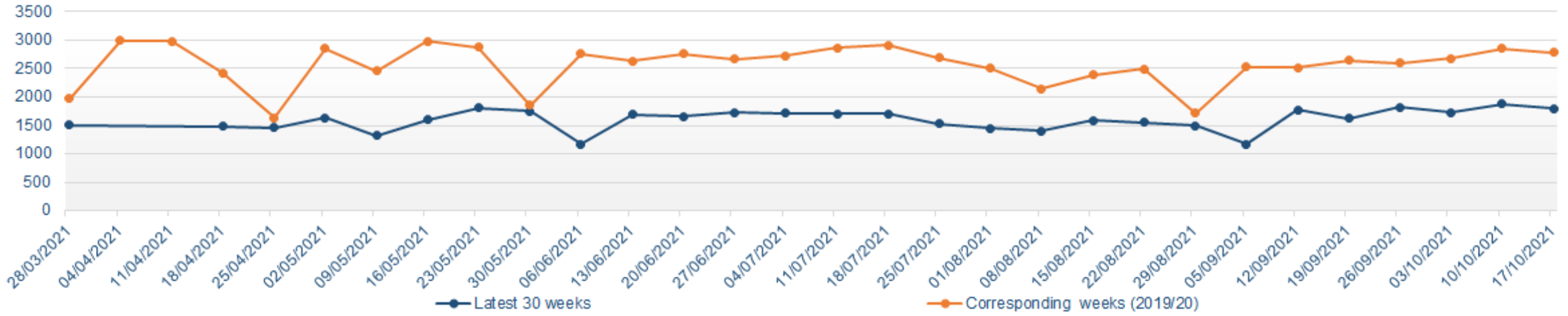




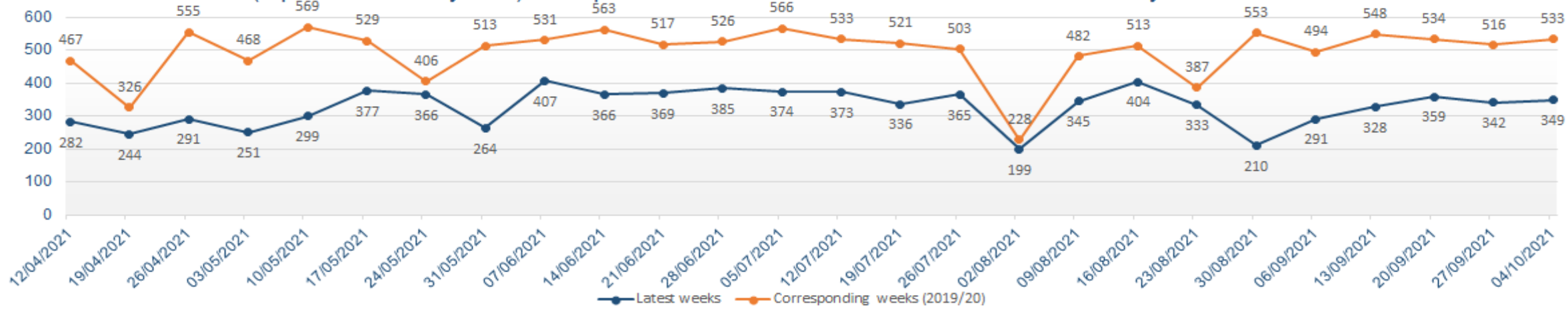


Planned Care Activity

RTT High Level Report - Core Outpatient Activity (new, RTT, face to face attended appointments)



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



Further Information

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

- tolerances for red, amber and green

Further information on our performance can be found online at:

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

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

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

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 2nd November 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quality Highlight Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing & Midwifery/Deputy CEO
Awdur yr Adroddiad Report Author:	Julie Ward-Jones, Head of Quality Assurance
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Associate Director of Quality Assurance Gill Harris, Executive Director of Nursing & Midwifery/Deputy CEO
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Committee is asked to note this report.

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

Sefyllfa / Situation:

The Committee is advised this is the first report of this kind, intended to replace the Serious Incident Report with a broader and more integrated summary of key quality information and matters. Feedback is requested and welcomed on this report to support the Committee's business.

This paper provides a summary of key quality related information from the months of August and September 2021. The aim of this new report is to provide the Committee with key quality highlights at each meeting. Detailed information relating to trends, themes, learning and improvement is provided in the Patient Safety Quality Report and Patient and Carer Experience Report.

Cefndir / Background:

Nationally reportable incidents

As part of the new NHS Wales National Incident Reporting Policy, a revised reporting requirement is in place from 14th June 2021. This covers both Serious Incidents (now to be called nationally reportable incidents) and sensitive issue/no surprise notifications (now to be called Early Warning notifications).

There were 19 nationally reported incidents, including 2 Never Events, in total for the two month time period:

Wrexham Maelor Hospital – Acute (7)

Location	Incident	Learning from Make it Safe Rapid Reviews
Acute Assessment Unit	Inpatient fall with harm (fracture neck of femur)	The initial review identified that falls documentation was completed but improvement could be made to update enhanced observation risk assessments (communicated via safety brief) and the clear documentation of date and time of events.
Emergency Department (ED)	Delay in diagnosis and treatment. Self-presented to ED with chest pain at 20.05hrs, seen and treated at 06.54hrs the following morning. Transferred to YGC for PCI.	Learning includes the Nurse in Charge to be informed of any patients with active chest pain, with suggestive cardiac features and need for repeat diagnostics, and an appropriate space found within the department – to be communicated via the safety brief.
Emergency Department	Delay in diagnosis and treatment. Self-presented to ED following a road traffic accident. Delay in identifying the full extent of trauma injuries and no trauma call. Transferred to Stoke where the patient died.	Learning includes the timely activation of the trauma team – display of activation criteria in triage and resuscitation areas of ED. Trauma images to be sent to Stoke (not Walton) and staff training on assessment of trauma patients and when to activate trauma call.
Fleming Ward	Inpatient fall with harm (fracture neck of femur)	Learning includes to ensure the appropriate risk assessments are completed and updated consistently, and to check brakes on commodes when in use. Fall ‘grab bags’ have been implemented and contain all post fall documentation.
Pharmacy (near miss incident):	Due to a change in Welsh Government contracts and purchasing it was noticed that two medications were in similar packaging with the potential for products to be mixed up.	A safety alert was circulated, and issue escalated to the Medication Safety Officer network and procurement. Another product has been put on contract.

Surgical Assessment Unit	Patient admitted with testicular pain; diagnosed as Epididyorchitis and discharged with antibiotics and a plan for outpatient ultrasound. No arrangements were made for the ultrasound (awaiting electronic discharge letter to be written). Readmitted 9 days later and underwent an orchidectomy for ischaemic teste.	The investigation identified that all appropriate care had been given but highlighted that discharge documentation must be completed on the day of discharge – all doctors will be reminded of this and an audit will be put in place to monitor progress.
Urology	Delayed diagnosis and treatment. Treated as urinary retention, unresolved for 2 months. Further investigations found large ovarian mass and metastatic disease	The appropriate patient pathway must be followed e.g. male or female/gynaecological. A senior check of referrals should be done before treatment. Greater awareness of gynaecological red flags will be raised with staff. It was noted that an increasing number of patients are presenting to ED with late presentation cancers that pre-COVID would have been picked up by GPs at an earlier stage.

North Wales Cancer Treatment Centre (1)

Location	Incident	Learning
Outpatients:	Delay in acting upon results.	Abnormal results were sent to clinician who was on leave, and were not acted upon until the clinician returned. A checking system will be put in place to mitigate.

Ysbyty Glan Clwyd – Acute (6)

Location	Incident	Learning
Gastro Unit:	Perforation of the gastrointestinal tract. The patient had undergone a flexible sigmoidoscopy a few days previously.	Earlier imaging to detect perforation should be undertaken. Timely administration of antibiotics to mitigate the risk of sepsis developing. Staff education in the use of NEWS scoring to be undertaken.
Pathology:	Incorrectly reported breast biopsy in 2015 resulting in incorrect treatment	A desktop review has been completed led by the Interim Deputy Executive Medical Director supported by Corporate Patient Safety

		including a sample audit of other cases – no further concerns were identified.
Surgical Assessment Unit	Fall with harm (fractured skull and subdural and subarachnoid haemorrhage).	Staffing to be reviewed to assess core nursing levels.
Theatres (orthopaedic surgery):	Never Event. Small guide for philos plate was left insitu	Distraction was a contributory factor due to a very busy theatre day of complex cases. Whiteboard to be introduced to support the accounting of instruments that are left for any period of time and should be removed prior to finishing. Work to be undertaken around the WHO Checklist at site and pan-BCU level.
Ward 9:	Patient brought into ED in cardiac arrest; had received a blood transfusion earlier that day and discharged home.	The initial review found that the patient was clinically stable prior to discharge and follow up care was arranged. Further investigation is being undertaken.
Ward 9	omissions in observations noted by the Medical Examiner	Education of the clinical staff of the limitations of prophylactic Enoxaparin and the importance of completing the Venous Thrombi-prophylaxis Risk Assessment. Education of nursing staff regarding the implications and potentially serious consequences of omitting regular recording of observations and ensure professional reflections.

Ysbyty Gwynedd – Acute (3)

Location	Incident	Learning
Emergency Department:	Delay in assessment; long wait to triage, pressures identified in incident report.	Review of staff roster to ensure sufficient support to the department. Timely submission of requests to bank/agency for staff need to be undertaken. Dedicated staff to act as waiting room manager. Timely review of speciality referrals and identification of alternative pathways
Emergency Department	Delay in transfer for vascular interventions	A need for pre-hospital vascular pathway to support patient prognosis and management. A multi-disciplinary incident review has been commissioned including the Welsh Ambulance Service.

Tryfan Ward	Never Event. Ascitic drain inserted into the wrong patient	LocSSIPs (checklist) process developed for paracentesis. Incident shared with staff via safety brief.

Mental Health and Learning Disability (2)

Location	Incident	Learning
Ty Celyn, Community Mental Health Team (CMHT)	Unexpected death of a patient known to services	Improvements to be made to the use of electronic records.
Ty Derbyn, CMHT	Report received that a patient known to mental health services had been arrested on suspicion of murder	An external independent review has been commissioned. No immediate care or service delivery concerns have been identified.

The independent investigation into the inpatient suicide at the Hergest Unit, Ysbyty Gwynedd remains underway. It is anticipated this report will be made available to the Health Board for factual accuracy checking in mid-November 2021. It is planned to being this report, and resulting action plan, to the next meeting of the Committee held in public.

The Health Board responded to the Health and Safety Executive Improvement Notice regarding the management of inpatient falls. The Inpatient Falls Group will monitor delivery of the improvement plan in place.

Ombudsman

The Public Services Ombudsman for Wales (PSOW) issued two Public Interest Reports during August and September:

Case 202000661 (investigation of a complaint) an investigation of a complaint against the Health Board and Denbighshire County Council concerning the care and treatment received at Ysbyty Glan Clwyd and Llandudno General Hospital.

Case 202002273 (own initiative investigation) concerns raised in relation to urology service waiting time breaches and harm reviews including those patients treated outside NHS Wales.

The hyperlinks above will open the publically issued Ombudsman reports. Both reports have been subject to specific papers to the Committee.

Inquests

There have been no Regulation 28 Prevention of Future Death (PFD) reports during August and September.

The coroner did indicate, at an inquest held in September, into the care and treatment of patient who had been held in an ambulance outside an Emergency Department that he would be watching events progress post pandemic in relation to hospital handover delays and whether a further PFD would be indicated in future cases.

Claims

No high value claims were settled during the period under review.

Healthcare Inspectorate Wales (HIW)

On 06 September 2021 HIW paid an unannounced visit to the Hergest Mental Health Unit, Ysbyty Gwynedd. Due to COVID on the unit, the unannounced inspection was suspended and HIW continued their inspection remotely. During the short time HIW were onsite they identified a number of immediate concerns around the delivery of safe and effective care. On 09 September 2021 the Health Board provided a response to the immediate concerns raised, and an Improvement Plan on 17 September 2021. On 21 September, HIW returned to the Unit, with more positive feedback following their inspection. We are currently awaiting their final report and this will be provided to the Committee as a specific paper in due course.

The Health Board provided HIW with an Improvement Plan in relation to the impact of ambulance waits outside Emergency Departments as part of a local annual review into Welsh Ambulance Services NHS Trust: Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover. A separate paper to the Committee provides more detail.

Asesu a Dadansoddi / Assessment & Analysis

As above, detailed information and analysis relating to trends, themes, learning and improvement is provided in the Patient Safety Quality Report and Patient and Carer Experience Report.

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.

Cyfarfod a dyddiad: **Meeting and date:**	Quality Safety and Experience Committee 2nd November 2021						
Cyhoeddus neu Breifat: **Public or Private:**	Public						
Teitl yr Adroddiad **Report Title:**	Covid-19 update						
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Executive Director of Nursing & Midwifery						
Awdur yr Adroddiad **Report Author:**	Co-ordinated by Sally Baxter, Associate Director – Coronavirus Co-ordination Unit Programme reports produced by senior strategic leads						
Craffu blaenorol: **Prior Scrutiny:**	Executive Director of Public Health						
Atodiadau **Appendices:**							
Argymhelliad / Recommendation:							
The Committee is requested to note the position outlined in this report and provide comments on progress of the programmes and issues raised.							
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**	

The report is brought for assurance. As the next stages of plans are developed – e.g. for the vaccination programme – the SED will be considered and future plans will take the duty into account. A SED IA is currently being developed for the next phase of the vaccination programme.	

Sefyllfa / Situation:

Wales moved to Covid-19 alert level 0 in August 2021 and has remained at this alert level, despite the increased levels of community transmission and consequent increased need for healthcare support at all levels. Incidence rates for Covid-19 rose again following the further easing of restrictions. In October the Welsh Government produced a revised and updated Coronavirus Control Plan for Wales, which described two potential scenarios: Covid Stable and Covid Urgent, the latter of which might require further measures should the incidence and impact of Covid increase to the point that healthcare services risk becoming overwhelmed.

Within this context the Health Board has continued to deliver the Test, Trace & Protect (TTP) and vaccination programmes, and to deliver care focused on safety and quality, working in partnership with other organisations on the response to the pandemic. This report provides an update on key programme areas of the Covid-19 response and issues of significance.

Cefndir / Background:

The programmes established to respond to the pandemic within the Health Board and with partners have been working to address the immediate impact and also to ensure readiness to respond to incidents, outbreaks and future trends. Across each programme, there have been changes as lessons are learned and the response amended. This report summarises some of the more significant issues in respect of:

- Vaccination
- Test, Trace and Protect
- Health and Safety
- the Nosocomial Action Plan
- brief update on Executive Incident Management Team (EIMT)

It should be noted that there are mandated (and in respect of certain areas, statutory) reporting requirements in respect of all programmes.

Asesiad / Assessment & Analysis

Strategy Implications

The programmes work within and respond to national and BCUHB strategy in respect of the pandemic including the Welsh Government (WG) Coronavirus Control Plan (revised March 2021.) There are a range of more specific strategies in existence including, for example, the Testing Strategy, and the national Vaccination Strategy. In respect of Health and Safety, the Health Board is in the process of implementing the Occupational Health & Safety (OHS) 3-year Strategy.

Options considered

Each of the programmes has considered operational delivery options in respect of the model of operation as appropriate (such as vaccination delivery models.) As each programme is now well established, ongoing review of delivery is relevant to ensure ongoing response to revised national strategy and local circumstance.

There are limited alternative options in respect of compliance with legislation and guidance. Furthermore, failure to implement recommendations in respect of Health and Safety may result in criminal proceeding against the body corporate or individuals.

Financial implications

There are significant budgetary implications arising from the pandemic response, which are recorded and reported against Covid budgets. In respect of Health and Safety, a business case is being further developed and will be shared with the relevant Executive Directors. All programmes are incurring costs against Covid funding. Ongoing funding for TTP and vaccination programmes

has now been confirmed to June 2022. Confirmation regarding the future of the vaccination programme after March 2022 has not yet been received.

Risk analysis

The significant risks have been escalated to the Board Assurance Framework (BAF) and were previously agreed by the Quality, Safety & Experience (QSE) Committee. A weekly report is run from Datix identifying any risks that might need escalating and each Covid-19 programme presents a summary of key risks weekly with the programme highlight reports.

Legal and compliance

Failure to comply with Health and Safety legislation can lead to the increased risk of accidents and incidents occurring and the risk of enforcement action, prosecution, fines and compensation claims. Failure to comply with Covid related regulations might also lead to fines and potential future compensation claims.

Impact Assessment

The newly established and defined programmes, including Vaccination and TTP, have undertaken Equality Impact Assessment (EqIA) and are continuing to review the action plans and mitigations on an ongoing basis. The Equity Steering Group of the Vaccination Programme has supported the operational delivery teams in targeting support to specific groups identified as being under-served by the programme, supported by the engagement team. An updated EqIA and a Socio-Economic Duty (SED) Impact Assessment are now being undertaken on the booster programme and the young people's vaccination programme, and mitigating actions being identified to promote equity of access to the programme, recognising the overall positive impact on health and broader socioeconomic impact.

1. VACCINATION PROGRAMME

1.1 Delivery of the vaccination programme

The Vaccination Programme has continued to deliver vaccinations across North Wales, with targeted support to specific groups where uptake may be lower.

All targets to date have been met:

- Vaccination of cohorts 1- 4 by 14th February
- Vaccination of cohorts 5 – 9 by 18th April
- Offer of a first dose vaccination to all adults over 18 in North Wales was achieved by 7th June

Additionally, over 1,034,000 COVID-19 vaccinations have now been given to people living or working in North Wales (as at 20 October 2021.) More than 499,000 have received both first and second doses.

The JCVI, CMO, MHRA and UK Governments announced the delivery of the Covid-19 Booster Programme on the 14 September, to commence from the 20 September for priority cohorts 1-9. The timing of the Covid-19 Booster is 6 months plus from the 2nd dose vaccination, and the delivery will in general run aligned to priority groups1-9.

The delivery of the Covid-19 Booster Programme will be through booked appointments via letters. Citizens will be able to call to change their appointment if this is not suitable, but we urge that where they can they stick to the given appointment slot, they should.

Frontline health staff and staff in Care Homes were called for vaccination in the first instance, from 20 September. Booster vaccinations in Care Homes for residents commenced on 23 September and the first pass has been completed. Primary Care are supporting with the Care Homes booster programme and have administered the majority to date. Social and other frontline staff outside of the Health Board have been invited to attend from 27 September.

Vaccination of young people aged 12 – 15 who are immunosuppressed had commenced and is continuing, with inclusion criteria extended in line with the Green Book. The third primary vaccination has also commenced being delivered for immunosuppressed adults and this continues.

Vaccination of all other 12 – 15 year old young people commenced on 4 October in line with the agreement of the CMOs of all four UK nations. Vaccinations are currently being offered through vaccination centres. The issue of consent is important in vaccinating all younger people and currently the consent of one parent or guardian is required, in accordance with legislation.

Leaflets and further information are being distributed to 12 – 15 year olds and their parent or guardian to enable informed decision-making. There are extended hours of opening to accommodate appointments times outside school hours and paediatricians are on site for the clinics.

In addition to the current programmes, all vaccination sites are accepting bookings and walk-ins for citizens who have not had first or second doses.

Ongoing issues include:

- Recruitment and capacity challenges which are being supported by the Workforce and Organisational Development team
- the limitations on the delivery programme arising from the selection of vaccine and the delivery arrangements, including the packing down of vaccine available for onward distribution, and physical capacity within centres
- uptake rates amongst certain groups: the Equity Group continues to work to identify means of increasing uptake, and the updated EqIA and SED IA are being developed to ensure a thorough analysis of any barriers, including feedback on experience of the programmes to date
- the need to plan for the longer term strategic model, in the absence currently of any clarity on the status of the programme beyond March 2022.

2. TEST, TRACE AND PROTECT

The TTP programme continues to experience high levels of demand as the incidence of Covid-19 remains high together with the consequent need for testing and tracing, although there have been some reductions in recent weeks. Partnership work with Local Authorities is essential to the

successful delivery of the programme. All staff – Health Board, Public Health team and Local Authorities – are facing the challenge of the ongoing return to business as usual conflicting with the need to sustain the TTP service.

2.1 TESTING

The most recent report on Testing activity (as at 11.10.21) is summarised below.

- Polymerase Chain Reaction (PCR) testing capacity across North Wales is slightly increased at 35,175 slots per week
- Lateral Flow Device (LFD) Collect capacity is 7,000 kits per week. This does not include the additional availability in Local Authority areas, Pharmacies and the Covid Support Hubs
- Community Testing Unit (CTU) testing activity for the period 04.09.2021 - 10.10.2021 was 2,016 which is a 14% decrease from the previous week, however high in comparison to the trend over several weeks
- Between 04.09.2021 – 10.10.2021, 15,931 kits were registered for Mobile Testing Units (MTUs), Local Testing Sites (LTSs) and Regional Testing Sites (RTSs), which is a decrease of 513 (3%) from the previous week
- MTUs are currently located in Porthmadog, Llanfairpwll, Corwen until 12/10/2021 then moving to Denbigh from 14/10/2021 and Flint. WAST are currently deployed in Johnstown every Monday and Holyhead for the remainder of the week
- Latest turnaround figures received for 27.09.2021 to 03.10.2021 were as follows:

North Wales Testing Turnaround Time	Hospitals	PHW	Lighthouse Labs
94.7%	98.3%	97.0%	93.0%

Laboratory Incident and impact on North Wales samples

The United Kingdom Health Security Agency (UKHSA) has been investigating reports of symptomatic people receiving negative PCR test results after they have tested positive on a Lateral Flow Device test. This investigation identified issues at a private laboratory based in England

that has also processed some Welsh tests. The issue is likely to have resulted in people being given incorrect PCR test results, mostly in the South West of England but also including Wales.

Whilst the majority of the numbers of Welsh samples tested at the laboratory are from South Wales areas, BCUHB has been notified of a number of tests undertaken for staff in care homes. A full risk assessment has been carried out and NHS Test and Trace has contacted all those people who may still be infectious first and has contacted all individuals that received a negative result processed at the laboratory from 2 September. UKHSA is investigating and has contacted all affected care homes directly. BCUHB will be working closely with Public Health Wales to understand the implications and has shared the summary information with representatives of the independent care sector and with Local Authority partners through the care home forums that have been operating on a regular basis throughout the pandemic. UKHSA has confirmed this is an isolated incident related to this specific laboratory and have not identified issues with other laboratories within the UK network.

Tracing

- The case volume experienced in North Wales remains high; although there are some indications that we may have passed the latest peak, incidence has fluctuated and therefore close monitoring will be required to determine the current trajectory. In the 7 days up to 10 October, index cases decreased by 10%
- 612 of the index cases were confirmed as previous contacts, a decrease of 3% on the previous 7 days
- The largest proportion of cases in the 7 day period was in the 10-19 age group (916), which is a 24% decrease on the previous 7 days
- The largest number of index cases in the last 7 days were found to be in schools, hospitals and residential homes
- The rate of contacts declined by 8% in the 7 days up to 10 October, with all counties except Conwy seeing a decrease
- The ratio of contacts to cases regionally stands at 2.3 which has remained constant from the previous 7 days. The ratio is at its greatest in Conwy (2.9), Denbighshire (2.4) and Anglesey (2.4)
- 76% of contacts were exempt from Self-isolation (an increase of 6% on the previous 7 days)

PROTECT

- The recently-approved Conwy hub will be operated by Community and Voluntary Support Conwy from 11 October, offering the same level of service and working with a wide range of delivery partners across the whole county. Key partners include iCan / iCanWork, WarmWales, CAB, Homestart Wales, Foodbank groups and Conwy County Borough Council. The hub will also be taking advantage of the Gwynt y Môr funding to support hub delivery and trial new initiatives
- Over 66,600 LFD tests have been issued by the hubs (up to 11 October)
- Proposal being submitted to Welsh Government (WG) to extend the six month pilot phase to the end of March 2022
- Planning to expand Covid Support hubs to locations where iCan have hubs across the region
- On-going evaluation embedded, and qualitative evaluation to be progressed in partnership with Glyndwr University
- Hub partnership group focussing on promotion of service, engagement and use of the Elemental system for recording
- Currently meeting with all GP Clusters and social services teams to encourage partnership working.

- We are now working in partnership with the following projects to share value: Long Covid Rehabilitation, Inverse Care Law, Equity of Access, National Exercise Referral Scheme (NERS) and social prescribers across the county.
- Social return on investment evaluation is being considered to demonstrate value for money

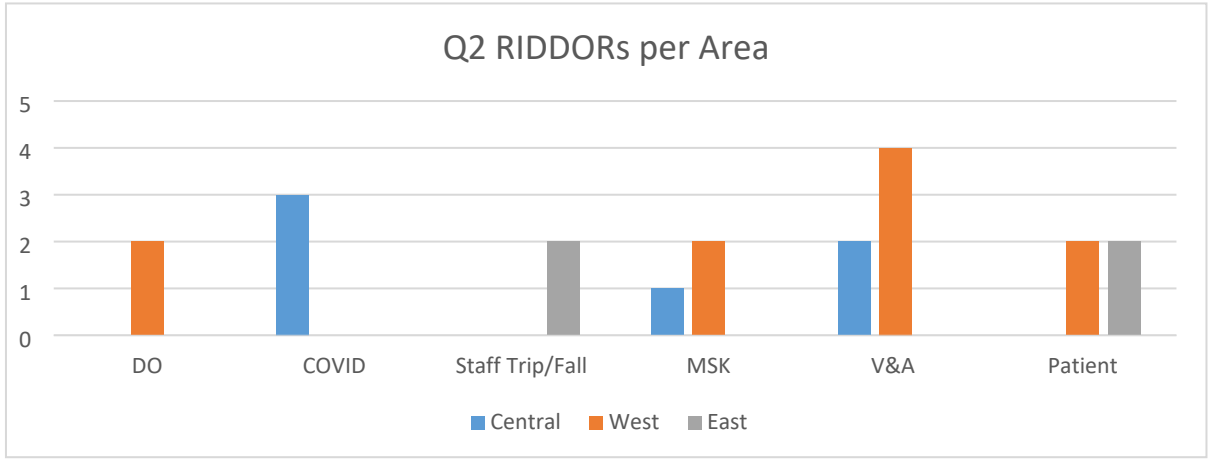
3 HEALTH AND SAFETY UPDATE: RIDDOR REPORTING

With effective COVID-19 management in clinical and non-clinical settings, a marked decrease was seen in Q1 in the number of occupational disease reports that were made to the Health and Safety Executive (HSE) under RIDDOR. This was further evidenced in Q2 with only 3 occupational disease reports being made to the HSE under RIDDOR, for a small staff cluster in Central. Despite two further COVID-19 Outbreaks being declared, in both West and Central, no work-related transmission of COVID-19 to staff has been identified, indicating the effective measures are being undertaken to manage this risk.

A total of 20 RIDDOR reports were made to the HSE in Q2. These break down into:

- 16 incidents involving staff: 2 Needle-stick injuries reported as Dangerous Occurrences, 6 violence and aggression incidents, 3 musculoskeletal injuries, 2 slip, trip and fall incidents and 3 occupational acquired COVID-19.
- 4 Patient related falls with Specified Injury

Area	COVID-19 RIDDORs	Non COVID-19 RIDDORs	Total Q2 2021	Comparison total Q2 2020
Central	3	3	6	9
West	0	10	10	9
East	0	4	4	1
Totals	3	17	20	19

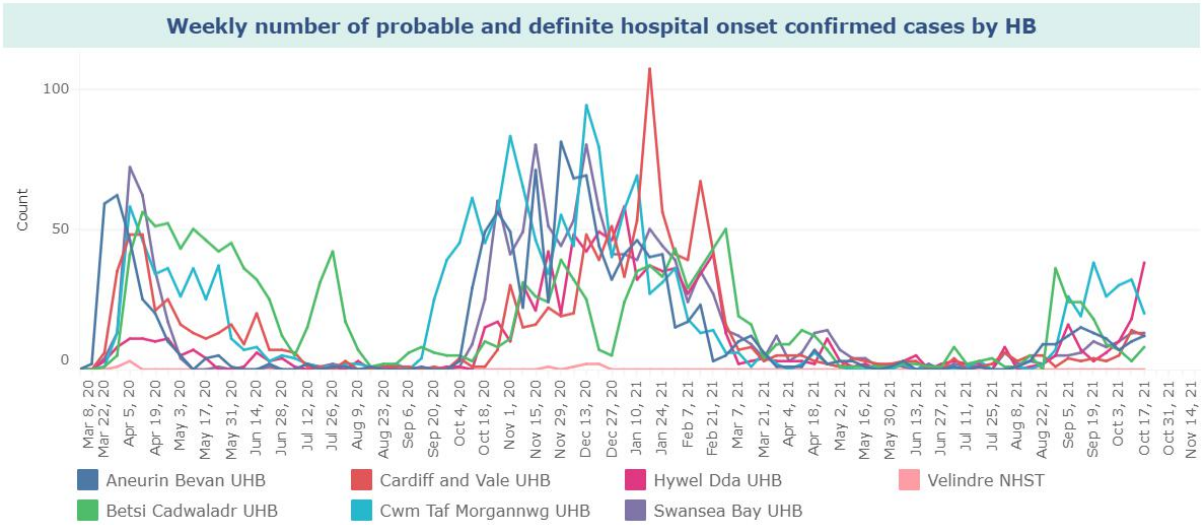


The Corporate Health & Safety (H&S) Team report all RIDDORs weekly through the Executive Bulletin and to the Acute Care Directors and monthly through the H&S Leads' meeting. All Root Cause Analysis (RCA) reports are currently scrutinised monthly by the Corporate H&S team for quality, suitability and effectiveness. Any identified lessons learnt are shared locally and escalated through the H&S Leads' Group pan-BCU HB, H&S Alerts and the Strategic Occupational Health and Safety (SOHS) Group as appropriate. These RIDDOR reports and RCA scrutiny are team KPIs and the target has been reached consistently through Q1 and Q2 of 2021-2022.

The Terms of Reference for a pan-BCUHB multi-disciplinary RCA Scrutiny Group have been agreed and ratified first by the SOHS Group for comment. This will commence in Q3.

4 MANAGEMENT OF OUTBREAKS AND NOSOCOMIAL ACTION PLAN

As the incidence of Covid-19 in communities and admissions to hospital increased during the third wave, unfortunately there was a parallel increase in Hospital Acquired Infections (HAIs), consistent with but at a lower level than previous waves. The chart below shows the patterns of probable and definite hospital onset or HAI confirmed cases across Wales, by Health Board.



Since the previous report to QSE Committee, there have been two further level 3 outbreaks within the Health Board's hospital facilities.

- An outbreak affecting Ysbyty Gwynedd and Ysbyty Eryri was declared at level 3 on 25 August. A total of 19 patients at Eryri were identified as Covid-positive and probable or definite Healthcare Acquired Infections. Sadly, 5 of these subsequently died. 16 patients were probable or definite HAIs associated with the outbreak at Ysbyty Gwynedd, of whom 4 patients subsequently died. The West outbreak was declared over on 8 October having reached 28 days with no new HAIs identified.
- A level 3 outbreak was declared affecting Ysbyty Glan Clwyd and Llandudno Hospital on 8 September. Subsequently there was a small number of cases identified at Colwyn Bay Hospital, which were associated with the overall outbreak. At the community hospitals a total of 11 patients and 5 staff were identified as probable or definite HAIs, and 3 patients subsequently died. At Ysbyty Glan Clwyd 21 patients and 14 staff were identified as probable or definite HAIs, and 9 of these patients subsequently died. The Central outbreak has now been stepped down to level 2 and will be declared over on 29 October if there are no further new HAIs.

In the light of the outbreak status, the visiting guidance for the West and Central sites affected was revised to ensure that visiting with a purpose was reinforced. The testing of visitors to patients who are more vulnerable to the impact of infections has also been increasingly adopted to establish additional safeguards.

Given the Continuing incidence rates within the community currently, the lessons learned from the outbreak management and the actions ongoing within the Nosocomial Action Plan are critical to support the effective prevention and management of potential HCAIs across healthcare settings.

Further Welsh Government guidance has been issued recently relaxing the requirement for frontline staff who are asymptomatic contacts of confirmed Covid-19 cases to self-isolate or work away from patient care settings. There remains a requirement for a negative PCR test, isolation on occurrence of any contacts and a strict testing regime. At the time of writing of this report (21 October) the guidance was being reviewed in the light of local assessment of the balance of risk.

5 EXECUTIVE INCIDENT MANAGEMENT TEAM

Following the significant increase in incidence of Covid, the Executive Incident Management Team (EIMT) is meeting three times a week, with additional workstreams or hubs linked in and all programmes required to submit a highlight report and review and update programme risks. Surveillance data is monitored on a minimum weekly basis and any significant change reported through Gold commander to the Executive Team. The Cabinet has also been reconvened for escalation of urgent or significant issues.

7. RECOMMENDATION

The Committee is requested to note the position outlined in this report and provide comments on progress of the programmes and issues raised.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 2nd November 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quality Awards, Achievements and Recognition
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing & Midwifery/Deputy CEO
Awdur yr Adroddiad Report Author:	Julie Ward-Jones, Head of Quality Assurance
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Associate Director of Quality Assurance Gill Harris, Executive Director of Nursing & Midwifery/Deputy CEO
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Committee is asked to note this report.

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

This paper provides an outline of quality related awards, achievements and recognitions for the period August and September 2021. It is important to note that the COVID-19 pandemic has had a significant impact in this area, with the focus rightly being on service delivery and services changes in response to the pandemic, and many award and recognition schemes were deferred or cancelled.

Cefndir / Background:

During the last two months, a number of staff, services and initiatives have received a quality related award, achievement or recognition, a summary of which is below:

Innovative technology used at Wrexham Maelor Hospital for kidney stone patients' scoops award: A surgeon at Wrexham Maelor Hospital has been recognised for using innovative technology to improve patient care with a special award. Consultant Urological Surgeon, Mr Mohamed Yehia Abdallah was joint winner in the Patient Impact Innovation Category at this year's Betsi Cadwaladr University Health Board's Research & Innovation Excellence Awards. Mr Yehia was praised by the judges for introducing MINIPERC Technology at Wrexham Maelor Hospital for kidney stone

patients. The MINIPERC technique uses smaller cameras and specialised tools to create a smaller incision in the skin to carry out minimally invasive keyhole surgery. The new technique provides a much safer procedure and allows the patient to recover quicker with shorter post-operative hospital stay. This would also help to attract more clinical fellows and training doctors in order to expand their knowledge and surgical skills.

Hat-trick of award chances for 'inspiring' eye unit after 'life-changing' student experience: A student's "inspiring" ophthalmology work placement with Betsi Cadwaladr University Health Board was the catalyst for three nominations at nursing's benchmark awards ceremony. Student nurse Chloe Scott entered the Stanley Eye Unit, at Abergele Hospital in February, and during her 12-week placement the final year student at Bangor University's Health Sciences School not only learned from staff, she fully contributed to the unit. Chloe subsequently nominated staff nurse Annie Sealey as Practice Supervisor of the Year for the prestigious Nursing Times Awards 2021 and the entire unit for Placement of the Year. Her tutor Naomi Jenkins submitted her name for the Most Inspirational Student prize, based on reports from her placement supervisors. Incredibly, all three nominations were accepted onto their respective shortlists for the glittering awards night in Mayfair, London, in November. Chloe is also a Patient and Carer Experience Champion.

Researchers and patients across North Wales to support national multi-cancer detection test trial: Betsi Cadwaladr University Health Board staff and patients across North Wales are supporting a new trial to help evaluate a new multi-cancer detection test. The Health Board has joined Health and Care Research Wales in supporting GRAIL and the University of Oxford, to evaluate the use of a new multi-cancer early detection (MCED) test which can detect over 50 types of cancers. Health and Care Research Wales teams across NHS Wales are taking part in the SYMPLIFY study, which will investigate a multi-cancer early detection test developed by GRAIL, known as Galleri, for patients with non-specific symptoms that may be a result of cancer.

'Contraceptive Champions' recognised with award: A group of doctors at Wrexham Maelor Hospital have been awarded for improving access to postnatal contraception during the COVID-19 pandemic. Speciality trainees Dr Noreen Haque, Dr Anu Ajakaiye, Dr Maria Kaloudi and Consultant Obstetrician & Gynaecologist Dr Ruth Roberts from the hospital's Women's and Maternity Department were joint winners of the Patient Impact Innovation Award at this year's Betsi Cadwaladr University Health Board's Research & Innovation Excellence Awards. To help improve access to contraception the team improved education for staff and patients as well as the availability of contraception for women on the maternity unit. The team also provided staff with tools to ensure safe prescribing of contraception. In June 2020 0.5 per cent of women left Wrexham Maelor Hospital maternity unit with contraception. In April 2021 47 per cent were discharged with suitable contraception.

The Pharmacy and Harm Reduction Team were runners up in the Betsi Cadwaladr University Health Board's Research & Innovation Excellence Awards for providing a rapid test and treat hepatitis C (HCV) service for homeless patients in the community.

Dr Chris Subbe, Ysbyty Gwynedd, awarded for his commitment to research during pandemic: Dr Chris Subbe received the Patient Impact Award at this year's Betsi Cadwaladr University Health Board's Research & Innovation Excellence Awards. Ysbyty Gwynedd's Research & Development Team nominated Dr Subbe for the major part he played in his willingness to undertake the role of Principal Investigator for the RECOVERY trial. The high profile international research trial opened during the height of the first wave of the pandemic and aims to identify treatments that may be beneficial for people hospitalised with suspected or confirmed COVID-19.

The Health Board's Research & Development Team were runners up in the Betsi Cadwaladr University Health Board's Research & Innovation Excellence Awards for leading the Novavax Vaccine and Cov-Boost trials that have recruited over 600 participants so far.

Nature classes helping patients stay connected to the outdoors awarded Big Lottery funding: Nature-themed classes helping community hospital patients stay connected to the outside world have been awarded Big Lottery Community Funding due to its success. The sessions, called Grow4it, encourages psychological wellbeing and social contact through interactive nature activities including the study of animals and nature-themed games and quizzes. Isa Lamb, who runs the sessions as part of her social enterprise King's Garden, was delivering sessions at Denbigh Community Hospital and Holywell Community Hospital until the pandemic forced the sessions to end last March. By implementing strict infection prevention measures including social distancing, decontamination of session materials and keeping patients safe in a small controlled group, Isa was able restart nature study sessions in Holywell Community Hospital in September 2020. The new Big Lottery Community Funding will support Grow4it to be delivered in person to Colwyn Bay Community Hospital for one year, whilst developing an additional virtual element for both Holywell and Colwyn Bay. Isa will work with dementia support workers and patients at both community hospitals to design and create their own virtual sessions, for patients to access at their bed sides any time they want. Sessions can help reduce boredom among patients, promotes wellbeing and socialisation, as well as helps stimulate interest, activity and conversation, and are a distraction from physical and psychological pain.

North Meirionnydd District Nursing Team receive funding award to set up innovative project to improve care within their community: District Nurses working in North Meirionnydd in Gwynedd have been awarded funding from the Queen's Nursing Institute to improve complex care in their community. The District Nursing team in the West supports over 4,280 patients who are housebound across Gwynedd and Anglesey. Their project, District Nursing Single Point of Contact, has received £5,000 funding and will help the team establish a more coordinated, person centred seamless service close to home. The project will help prevent patients with complex needs having to be admitted to hospital for conditions that can be managed in the community if there is access to the right people at the right time. A hub is now set up and is manned by a District Nurse between 9am – 5pm Monday to Friday, and prioritises and co-ordinates each individual's care and concerns whilst drawing in specialist support from colleagues from Community Care, Secondary Care and Primary Care if needed.

Health Board Dietetics team supports record number of schools running summer holiday Food and Fun activities: More children across North Wales have been enjoying food and exercise activities this summer with almost 50% more schools taking part in the award-winning School Holiday Enrichment Programme (SHEP). SHEP is a school-based education programme, supported by Public Health Dietitians and Dietetic Assistants from Betsi Cadwaladr University Health Board, designed to engage children in fun nutrition and physical activity sessions during three weeks of the summer holidays. Children take part in hands on 'Food and Fun activities like the Eatwell relay game, how to build a healthy plate and design their own healthy meal, and exploring the sugar content of snack foods and drinks. Each week the children are encouraged and rewarded for setting their own healthy food target, for example trying a new vegetable. SHEP is supported by Welsh Government funding and is coordinated by the Welsh Local Government Association. In North Wales the partnership between local authorities, Dietetics, the school meals service, leisure services, and many others has led to the year-on-year growth and success of the scheme. Before the scheme starts each year, the Dietetics team work with all six North Wales local authority educational teams to provide accredited food and nutrition training for teachers and teaching assistants to run the nutrition sessions. Schools also receive a bumper box of nutrition resources and games all prepared by the Dietetics team to provide everything needed to run sessions with the children. The summer holidays can be a time when some families struggle to afford or access healthy food, and some children may experience social isolation or a lack of intellectual stimulation during the school break. The intent for SHEP 2022 is to be bigger and better so even more children and families can benefit from taking part.

Wrexham Maelor Hospital Pharmacy publishes new edition of esteemed guidelines sold worldwide: A clinical guide that has become a 'best-seller' for the Pharmacy Department at Wrexham Maelor Hospital is being published in its fourth edition this month. The guide called, The NEWT Guidelines, is a resource for healthcare professionals and carers to help people with swallowing problems. The guide is listed on the essential resources list of UK Medicines Information, as it's become so well-respected and used amongst healthcare professionals across the world. The NEWT Guidelines started life over nineteen years ago as a guide for nurses in Wrexham who were caring for patients that were unable to take medicines in tablet form.

Gastro Clinical Specialist Nurse recognised with special award: A Gastroenterology Clinical Specialist Nurse has been recognised for her outstanding leadership skills with a special award. Iola Thomas received the Novice Researcher Award at this year's Betsi Cadwaladr University Health Board's Research & Innovation Excellence Awards. Iola has been praised for her involvement in the recent Clarity Study. This is looking at the impact of two biologic medicines on COVID-19 infection, vaccination and immune response in people with Inflammatory Bowel Disease (IBD). The study gave the research team the opportunity to investigate the impact of biologic and immunomodulatory therapy on COVID-19 infection and immunity in patients with IBD.

A runner up in the Betsi Cadwaladr University Health Board's Research & Innovation Excellence Awards was **Joanne Goss who was recognised for her contribution to the Hearing Aids foR tinnitus and mild hearing loss (HEAR IT trial)** that aims to answer whether hearing aid/s are effective in helping people with mild hearing loss and tinnitus to make their tinnitus symptoms.

North Wales nurse shortlisted for top national award: A nurse leader who is passionate about broadening the skills of others in her profession has been shortlisted for a top national award. Nia Boughton, a Consultant Nurse for Primary Care with Betsi Cadwaladr University Health Board, has been shortlisted for a prestigious Royal College of Nursing award, under the Advanced Nursing Practice category. Nia, who has worked in the profession for over 20 years, has been recognised for her work to improve the quality and consistency of training provided to nurses working in primary care settings across North Wales. This includes introducing a training framework based on a social model of care – which examines the range of factors that contribute to a person's health, rather than just their medical presentation. Practitioners using Nia's framework have reported a significant improvement in their training experience, while an initial evaluation suggests it has improved patient outcomes and led to greater consistency in the quality of consultations carried out by Advanced Nurse Practitioners.

Patient experience champion first to receive bronze and silver awards for going above and beyond: Diane Sweeney, who works at Mold Community Hospital, volunteered to be a Patient Experience Champion and has received both bronze and silver awards for her extra efforts. Diane has created and developed exciting activities for her patients. Diane involves not only the patients and staff, but also all their relatives, to help her identify their interests, bring out their personalities and encourage social interaction. Diane has also gathered information and pictures of local care homes to show patients and help their transition from hospital to a care facility. She also arranges virtual tours so that patients can see where they are going once discharged. Over 90 members of staff from all hospitals, clinical and service areas in Betsi Cadwaladr University Health Board have signed up to become champions.

Unique partnership helps teen with life-limiting health conditions expand his horizons: A teenager who has complex learning disabilities and kidney disease has been given a new lease of life, thanks to a pioneering initiative led by staff, which has been shortlisted for two prestigious Nursing Times awards. Darren (19), whose real name has been changed to protect his identity, is thought to be the first person in the UK to receive regular lifesaving haemodialysis treatment in a learning disability community hospital. The treatment is being provided by learning disability nurses at Bryn y Neuadd Hospital, Llanfairfechan, who have received specialist training and ongoing support from the Renal Home Therapy Team, based at Ysbyty Gwynedd, Bangor. Thanks to their dedication and forward thinking, the fun-loving teen has been able to leave his wheelchair behind,

make new friends, and take part in a range of new activities, including kite flying, nature walks, and even water fights with his carers!

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience (QSE) Committee 2nd November 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Vascular Steering Group Update
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Nick Lyons, Executive Medical Director
Awdur yr Adroddiad Report Author:	Neil Rogers, Acute Care Director
Craffu blaenorol: Prior Scrutiny:	Vascular Steering Group 25th October 2021
Atodiadau Appendices:	1. Action plan 2. Vascular Network Task & Finish Steering Group Terms of Reference

Argymhelliad / Recommendation:

The Committee is asked to note the update from the Vascular Steering Group and approve the attached Terms of Reference

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	**X**	**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:

This report provides an update on the work overseen by the Vascular Steering Group following the Royal College of Surgeons (RCS) review of the vascular service in 2021.

A review of the leadership and oversight of the vascular improvement programme has now been completed and the Vascular Oversight Group has been formed. This has now met 3 times and will continue to meet on a fortnightly basis. This group is chaired by the Executive Medical Director and includes senior clinical and operational leadership from all 3 acute sites.

An experienced interim Vascular Network Manager is now in post.

The action plan is currently under review to ensure actions are correctly owned, mitigations are in place, and that these are appropriate and sufficient. The revised action plan is currently in draft and is attached to this report at Appendix 1. The revised approach was welcomed at the Vascular Steering Group on 25th October 2021.

The Acute Care Director of the hub site (Ysbyty Glan Clwyd) retains responsibility for implementation of the network arrangements in liaison with the other two Acute sites and Area teams where appropriate.

An approach has now been agreed for the analysis and presentation of clinical vascular activity prior to adoption of the current network model to allow comparisons with current activity. It is

expected that this analysis, which will use informatics expertise external to the Health Board, will be completed in January 2022.

Following receipt of a letter in October 2021 an external review of the Health Board decision making leading to the adoption of the current networked service model is being commissioned.

There is also a need to consider how the Health Board can learn from the implementation of the current vascular network. This will inform the engagement and implementation of future service developments. This review will take place as part of the development of the Clinical Strategy and will be complete by end March 2022.

Cefndir / Background:

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

The second stage of the RCS review, based on the analysis of 50 case notes, began in July 2021. This review is expected to give further insight into both patient safety and patient experience within the service and is now expected in December 2021.

Asesiad / Assessment & Analysis

Strategy Implications

The response to the College review and actions to improve quality and patient safety are monitored at the Quality, Safety and Experience Committee.

The updated action plan is appended to this report, but key priorities include:

Summary of key RCS recommendations and current position

Action Plan Ref	Action	
4.1.8	Need for an agreed pathway for timely and effective treatment at the hub site	Emergency transfer pathways agreed and in place.
4.1.2	Bed capacity and associated nursing resources should be adequate to allow timely transfer from spoke to hub sites	A review of the capacity and demand for inpatient beds across the service was completed in June 2021 and remains under review.
4.1.3	More effective use of the hybrid theatre	Standard operating procedures have been agreed and are now monitored to ensure effective use. Fortnightly multidisciplinary and operational meetings take place with the theatre team.

4.1.4	Vascular consultant presence to enable patient review within 24hrs at spoke sites	A revised consultant rota now ensures presence across all 3 sites on weekdays with access to a “Consultant of the Week” and on-call advice from the hub. A review of the medical and nursing establishment is now underway with progress in senior clinical appointments following interviews in October 2021.
4.1.6 4.2.15	Develop non-arterial diabetic foot pathway	The pathways are now in final stages of agreement and implementation has begun and is closely monitored.
4.1.8	Confirm pathways for non-complex/low risk vascular interventions at spoke sites	Day case activity is now in place at spoke sites and pathways in the final stages of agreement
4.1.9 4.2.13	Improve effectiveness of clinical governance process	Multidisciplinary Governance meetings continue to take place and now report through to Vascular Steering Group with a report on audit expected by January 2022.

The changes to the Steering Group’s structure and function, including the Terms of Reference, have been implemented and the revised Terms of Reference are attached to this report and approval is sought from the QSE Committee.

The vascular services currently provided at Wrexham Maelor Hospital (WMH) and Ysbyty Gwynedd (YG) as the “spoke” sites comprise outpatient clinics, day case surgery and provision of reviews by vascular consultants for patients referred via the Emergency Department or from inpatient settings.

The service model shows a hub that provides outreach service to the spoke sites whilst retaining all on call and ‘hot’ activity at the hub site. Vascular Consultant of the Week (VCOW) and on call arrangements allow for appropriate escalation of emergency presentations at any site, and there are now referral pathways across the Health Board for vascular patients.

Day case activity at spoke sites includes simple renal access, angioplasty, debridement and varicose vein procedures ensuring procedures take place as close to home as possible for patients, with only more complex procedures taking place at the hub site.

The Vascular Network Manager is now working closely with hub and spoke site operational teams to ensure that there are clear lines of communication and plans to address waiting list backlogs, renal access patient management, and support management of rotas when needed,

Fortnightly meetings commenced on 8th October 2021 with the Vascular Network Manager / spoke site operational and clinical teams to ensure all aspects of the service are discussed and any breaches in pathway are identified to ensure that improvements can be made to the service.

Work is ongoing with the Welsh Ambulance Service (WAST) to ensure that patients requiring the hub services are transported directly to YGC to minimise any delays in treatment.

Develop the non-arterial diabetic foot pathway

The diabetic and podiatry teams in the acute spoke sites and in the community are key to successful delivery of this pathway, which is crucial in preventing vascular disease. A review of the resources need to ensure sustainable delivery of these services is now underway

Fortnightly non-arterial diabetic foot pathway group meetings are now taking place to expedite final sign off of these key pathways.

Opsiynau a ystyriwyd / Options considered

Next steps

1. Review of current risks relating to vascular pathways (action reference 4)
2. Work required for a systemic review of resource gaps to support the overall RCS recommendations but in particular, the non-arterial diabetic foot pathway through local spoke site ownership. (action reference 4.2.15)
3. Increase engagement with teams across BCU to work more collaboratively to support the agreed hub and spoke model of care, facilitated by the Vascular Oversight Group that is now in place (action reference 4.1.4, 4.2.11, 4.2.15, 4.2.16)
4. Review of the resource gap within the vascular consultant, middle grade and Advanced Nurse Practitioner workforce (action reference 4.2.15)
5. Second phase of RCS report anticipated December 2021

Goblygiadau Ariannol / Financial Implications

As part of the initial work on the gap analysis it is now clear that additional workforce is required in some parts of the service to deliver fully on the recommendations. The detail and timescale for this will now be included in the updated action plan reference 4.2.15, 42.17.

Dadansoddiad Risk / Risk Analysis

The risk register is now a standing item on each Steering Group meeting.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

There are no regulatory implications associated with this report.

Asesiad Effaith / Impact Assessment

Impact assessments will be completed as part of the final development and approval of clinical pathways.

DRAFT

Headings	Ref from RCS Report	Recommendation	Actions required	Operational / Clinical	Action by	Owner	Original Start Date as per report	Original End Date	Revised End Date	Actual Start Date	Actual End Date	Task Status	If overdue, what are the issues?	Progress update - include reasons in here for revised start or end date, and impact this will have on the overall deliver of the milestone	Assurance Links	Comments	Legacy Project infromation
														RCS Report Recommended Actions			
Pathways			Timely MDT at all sites. For spoke sites, this should be led by a spoke based Vascular Consultant making use of on call surgeon if this is not available	Clinical	Soroush Sorabi	Ramesh Balasundaram	01/04/2021	31/05/2021				Complete		A North Wales MDT is held every Friday pm involving all available vascular consultants, interventional radiology and anaesthesia which covers patients from all three areas. In addition a meeting has been established in June 2021 at YGC involving vascular and microbiology to discuss the ongoing care of inpatients. Local MDT are job planned for spoke sites		Curmetly in all job plans for spoke MDT mid week. Complex patients are then dicsussed in the NW MDT meetings.	
	4.1		Diagnostic and assessment services should be available in a timely manner. CT/MRI/Sonography etc	Clinical	Radiology Leads	Medical Directors	01/04/2021	31/05/2021	01/12/2021			In Progress		8/10/21 Awaiting feedback from Kakali Mitra relating to audits relating to provision of timely access to diagnostics for vascular patients from a pan perspective. 13/10/21 Requested information from informatics	SS Recovery Plan 24/5/21	Further work required to pull together full capacity gap to ascertain the investment requirements for Pan Business case Further work required to review the blue print for management of renal patients across hub and spoke sites.	The vascular recovery plan was drafted based on national guidance and approved by the Clinical Advisory Group and Executives on 25/09/20. This provides timelines for the assessment and management of patients with vascular conditions. This recovery plan has been updated during May 2021 and circulated to all three Hospital Medical Directors for dissemination. Communication to all senior management teams at all three hospitals will be ongoing during Q2 2021/22 to ensure that it is fully understood and embedded. Diagnostic services are available at all three hospitals. The Clinical Lead for Radiology has confirmed that this is the case though there are some capacity constraints which will require investment to address. Assessment and management of renal patients with dialysis needs has been discussed in a meeting with renal and vascular leads and a draft route into the hub dialysis ward proposed. Further meeting held on 21/05/21 with Acute Care Director, Head of Nursing for Medicine, CD for Medicine and Vascular Network Manager at which requirements were agreed.
		Requirement for agreed and clear pathways to ensure timely and effective treatment at Hub and Spoke sites	Repatriation pathway to be compiled, signed off and utilised for admission to Hub from Spoke sites.	Operational	HoNs suppported by DGMs and Clinical Leads	Acute Site Directors	01/04/2021	31/05/2021	28/12/2021			In Progress		Document previously completed and sentoff by CAG but anecdotally heard of some nursing concerns. For SM to pick up with HoN and liase with counterparts at spoke sites 6/10/21			
			Any non-vascular clinical needs must form part of the transfer to hub sites and ensure inclusion of the hub specialty teams (dual / multiple referrals)	Clinical	Specialty Leads	Medical Directors	01/04/2021	31/05/2021	08/11/2021			In Progress		? Referral form for use via email SM to complete and include in referral SOP			
	4.1.8		Requirement of a vascular review / escalation and transfer pathway into the hub site	Clinical	Soroush Sorabi supported by Specialty Leads	Medical Directors	21/09/2021	31/10/2021				Complete		See Emergency pathway for spoke site transfers			
			Finalisation and sign off for IVDU pathway	Clinical	Specialty Leads GS / Vascular/Radiology / ED	Medical Directors	01/04/2021	30/06/2021	01/12/2021			In Progress		A version in us use by the General Surgery teams acrss the spoke sites, requires further agreement with East only now		Signed off by Karen Mottart, Soroush Sorabi, Kikali Mitra, West ED lead, awaiting East ED Leadsand Gen Surgery. Can then go to CAG once confirmed and be implemented across BCU	
	4.1.7		Day Case Angioplasty pathway finalisation and sign off	Clinical	Soroush Sorabi supported by Specialty Leads	Medical Directors	01/04/2021	30/06/2021				Complete		Approved by CAG and the Executive team Jan 2021 and has been implemented			
			Final sign off for the Non-surgical arterial conditions for palliative patients pathway	Clinical	Soroush Sorabi supported by Specialty Leads	Medical Directors	01/04/2021	30/06/2021				Complete		In conjunction with the Palliative Care team, was incorporated into the agreed pathway for management of patients post vasculare intervention. Approved by CAG and implemented Jan 2021			
	1		Clarity on role of the leadership and management in spoke sites, hub site and the vascular network manager. Review of pathways to ensure that this is reflected for escalation	Operational	DGMs	Acute Site Directors			14/12/2021	16/09/2021		In Progress		Fortnightly meetings to work look at working more collaboratively across the hub and spoke sites to improve engement and help to clarify with support from DGMs the expectaiton across sthe sites.			
	4.1.5	Management of patients post major arterial vascular surgery Pathway requires final sign off ensuring communication between hub and spoke regarding discharge and follow up is improved	Rehabilitation needs are assessed by the relevant clinical teams prior to discharge and appropriate rehabilitation services are accessed locally wherever possible	Clinical	Soroush Sorabi	Ramesh Balasundaram	22/05/2020	27/01/2021				Complete		Referals completed in line with required rahbilitation needs. Issues relating to full delivery of this action at the YGC site relate to resource gap in therpies to support timely follow up and some environmental ./ capacity issues for post operative follow ups. The action itself as described is complete. the timeliness aspect requries attention			**Delivered under the remit of the Vascular Task and Finish Group**: Approved at CAG on 27/01/21. Implemented. Focus now on communication of the process across sites and teams. • (i) The process details the referral pathway and includes the access to assessment by the clinical specialty locally as required to ensure rehabilitation needs are appropriately assessed. • (ii). This pathway has now been discussed with the acute care directors and includes transfer within 24 hours of acceptance and the patient being medically fit and the escalation process.
			All relevant clinical services at hub and spoke sites are aware of the pathway and have robust mechanisms in place to ensure discharge plans are communicated to relevant teams	Operational	Specilaty Leads supported by , Vascular Network and DGMs all sites	Acute Site Directors supported by Medical / Nursing Directors	22/05/2020	27/01/2021				Complete		Pathway signed off and communcated as per legacy project plan comments			**Delivered under the remit of the Vascular Task and Finish Group**: Approved at CAG on 27/01/21. Implemented. Focus now on communication of the process across sites and teams. • (i) The process details the referral pathway and includes the access to assessment by the clinical specialty locally as required to ensure rehabilitation needs are appropriately assessed. • (ii). This pathway has now been discussed with the acute care directors and includes transfer within 24 hours of acceptance and the patient being medically fit and the escalation process.
	4.1.8	Pathways are required to enable non-complex / low risk periperal vascular interventions to be undertaken (in line with VSGBI guidelines) mainly as day cases at spoke sites	Agreement regarding interventions to be undertaken at Spoke sites	Clinical	Clinical Leads supported by DGMs all sites	Medical Directors	01/04/2021	30/06/2021				In Progress		It has been agreed which vascular procedures can be completed at spoke sites in addition to Orthopaedic interventions. Changes have not yet been fully implemetned due to ongoing discussion relating to theatre capacity and bed availability.			
			Details for inpatient responsibility for patients requiring admission following general anaesthesia - Agreed Shared Care Model	Clinical	Medical Directors	Nick Lyons	01/04/2021	30/06/2021	08/11/2021			In Progress		5/10/21 Meeting planned with Medical Directors to agree IPS and accointability and reponsiblity for Shared care to be dissmeinated thorugh the medical teams		Day case activity is carried out at both WMH and YG. Inpatient activity is all carried out at YGC. The final aspect of the diabetic foot pathway that needs to be resolved is how the beds and care can be provided at WMH and YG. The recommendation is that there is a shared care model as vascular don't have sufficient resources to clinical cover inpatient beds at WMH and YG.	
Diabetic and Vascular patient management			Agree assessment protocols from Diabetology team for the Non arterial Diabetic Foot Pathway	Clinical	Diabetology leads	Medical Directors	01/04/2021	30/06/2021	16/11/2021			In Progress		5/10/21 Draft of Diabetic Foot Pathway (DFP) circulating for sign off by BCU DF meeting. Require a single Pathway with individual sites having a bref document with their specific caveats. Diabetology input in relation to assesment is inkeeping with NICE guidance and agreed. Remaining aspects of the pathway yet to be signed off		Signed off from West and Central, awaiting East outcome following meeting with the Executive and Site Medical Director	
			Identify a diabetic foot / foot salvage lead within the vascular team to support all sites and support spoke teams to standardise care and pathways	Clinical	Soroush Sorabi	Ramesh Balasundaram	01/04/2021	30/06/2021	08/11/2021			Complete		Soroush Sorabi is the Diabetic foot lead across BCU with along with spoke site leads Fasial Shaikh and Laszlo Papp undertaking this role at YGand WMH.			
	4.1.6		Ensure a robust MDT approach across the network with input from podiatry, anaesthetics, diabetology, microbiology, orthopaedics, prosthetics and specialist vascular nursing.	Clinical	Medical Directors supported by DGMs / Vascular network manager	Executive Medical Director	01/04/2021	30/06/2021	01/12/2021			In Progress		MDT arrnagements in place albeit some completed outside of FORMAL job plans however are completed during other allocated spoke activity. There is work to be done to ensure that all disiplines are in attendance at all sites.			
			Patients at spoke sites diagnosed with diabetic foot sepsis without arterial comprimise should remain at spoke sites if possible. If not possible, a pathway is required for urgent transfer to the hub.	Clinical	Medical Directors supported by and Specialty Leads / DGMs	Executive Medical Director	01/04/2021	30/06/2021	01/01/2022			In Progress		5/10/21 Emergency pathway in use for spoke to hub transfer. Pending sign off and implementation of the DFP, there are a small number of patients likely being treated at YGC. In order to implement the DFP - resource is required hence the longer date to allow for recruitment. The East group is not currently in agreemnt with the management of the non-ischaemic foot being managed by Orthopaedics. Also citentious is the shared care model. West have signed off and Centre meeting is 12/10/21.		Nick Lyons and Steve Stanaway to meet with East 9th November to discuss a way forward with the DFP	
		Develop Non-arterial Diabetic Foot Pathway should be finalised urgently with involvement of all relevant teams	Clear admission arrangements are required at spoke sites, including the specialty that the patient is being admitted under allowing for input from vascular	Operational	Medical Directors	Executive Medical Director	01/04/2021	30/06/2021	01/12/2021			In Progress		5/10/21 Awaiting final sign off for DFP , Meeting planned to agree IPS and shared care model with Medical Directors to encompass all admissions under alternative specialties with vascular involvement			
	4.2.15		Review the resource required for a diabetology consultant to Spoke sites (including non-consultant grade support) to ensure that capacity meets the demand and enables ward beds to be covered by a diabetologist and play a key role in vascular care	Operational	DGMs YG / WMH	Acute Site Director YG / WMH	01/04/2021	30/06/2021	01/12/2021			In Progress		Awaiting capacity gap information. Est / West DFP groroups have been asked to rpovide a rought estimate in the first instance and demand information has been shared to support their decision making. Centre to be asked 12/10/21 meeting			
			Review the resource for Orthopaedics required to support the implemetnaiton of the DFP	Operational	DGMs	Acute Site Directors	01/04/2021	30/06/2021	01/12/2021			In Progress		DFP East /West meeting - outline requested from all members for their service to review a rough idea of what would be reuqired for implementation of pathway. Cntre are having discussion amongst the Orthopaeidc team as to future arrangements/ plans / resource requriements			
			Review of resource for Podiatry at spoke sites to support the pathway following sign off	Operational	Podiatry Leads	Head of Therapies	01/04/2021	30/06/2021	01/12/2021			In Progress		5/10/21 Gap analysis completed but needs some additional detail for the business case. SM meeting with podiatry teams to collate			
			Review of Specialist Nursing support to realise the diabetic Pathway	Operational	HoNs	Directors of Nursing supported by DGMs	01/04/2021	30/06/2021	01/12/2021			In Progress		Awaiting capacity gap information Wd 3 have completed with a view to increasing bed base to 21 with a high observation area but CNS / ANP resource requires review across sites inclusive of succession planning to futureproof the service			
			Daibetic Foot clinics to be held jointly with vascular surgery and podiatry at all sites	Clinical	Soroush Sorabi	Medical Directors	01./04/21		08/11/2021			In Progress		WMH have been completing on an ad hoc basis. Requires formally planning into job plans 5/10/21 Job plan changes for WMH agreed - just need to add to allocate / change form. Aw formal review for YG as also completed ad hoc			
			Consideration of appointment for a network wide podiatric surgeon / orthopaedic surgeon with special interest in vascular to support the foot salvage service across all sites	Clinical	Medical Directors supported by the Therapy Director	Executive Medical Drirector	01/04/2021	30/06/2021	01/01/2022			Not yet commenced / Overdue		Discussed with Gareth Evans 8/10/21 No current progress on this consideration to date. May depend on the outcomes of Orthopaedic surgeon discussions in the first instance at this stage.			
ernance	4.1.9	Improvements are required in line with improving the effectiveness of clinical governance	Improve collaborative sign off for actions and learning from incidents. TOR for governance meetings require a review in addition those required to attend	Operational	Hans Desmorowitz supported by the Vascular Network Manager	Soroush Sorabi supported by governance lead (site)	01/04/2021	28/05/2021						unsure of current position - seeking clarification from SS and governance team		• This feedback was provided to the vascular team for their reflection and ideas for improvement following the publication of the report on 13/05/21. • Meeting held on 20/05/21 with the vascular governance lead, vascular network manager, CD for vascular and acute care director for YGC to discuss actions for improvement. • Support will be provided from a specialty with a well established governance process. • Proposals for improvement to be presented to the site Q&S. • (i). The vascular service complies with the approved Health Board concerns and incident process.	
			Consider appointment of an external chair for governance meetings	Clinical	Soroush Sorabi	Balasundaram Ramesh	01/04/2021	29/05/2021	01/12/2021			In progress		Gary Francis had previously been overseeing aspects of the governance meetings and has since left the organisaiton. Awaiting update on his successor to continue with progress.			
			Robust process to ensure that agreed changes to clinical practice arising from shared learning are clearly identified and effected.	Clinical	Hans Desmorowitz	Soroush Sorabi supported by vascular network manager	01/04/2021	30/05/2021				In progress		Action log and minutes maintained. Need some small changes to collation and dissemintaiton to aid the process. Will be supprtoed by the new Band 5 appointment as outlined below. Requested governernace rep to attend the next governance meeting 9 November for review of progress			
			Clarify the requirements for the process of root cause analysis for all major amputations	Clinical	Hans Desmorowitz	Soroush Sorabi	01/04/2021	31/05/2021						unsure of current position - seeking clarification from SS and governance team			

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Gov			Admin / governance resource required to support the process in line with organisational standards	Operational	Vascular Network manager	DGM Surgery YGC	01/09/2021	01/12/2021				In progress		Additonal resource is required as e currntly have Consultants undertaking activity not in keeping with efficiency. Band 5 has been appointed to aid with rota management and will support the governance reocrding of actions / outcomes and assist with feeding back to the team		• (ii). Appointment of the Secondary Care Medical Director as Chair of the vascular clinical governance meetings to oversee the process. • (iii). The service now ensures that actions from goverance meeting including sharing of learning are now documented and tracked in an action log. • (iv). Clinical Director presented to the Vascular Clinical Governance meeting on 22/04/21 on civility and partnership working. An Anaesthetic consultant will also attend Vascular Clinical Governance meetings as well as General Surgery consultant on an as required basis.	
	4.2.13	Improve effectiveness of M &M meetings enabling comprehensive MDT discussion and shared learning	Timing of meetings to enable anaesthetic attendance	Clinical	Soroush Sorabi	Balasundaram Ramesh	01/04/2021	01/06/2021				Complete		Anesthetic Consultant is invited and attend ths meetings along with the MDT. Membership review requried to separate M&M form true governance meeting to improve attendance and quality			
			A robust system required to ensure discussion of all cases, issues to carry forward to next meeting if required. Robust recording and sharing of agreed actions	Clinical	Soroush Sorabi	Balasundaram Ramesh	01/04/2021	02/06/2021	18/11/2021			In progress		Further work is required to formulate robust methods of capturing and sharing the information and the methodolgy of doing so. Sally Morris to review with Governance lead before 9 November meeting.			
Patient Flow	4.1.2	Review of vascular bed capacity and nursing resource. This section also relates to reduction of cancellations on the day due to bed / ITU / HDU availability	All vascular patients via elective / emergency / transfer from spoke should ideally be placed directly into a vascular bed. If this is not possible, robust plans for reviews must be in place.	Operational	Site Directors supported by Bed Managers and Nurse Directors	Executive Medical Director	01/04/2021	30/06/2021	31-Dec-21			In progress		Current work is being undertaken to review the potential for Vascular Ward 3 to manage its' own bed base with a view to ringfence the beds for vascular patients and reduce the number of vascular outliers to ensure the right patient in the right bed is achievable. The emergency Vascular trasfer pathway stipulates that patients should go directly to ward 3 from referring hospital / theatre and this is often not possible as the bed base is resourced for 18 beds (often escalted to 22) and due to medical outliers requires vascular patients to be displaced to other wards. A recent crude review of bed usage indicates a need for 23 vascular beds but this may in time reduce if pathways are signed up to and implemented in line with DFP and shared care arrangements for patients to be managed st spoke sites where non-emergent. Reviewing a potential for ward 3 to move to a more apporiate area - unsure currnetly if viable option. But if so would make provsipon for clinic rooms for wound care reviews ansuring timely post-operative follow up of patients that could be utilised by CNS / ANP / Podiatry / Prosthetist etc and the potential for a 'hot clinic' to manage referrals in and divert them awaay form ED. Requestd blue prints to review if a viable proposal and in discussion with HoN and Vascular Nurses in a weekly meeting as part of transfer / repatriation pathway development and liasing with spoke site equivalents to engage			Prior to the centralisation of major arterial vascular surgery, the lower limb service at Ysbyty Gwynedd admitted patients from across North Wales, managing the care for patients with diabetic foot disease and difficult to manage lower limb tissue loss and limb ischaemia. Post centralisation, these patients would continue to be managed at Ysbyty Gwynedd (although lower limb surgical arterial procedures would be performed at the hub). Maintaining this model of care in Ysbyty Gwynedd, an analysis of the caseload by patient episode indicated a bed requirement of 15 beds. However, this was based on 2015/16 coded data and did not take into account the increase in demand from East and Central. There were also plans to implement a community hub and spoke model with community beds to allow a reduction in the number of these beds. The Health Board's plans to retain beds in Ysbyty Gwynedd for the lower limb salvage service had to be severely curtailed due to the resignation of senior clinicians and resultant staff shortages. This has provided the opportunity to review and determine the most appropriate pathways for vascular related patients across North Wales in line with national guidance. The NICE guidance for the management of patients with diabetic foot problems recommends that each hospital should have a care pathway for people with diabetic foot problems managed by a multi-disciplinary foot care service. There is now work underway through the Diabetic Foot Task and Finish Group to agree the pathways for the assessment and management of patients including patient requiring admission. A full audit of beds used since centralisation is underway and once the pathways and the audit are completed a recommendation will be made on the number of beds required at each of the three hospitals will be made. **Delivered under the remit of the Vascular Task and Finish Group:** A new calculation of the beds required at each of the three hospitals will be undertaken when all pathways have been determined and an audit of actual bed usage since April 2019 is completed.
			Bed management teams and ward 3 to co-ordinate repatriation or removal of outliers to accommodate appropriate placement for vascular patients	Operational	Bed Managers supported by HoNs and DGMs	Acute Site Directors			01/12/2021	16/09/2021		In progress		Process in place but not robustly adhered to. Relates to point above for ward 3 managing their own bed base transfers and the progress points above			
			Admission and transfer pathways to be developed to ensure that patients are safely and appropriately placed and that any delay in transfer has clear non-surgical optimisation in place prior to transfer	Operational	HoN supported by DGMs	Acute Site Directors			01/12/2021	16/09/2021		In progress		Weekly meetings in place with HoN YGC and Vascular nurses to develop pathways and to be discussed and agreed in the first instance with HoNs at spoke sites to then be shared more widely for comment			
			Consider development of a high observation area within Ward 3 to allow for quicker step down from HDU / ITU and provide an element of ringfence for vascular beds.	Operational	HoN YGC	Acute Site Director supported by Nursing Director			01/12/2021	16/09/2021		In progress		Head of Nursing and Vascular Matron reviewing the possibility of this partially to expedite step down but also to make recruitment and retention more attractive to ward 3 and provide variation and exposure for career development for nursing teams			
Theatres	4.1.3	More effective use of the Hybrid Theatre	Ensure that only cases requiring hybrid facilities are undertaken within hybrid theatre	Clinical	Theatre Manager supported by Critical Care Lead YGC	Soroush Sorabi	01/04/2021	28/05/2021		01/12/2021		In progress		Weekly allocation meeetings 'book'known inpatient and outpatients onto the appropriate list with / without IR support. Potentially a lack of a separate emergency list can hinder this action to be fully complete given the nature of the service. More work required. Meetings in place but need to determine utilisation data review from the theatre teams to enable discussion			TOR agreed for theatre meeting involving CD Surgery, vascular and Ops leads. Meeting to review: *Agree allocation of operating lists *Ensure aadherence to OD SOP *Agree cancellation and relocation of lists * Analyse cancellation trends and action as required *Ensure only cases requiring HT as listed
			Commence lists on time using 'golden patient model'.	Clinical	Theatre Manager supported by Critical Care Lead YGC	Soroush Sorabi	01/04/2021	28/05/2021		01/12/2021		In Progress		Implemetationof a golden paitent for use of the hybrid theatre may require the listing a fistulas etc that do not require IR support. This is mostly due to lack of ITU bed availabilty or decisions to procedd with thetre being delayed pending ITU approval to proceed. Vascular and Intensivist CDs to discuss a way forward in expediting decisions. Cancellations on the day SOP also required for theatre to ensure that decisions to cancel are made following all avenues being exhausted by the Manager of the Day (MOD)			
			Reduce vacant sessions through backfill for surgeons	Operational	Vascular Network Manager supported by DGM Surgery	DGM Surgery YGC	01/04/2021	28/05/2021				In Progress	Human resource issue for cover	Locum consultant starting 4/10/21 and 1//11/21 to cover a gaps in funded consultantsm, 1 is additional to numbers to aid picking up lost activity' due to VCOW / SOD activity to aid increased capacity			
			Consider lengthening lists to 3 sessions to allow more flexibility and less overloading of lists	Operational	Theatre Manager supported by Critical Care Lead YGC	DGM Surgery YGC	01/04/2021	28/05/2021		01/01/2022		Not yet commenced / Overdue	Cuurently starting times are an issue so not viable to extend but could amend start time for efficiency	Need to improve efficiency before lokoing to lengthen sessions - requires further review			
			Anaesthetic involvement in Friday theatre meetings to reduce those cancellations relating to anaesthetic concerns	Clinical	Anaesthetic CD supported by Soroush Sorabi	Balasundaram Ramesh	01/04/2021	28/05/2021				Complete		A North Wales MDT is held every Friday pm involving all available vascular consultants, interventional radiology and anaesthesia which covers patients from all three areas. In addition a meeting has been established in June 2021 at YGC involving vascular and microbiology to discuss the ongoing care of inpatients.			
Spoke Vascular presence	4.1.4	Vascular presence at Spoke Sites	Consultant review of all vascular (sole or shared care) patients withing 24 hours	Clinical	Soroush Sorabi	Secondary Care Medical Director	01/04/2021	30/06/2021				In Progress		Gap anaylsis previously undertaken - need to source the data - or complete again. Locum consultants will cover planned activity that is dropped due to VCOW / SOD or Leave in the interim. Need to also factor in MG cover for spoke sites to support sustainabky. This must be rotational to aid the roles being attractive as spoke site activity perhaps not exciting enough to attract on its' own. 5 days coverage at Spoke sites means that the weekend may extend to 48 hours by exception with out Middle grade on call cover. VCOW / on call provides virtual review			
			Spoke site consultant vascular surgeons should be accessible to Diabetology, Orthopaedics, General Surgery and Endocrinology etc Availability and means of access also need to be clear to all	Operational	Vsacular Network Manager supported by/ DGMs	Acute Site Direectors	01/04/2021	30/06/2021				Complete		Spoke site surgeons are have a rota which is shared across all sited with relevant specialty groups. The rota includes allocation of surgeons,sites, and contact details. Aim for Healthroster to be live in the next 2 months to aid a live rota version visible to all who need.			
	4.2.11		Support required to improve and facilitate communication and team working across hub and spoke sites to reflect a network approach	Operational	Vascular Network supported by DGM Surgery	Soroush Sorabi	01/04/2021	30/06/2021	28/11/2021			In Progress		The rota has been streamlined to be more clear where each consultant is based and their schedule. Fornightly meetings in place with Ops across BCU and rota co-ordinator and renal and vascular nursing to iron out cover / capacity issues			
	4.2.16		Regular Vascular Nursing staff meetings across the network	Clinical	Vascular nurses all sites	HoN YGC	01/04/2021	30/06/2021	07/10/2021			Complete		The CNS and ANP both have weekly meetings with spoke sites and are also joining the operational / renal / vascular nursing meetings fortnightly currently. There is some practice to be shared in line with nurse led clinics and this forum will support this venture			
	2		Full capacity and demand exercise requires completion across all sites. Job Plan reviews for all Surgeons following this	Operational	Vascular Network manager supported by DGM Sugery YGC and Soroush Sorabi	Medical Directors	01/04/2021	30/06/2021	01/01/2022			In progress		Not yet commence Capacity and demand work due to current operational capacity. All sites are covered with locum backfill for shortfalls in the short term. 24/10/21 Recruitment of additional consultant to cover spoke site will alter the current working pattern for surgeons based at the spoke site			
	4.2.17		Gap analysis of Junior / middle grade and Consultant vascular staff to be incuded in BU pan business case. Additional Deanery and non-training grade vascular surgeons required to allow for learning opportunities at spoke sites and to reduce reliance on general surgery trainees	Clinical	Soroush Sorabi supported by Vascular network manager and DMG Surgery YGC	Medical Directors	01/04/2021	30/06/2021	01/01/2022			In progress		Not yet started due to current operational capacity Initial discussion with Emma Wooley and Wndrew Foulkes to determine requirements for junior s and middle grades to mitigate the curmet risk 25/10/21. Funding approval wil be reuired and lead time for recruitment and start dates			
Audit	4.2.14	6 Audits identified by vascular T&F group to be undertaken using national vascular registry (NVR) data should be progressed as part of assessment, evaluation and shared learning	Audits on the following for completion: * Same Day discharge following endovascular intervention (FS) Complete * Timeframes for lower limb bypass or endovascular revascularisation proceduresfor patients admitted with CLI as emergency (AR) Awaiting * Below, through and above knww amputations since centralisaiton (SS) Completed * Carotid endartectomy - timefrom symptoms to referral, referral to surgery and outcomes (rRF) Awaiting * AAA timelines for referral to surgery open & EVAR and outcomes (LP) Awaiting * Complex aneurysm repairs EVAR / Open and outcomes (SS) Awaiting * Conversion of below knee amputation to through and above knee (SS) Completed	Clinical	Soroush Sorabi	Secondary Care Medical Director	01/04/2021	30/06/2021	01/12/2021			In progress		Awaiting details on the outstanding audit subjects. New Audit lead appointed given Mr Taha's leave. Fasial Shaikh now leading. 15/10/21 Same Day Discharge following endovascualr intervention - complete / presented 24/10/21 - Update from Soroush 3/7 commpleted and potential further 2 awaiting presentation, awaiting confrimation from audit leads			
Additional Recommendations	4.3.20	Additional Recommendations	Including Vascular surgical trainees in the vascular on call to enable exposure to more complex procedures	Clinical	Soroush Sorabi	Balasundaram Ramesh	01/04/2021	30/06/2021				Not yet commenced / Overdue		Middle graded / trainee on call arrangement to be reviewed. Will require additional wte to support a vascular on cal rota as currently there is simply a bleep holder 9-5pm. This will be reviewed inline with Capacity and demand / work			
			Agree guidelines for tenure length for leadership / management roles to facilitate rotation and support the potential for new ideas and leadership styles	Operational / Clinical	Medical Directors	Nick Lyons	01/04/2021	30/06/2021				Not yet commenced / Overdue		This has yet ot be reviewed			

Recc			Develop an action plan to maintain stability and attract further clinicians given the relatively rapid turnover of vascular surgeons within the service	Clinical	Soroush Sorabi	Ramesh Balasundaram	01/04/2021	30/06/2021				Not yet commenced / Overdue		This has yet ot be reviewed			
Communication	3	Completion of Comms section on intranet	The dedicated vascular services page on our website is under development to include a patient stories section, a 'meet the team' component and pictures and video content to demonstrate the high quality facilities and equipment available and is expected to be finalised by the end of November.	Operational	Jez Hemmings	Neil Rogers	01/04/2021	30/06/2021	01/12/2021			In progress					
		Development of Communications plan	To support the North Wales vascular service and highlight the progress being made, a communications plan is under development and will be reviewed by the Vascular Steering Group.	Operational	Jez Hemmings	Neil Rogers	01/04/2021	30/06/2021	01/12/2021			In progress					
Action Plan	4	Review of all risks to ensure captured in the risk log	Risk from all of the above actions are to be logged in the risk log and scored accordingly as to impact with current mitigations detail	Operational	Vascular Network Manager supported by Project support	Neil Rogers	01/04/2021		ongoing			In progress / Ongoing		24/10/21 Revised action plan in 1st draft for review at the vascular steering group 25th Ocotber 2021			
	5	Review of all issues to be added to the issue log	Issues from all of the above actions are to be logged in the issue log and scored accordingly as to impact with current mitigations detail	Operational	Vascular Network Manager supported by Project support	Neil Rogers	01/04/2021		ongoing			In progress / Ongoing					

Vascular Steering Group Terms Of Reference

Date of Sign off for TOR	Version Number	Date for Review of TOR
	V2	25th November 2021

Betsi Cadwaladr University Health Board

TERMS OF REFERENCE

Vascular Network Task and Finish Steering Group

Accountability	Quality, Safety and Experience Committee
Purpose	The purpose of the Vascular Task and Finish Steering Group as follows: To be responsible for overseeing the implementation of the recommendations identified in the following reports: • Royal College of Surgeons (RCS) invited review of the vascular service, the first part of this review was received by the Health Board in March 2021 • Vascular Review report, an internal review presented to the Health Board in May 2020
Remit and Responsibilities	The Group will ensure that the RCS report is cross-referenced with the existing recommendations from the Vascular review report and built into the action tracker with clear responsibilities and timeframes for completion. The group will ensure that the following urgent recommendations from the RCS report to address patient safety risk are delivered: • Agreed pathway for timely and effective treatment at the hub site • Vascular bed capacity and associated nursing resources should be adequate to allow timely transfer from spoke to hub site • More effective use of the hybrid theatre • Vascular consultant presence to enable patient review within 24hrs at spoke sites • Finalise pathway for management of patients post major arterial vascular surgery to ensure timely rehabilitation and repatriation • Develop non-arterial diabetic foot pathway • Finalise other pathways currently in draft • Confirm pathway for non-complex/low risk vascular interventions at spoke sites • Improve effectiveness of clinical governance process

	The group will ensure that the following recommendations for service improvement are delivered: • Clarify phase two of centralisation plans (services accessible at spoke sites) • Improve communication and team working across hub and spoke sites The Group will do this through a structure of subsidiary topic specific Task and Finish Groups, which will be established and terminated as the topic is fully implemented. Initially there will be the following subsidiary Task and Finish Groups: • Diabetic Foot pathway covering both primary and secondary care. • IVDU pathway for patients that use drugs intravenously presenting with groin abscesses • Pathway for timely and effective treatment at the hub site • Pathway for non-complex/low risk vascular interventions at spoke sites • Hybrid theatre utilisation The group will ensure that all relevant stakeholders with a responsibility for planning and delivering services have an opportunity to review/discuss pertinent issues and agree an achievable work plan for delivery of the recommendations. These will include clinical facilities, service delivery, scheduling and risk management issues as well as finance and performance.
Chair	Executive Medical Director or nominated deputy
Core Membership	• Deputy CEO / Executive Director of Nursing and Midwifery (Vice Chair) • Secondary Care Medical Director • Chief Operating Officer • Nominated Acute Care Director • Clinical Director Vascular Network • Nominated Hospital Medical Director • Nominated Area Medical Director • Vascular Network Manager • Community Health Council (CHC) Representative • CHC patient and carer representatives • Clinical Director of Therapies • Communications • Corporate Patient Experience Lead The core membership reflects the wide range of actions being considered by the group. Other members will be co-opted as required and the group develops.
Administrative Support	Provided by the PA to the Executive Medical Director

Quorum	Greater than five members including the Chair or Vice Chair, one of which must be in attendance.
Frequency & Venue	Monthly virtual meetings
Start Date	May 2021 and expected finish date of November 2021
Outputs and reporting	An action log will be maintained and circulated to agreed stakeholders after each meeting. Progress will be reviewed at each meeting and an assurance report will be provided regularly to the Quality, Safety and Experience Committee and every two months to Welsh Government. The Chair may raise specific matters at the meeting for information, discussion or approval. All members may submit items for discussion to be brought to the meeting.
Communication	Each member has a role that involves communicating and disseminating information.
Escalation	Escalation of issues to the Quality, Safety and Experience Committee

Quality, Safety & Experience Committee
2nd November 2021

Operational Report – Childrens Services
October 2021

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University Health Board

Neonatal Service Update

The service continues to operate across all three sites which are working together to maintain the in-patient service, community support and transport retrieval service. Twice weekly meetings with Womens services are now in place to facilitate improved communication.

The key challenges and risks relate to nurse staffing, which impacts on service delivery during periods of high demand. Occasionally this causes unit closures but more usually involves the adjustment of case mix and the transfer of staff between units to mitigate staffing gaps. Staffing vacancies in SuRNICC are high at 11.3wte. There are no current vacancies in East and West Special Care Baby Units (SCBU's). Staffing is also impacted by staff absence due to sickness, C-19 related issues and maternity leave. Availability of staff Qualified in Speciality (QIS) is affected by the training being suspended during the pandemic. Education leads are planning 2 cohorts/year to increase the numbers and through put of staff to be trained.

Mitigating Actions being taken: an options appraisal paper is in draft which considers a variety of ways to improve staffing levels. This includes a short competency based programme to facilitate improved knowledge and skills while the full QIS training takes place; greater use of professional judgment in staffing ratios in times of extreme pressure via an improved escalation process; temporary revision of care pathways ie increasing High Dependency Unit care in the two scbu's

Childrens Respiratory Winter Plans

In July concerns were raised about a predicted surge in children's respiratory illnesses in the autumn and winter months 2021/22. The prediction was that the surge may be 20 - 50% greater than previous years and start earlier in August and September. An over arching BCU plan has been developed which incorporates operational plans for the three District General Hospitals (DGHs). The plans involve developed working relationships with other interdependent services within the DGHs, Primary Care and tertiary care partners. Strong links between BCU and The North West and North Wales Paediatric Critical Care Operating Unit and with a Wales wide response are in place. There is now a daily sitrep report of BCU paediatric ward status.

Current Status: While there is a steady attendance of children on each of the 3 sites with a variety of respiratory illnesses and pockets of 'busy weeks' the predicted surge has not yet happened, nor significantly impacted on service provision. Case presentation in North Wales has mirrored that in North West England and demand remains manageable. So far there have been very few children needing transfer for critical care in relation to winter respiratory illness.

Along side the daily sitrep now in operation, if the demand increases there will be a daily Senior Manager led conference call to ensure the wards work collaboratively together to assess and escalate risks, share resources and develop solution focused site and regional plans.

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Childrens Respiratory Winter Plans

The key challenges and risks relate to:

Nurse staffing levels, particularly with the introduction of The Paediatric Nurse Staffing Levels Act Implementation on the 1st October 2021. There are vacancies across the 3 sites and there is also impact from staff absence due to sickness, C-19 related issues and maternity leave**.**

The normal paediatric cohort of respiratory illness and patients requiring isolation while waiting for infection screening, results in insufficient cubicle capacity. Discussions are ongoing with Infection Prevention and Control and to access Point of Care testing to facilitate safe cohorting of patients.

Complex CAMHS patients resulting in Delayed Transfers of Care – Assistant Area Director partnership work with Local Authorities takes place to facilitate safe discharge

Paediatric Transfers to Tertiary care

In paediatric respiratory illness it is usually Respiratory Syncytial Virus (RSV) infection that may require critical care, particularly in the very young. The North West of England and North Wales have not seen the RSV modelling originally predicted by Public Health Wales and Public Health England and only 1-2 patients have required transfer from North Wales for RSV management. RSV numbers are currently very low.

There are the usual Paediatric Intensive Care Unit (PICU) challenges including general respiratory illness which includes covid related illness, but there are no Datix incidents relating to delays or issues with transfers. Although there have been challenges with PICU capacity at times, the North West Critical network have been able to accept all referrals from North Wales for level 2 and 3 critical care.

There have been discussions regarding North West Transport Service (NWTS) and their ability to respond to a surge due to a possible shortage of ambulance drivers. Strategic discussions in England and Wales are taking place to develop contingency plans to address this if the need arises.

In relation to the transfer of all patients to tertiary care we have observed some delays in acquiring beds in tertiary centres as well as ambulances to transfer them at times. The patients have continued to be cared for locally with any necessary advice from the tertiary centre, until the transfer has been possible.

CAMHS Improvement Update

Targeted Improvement (TI) framework established with 12 identified work streams. Early indications of progression to Level 1 of TI maturity matrix within first 6 months. Progress to Level 2 of the maturity matrix is anticipated by May 2022

Priorities for delivery within the TI matrix include Workforce, Crisis Services, Strategy and Sustainability, Access, Involvement and Participation and Transition

Risks to delivery identified are the inability to recruit to key staff, increased demand for services, lack of engagement with partners.

Creation of regional risk management process aligned to established Area teams governance structures to support management of risk and mitigating actions

Mitigating actions being implemented:

- Workforce - Appointment of external support to develop recruitment campaign and strategy to maximise recruitment opportunities. Development of training “academy” in conjunction with HEIW and local Universities to provide identified training programmes to enhance recruitment and retention
- Access - Use of private providers for assessments and therapy. Review of private provision available for early intervention services and step down services to support throughput. Establishment of Family Wellbeing Practitioners in GP clusters and In reach practitioners in schools to provide advice and training to partners to build capacity for early help for children and young people and access to specialist liaison, consultancy and advice for partners when needed with the aim of reducing demand for Specialist CAMHS
- Engagement – Regular meeting/workshop meeting attendance by Local Authority and BCUHB colleagues. Development of joint strategy with Local Authority partners to address No Wrong Door report. Transition policy and audit tool developed and implemented in CAMHS and Adult Mental Health services.

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Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Neurodevelopment Service Update

Children's Neurodevelopment (ND) Services relate mainly to Autistic Spectrum Disorders (ASD) and Attention Deficit and Hyperactivity Disorder (ADHD) in under 18yr olds. There is a monitored Neurodevelopment Target set by the Welsh Government (WG): 80% of assessments to commence within 26 weeks of date referral received, which is currently not being met within BCU.

Demand for the service has increased during and as a result of the Covid pandemic. This has had a direct effect on the capacity of teams to respond in a timely way to the increasing trends, alongside the ongoing challenges to service delivery related to the Covid restrictions remaining in place and staff having to isolate. Demand currently outweighs capacity in all three regions across the Health Board. Without significant investment in internal capacity / resources the waiting list will continue to grow.

Mitigating Actions being Implemented: In order to support a reduction to the ND assessment waiting list, Children's Services have engaged the support of an external provider to undertake backlog assessments waiting over 26 weeks, which is currently in place until March 2022. Consideration is being given to extending this into 2022/23

There is an increasing realisation that there needs to be a move of focus away from purely waiting list management into a whole service improvement ethos. An action plan is now being put in place to manage this. This includes moving to an Improvement and Development focused Steering Group; Development of a robust workforce plan; Development of clinically driven pathways to reduce variation and improve access; Increased engagement with families; Increased multiagency working to address children and families real needs; the development of business cases to increase resourcing.

Diolch

Thank you

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 2nd November 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Immunisation programme delivery in BCUHB to September 2021
Cyfarwyddwr Cyfrifol: Responsible Director:	Teresa Owen, Executive Director of Public Health
Awdur yr Adroddiad Report Author:	Leigh Pusey, Matron Immunisation and Vaccination
Craffu blaenorol: Prior Scrutiny:	The data and information included in this report has been scrutinised by West Area Director.
Atodiadau Appendices:	1. Strategic Immunisation Plan 2019-2022 *https://bcuhb.nhs.wales/health-advice/immunisations/immunisations/strategic-imms-plan-2019-22/*

Argymhelliad / Recommendation:

The Quality, Safety and Experience Committee is asked to scrutinise the report and advise if any areas are to be escalated to the Board.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

The purpose of this report is to keep the Committee informed of progress in relation to some of the key vaccination programmes currently being delivered across North Wales. This provides an update regarding the planning, implementation and delivery of the main immunisation programmes currently being delivered across North Wales and includes key performance data for the two main vaccination programmes, the Routine Childhood Immunisation Programme and the Seasonal Influenza programme.

The Committee are asked to note the following:

- The *NHS Wales COVID-19 operating framework for quarter 1 (2020/21)* was published by Welsh Government (WG) in early May and highlighted the continuing need to maintain essential services which includes immunisation programmes.

- The vast majority of immunisation services have continued to be delivered via General Medical Services (GMS)/GP Practices, School Nursing Services, BCUHB Occupational Health and other services such as Community Pharmacies throughout the Covid-19 pandemic. Based on a national risk assessment some immunisation programmes were suspended on the instruction of the Chief Medical Officer but have since been reintroduced e.g. Shingles vaccination and travel

vaccines. Immunisation services were delivered using a modified way of working to accommodate the infection control procedures required to manage the coronavirus pandemic.

- Despite the impact that COVID 19 has had on the delivery of immunisation programmes, it is encouraging to see that children's immunisation programmes have continued to deliver throughout 2020/21 with 95.9% of eligible children receiving 6 in 1 Hexavalent by age 1 and 93.9% of eligible children receiving 2 doses of measles, mumps & rubella (MMR) vaccinations by age 5 in the most recent Annual COVER (Coverage of Vaccination Evaluation Rapidity) report. cover report Feb 95 [WP] (wales.nhs.uk)

- The seasonal influenza programme delivered during 2019-20 achieved the Health Board's best uptake in several categories reaching 78.2% for those people aged 65 years and over and 54.2% for those with an at risk condition. The workload increased significantly mid campaign as people aged 50 to 64 years were included in the eligible groups to be vaccinated.

- The seasonal influenza programme is well underway for the current year 2021-22. Additional groups have become eligible for the flu vaccine namely, all secondary school pupils and all inmates in prison. This year has seen a national problem with the main vaccine supplier which affected all providers resulting in a delay of the delivery of the vaccine for one to two weeks. Consequently providers had to adjust their plans to provide vaccination clinics.

- In an effort to avoid any vaccine supply issues, BCUHB has purchased a Flu vaccine contingency stock for the second year. If the demand for flu vaccination is high, then GP practices, community pharmacies and the staff campaign can all access the contingency stock if needed. (Several requests have already been made to access that stock as at 18.10.2021).

- The seasonal flu campaign in schools is progressing well, however there are some schools that have cancelled their planned vaccination session due to COVID infections in pupils or staff. Any cancelled date will be rearranged as soon as it practical to do so.

- All immunisation programmes are fully implemented in BCUHB, Vaccination uptake data is scrutinised and feedback given to providers where uptake is deemed to be lower than expected to enable modifications to be made to their campaign to maximise uptake.

Cefndir / Background:

The Committee should be aware that BCUHB has produced a 3 year Strategic Immunisation Plan (SIP) for the period 2019-22 which outlines how the Health Board and primary care providers will protect and improve the health of the population through maximising uptake of vaccines for eligible groups across the life course. This has focused on reducing variation in uptake, sharing learning and further embedding a culture of quality improvement, strengthening governance arrangements with the Area Operational Immunisation Groups, improving how we communicate and engage with key stakeholders, and taking every opportunity to immunise our public, patients, and staff.

Some of the key actions have been:

1. Improving the governance structure enabling the Area Operational Immunisation Groups to take forward the local agenda and have oversight of local issues and service delivery.
2. Structured media messages to the public with funding secured from Building a Healthier North Wales scheme.
3. Research project in conjunction with Bangor University to explore:
   - Insights into factors affecting childhood immunisation uptake across the pathway and amongst specific groups to improve uptake in smaller cohorts where uptake is low.

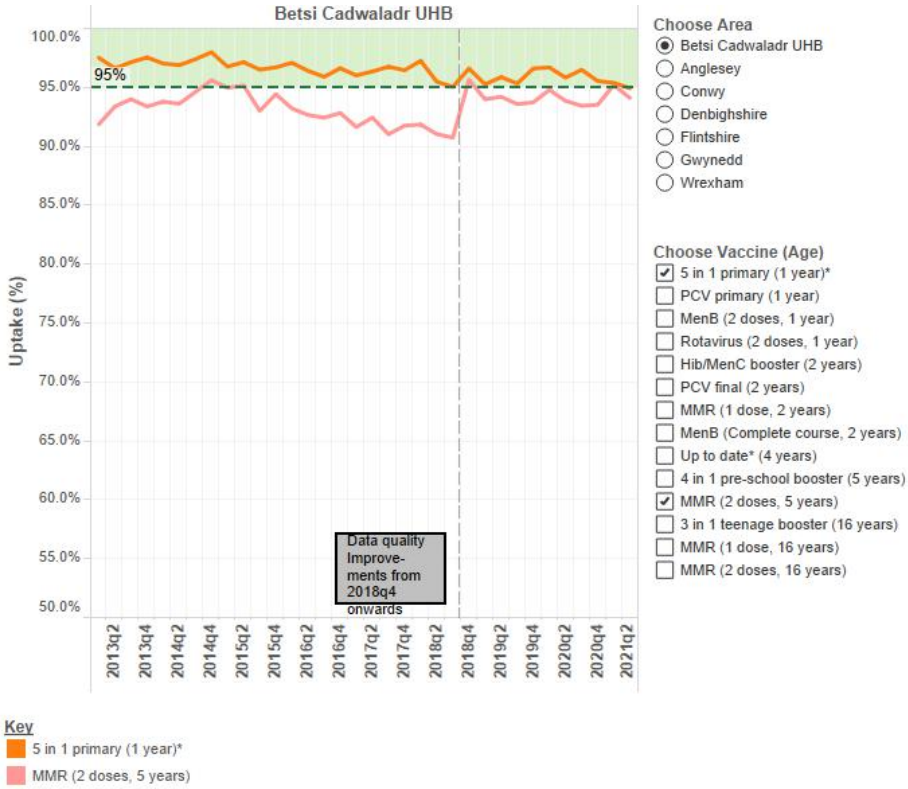
- Improving access and availability of information resources to promote childhood vaccination with minority ethnic/language groups

In addition to the SIP, other action plans are in place to ensure uptake is maximised in specific areas namely: Flu Vaccination plan and the Childhood Immunisation Action plan. These set out key activities for implementation to address specific operational issues. The SIP is currently being reviewed and updated by members of the Strategic Immunisation Group, in relation to forward planning for the next few years.

Wales has a comprehensive Childhood Immunisation programme and the NHS Delivery Framework targets set at 95% for the 3rd Hexavalent vaccine by the 1st birthday and two doses of the Measles Mumps Rubella (MMR) vaccine by the 5th birthday. The target of 95% is the uptake level required to provide herd immunity in the population. Each Health Board in Wales is required to report quarterly on uptake of childhood vaccines against the 95% target.

The main provider of immunisations to preschool children are GP practices who offer weekly or fortnightly immunisation clinics on their premises. The process works very well and is supported by the Child Health department to operate the appointment and recall system and the network of Health Visitors to provide expert clinical advice. A home vaccination service is available to support vulnerable families to ensure the child is protected from vaccine preventable diseases.

Chart One – Immunisation uptake of 3rd 6 in 1 vaccine by 1 year and two doses of MMR vaccine by 5 years 2013-2021 in Betsi Cadwaladr University Health Board. Accessed 16.10.2021

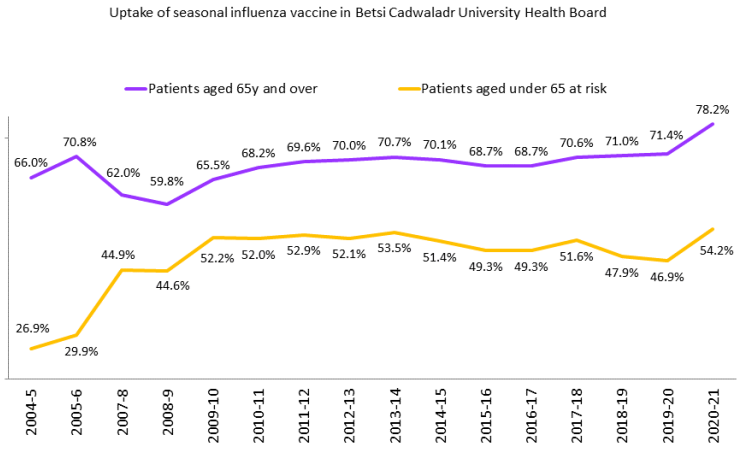


The Influenza vaccination programme is a major health prevention campaign commencing annually each September with aspirational vaccination targets. Achieving a high vaccination uptake will be an important priority this coming autumn to reduce morbidity and mortality associated with influenza, and to reduce hospitalisations during a time when the NHS and social care may again be managing

winter outbreaks of Covid-19. Vaccine uptake reporting is via local Area Operational Immunisation Groups.

The BCUHB Seasonal Influenza campaign is reviewed annually and lessons learned are noted. The plan is updated to reflect the learning and a new action plan developed to maximise uptake. Chart Two below demonstrates the trends in Flu vaccine uptake over the last 17 years in BCUHB.

Chart Two: Uptake of seasonal influenza vaccine in Betsi Cadwaladr University Health Board 2004—2021.



There are many other vaccination programmes that are in place to prevent other vaccine preventable diseases which are offered on an ad hoc basis due to the individual health needs of the person or their age. i.e. shingles or Hepatitis B that are not reported here.

The Strategic Immunisation Plan (SIP) is currently being reviewed with a view to publish a new three year plan by 1st April 2022.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

Within BCUHB, the Strategic Immunisation Plan sits under the Improving Health and Tackling Inequalities group.

These immunisation plans align to several strategies including:

- NHS Delivery Framework
- Building a Healthier north Wales
- A Healthier Wales
- Unscheduled care
- Informed by NICE guidance which sets out best practice to reduce inequalities in uptake

Opsiynau a ystyriwyd / Options considered

Not applicable

Goblygiadau Ariannol / Financial Implications

Not applicable

Dadansoddiad Risk / Risk Analysis

There are some risks to be considered at the next Strategic Immunisation Group prior to being added to the BCU risk register.

Opsiynau a ystyriwyd / Options considered

Not applicable

Goblygiadau Ariannol / Financial Implications

All immunisation programmes are implemented with a funding package from the Welsh Government via the Chief Medical Officer as set out in the form of Welsh Health Circulars

Dadansoddiad Risk / Risk Analysis

1. The COVID-19 pandemic produced a number of direct and indirect risks to the delivery of care across the healthcare system e.g. patients/parents being able to access trained staff who immunise who might have been off work due to shielding, self - isolation or illness. The situation has stabilised now and the risk has reduced.
   Mitigating actions:
   Bank staff were recruited to vaccinate. Immunisation clinics were delivered via a cluster collaborative scheme in alternative venues or via drive through clinics.
2. Vaccine supply issues may occur if the demand for vaccination is high
   Mitigating actions: BCUHB purchased a contingency stock to overcome any supply issues to support the BCUHB staff campaign, the GP and Community pharmacy campaigns.
3. Under vaccinated children or adults pose a risk of a vaccine preventable disease outbreak occurring.
   Mitigating actions: Continue to chase up children with missing immunisation records and if required offer home vaccination to catch up with the UK Children Immunisation Schedule. Encourage all services/providers to develop robust flu vaccination plans.
4. Flu vaccination uptake in schools may be lower due to COVID infections/outbreaks.
   Mitigating actions: Rearrange any cancelled school sessions at the earliest opportunity and provide catch up vaccination sessions for individual children. Ensure communications clearly demonstrate that Flu vaccination is an important vaccine for children to receive.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

All vaccination programmes are fully implemented as per Welsh Government instructions

Asesiad Effaith / Impact Assessment

This report updates and informs the Committee on the various immunisation schemes currently being implemented in BCUHB. The report does not have a negative impact on equality, socio economic disadvantage or human rights beyond what is highlighted in the risks identified.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Betsi Cadwaladr University Health Board

Strategic Immunisation Plan 2019 -22

Contents

1 Executive summary

Vaccination preventable diseases remain a significant risk to morbidity and mortality in north Wales. Protecting the health of the population through provision of vaccination programmes to eligible groups across the life course represents the most cost-effective public health intervention, second only to providing clean drinking water. All vaccines are safe and effective for the groups to which they are offered.

There are a growing number of vaccination programmes and this plan provides an overview of all which the Health Board and its partners have a responsibility to provide for people living in North Wales. It highlights how we are doing against targets and provides a clear vision of how we will improve the uptake of key vaccinations from 2019-2022, in particular those for Measles, Mumps and Rubella (MMR) and Influenza (Flu).

Whilst we are doing relatively well in North Wales in comparison to the rest of Wales, we need to continue to work together as a whole system, including the NHS, Local Authorities, third and independent sector providers, to improve vaccination uptake and reduce variation where it exists. Inequities in immunisation uptake within population groups and across geographies are a real risk to the health and wellbeing of the whole population, and we must remain committed and focused in tackling them together.

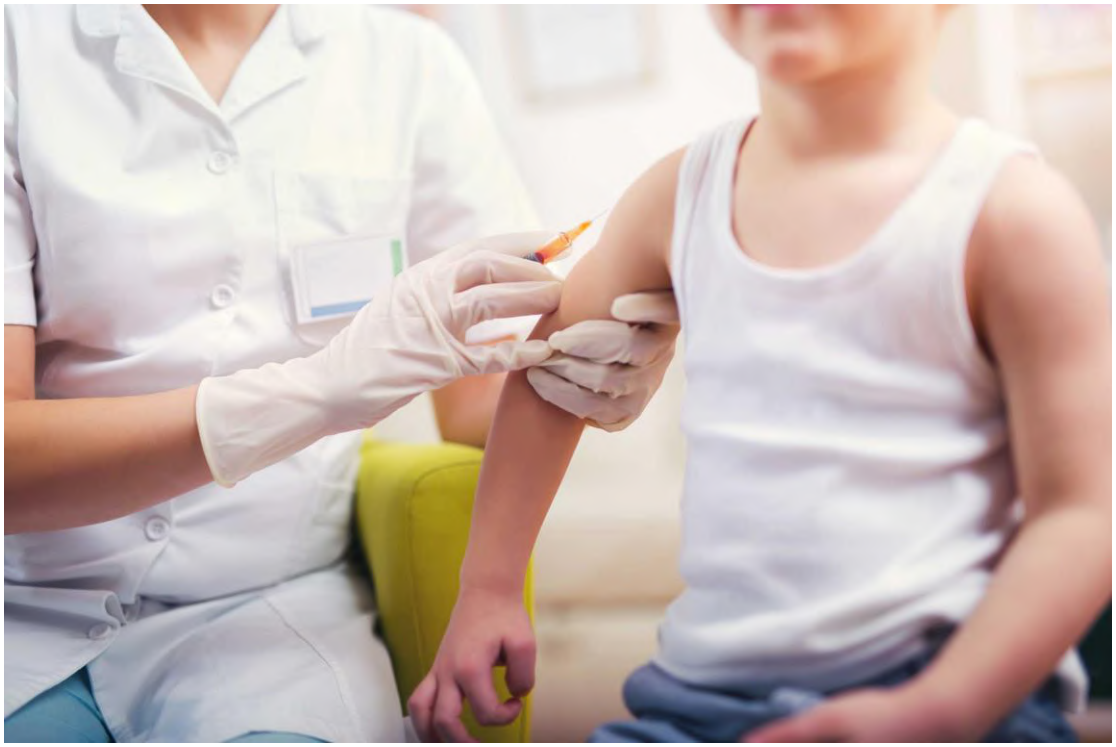
2 Introduction

The aim of this Strategic Plan is to outline how the Health Board and primary care providers will protect and improve the health of the population through maximising uptake of vaccines for eligible groups across the life course. This will be achieved by focussing on reducing variation in uptake, sharing learning and further embedding a culture of quality improvement, strengthening governance arrangements, improving how we communicate and engage with key stakeholders, and taking every opportunity to immunise our public, patients, and staff.

BCUHB has a workforce of around 16,500 staff who, alongside an extensive network of primary care contractors, provide healthcare services to a population of around 676,000 people. A broad range of different groups in the population are eligible to be vaccinated against vaccine preventable diseases; these groups are outlined in the Plan.

This document has considered existing BCUHB operational plans as part of its development, and provides the strategic direction for their ongoing review over the next three years. They include:

- Measles, Mumps and Rubella (MMR) Operational Plan
- Human Papilloma Virus (HPV) Vaccination Action Plan
- Childhood Immunisation Action Plan
- Immunisation Training Plan
- Annual BCUHB Influenza (Flu) Plan, and the Pandemic Influenza Vaccination Plan (both aligned with the pan-BCUHB Winter planning processes).



3 Strategic and Policy Context

The UK Immunisation Policy is informed by policies that are developed through the World Health Organisation (WHO) for the European region[1]. These include the coverage levels to be attained e.g. 95% uptake required for herd immunity against many childhood vaccine preventable diseases, and outcomes such as elimination of target diseases e.g. polio, measles, diphtheria.

Decisions on the most appropriate use of vaccines are made on advice from the UK Joint Committee on Vaccination and Immunisation (JCVI). The JCVI is an independent Departmental Expert Committee and a statutory body, and is constituted for advising the secretary of state in England and Welsh Ministers in Wales on *"The provision of vaccination and immunisation services, being facilities for the prevention of illness"*[2].

Following consideration of JCVI advice by the Welsh Government's Chief Medical Officer, the relevant actions regarding the implementation of vaccination programmes in Wales are communicated to Health Boards through the circulation of Welsh Health Circulars (WHC) and Chief Medical Officer Letters. Typically, funding is made available to Health Boards in order to facilitate the full delivery of each WHC.

Within BCUHB, the immunisation agenda sits under the Improving Health and Tackling Inequalities priority outlined in the current Three Year Plan (2018/19-2020/21)[3]. Section 11 of this Plan provides further details of the governance structure for vaccination and immunisation within the Health Board.

This Strategic Immunisation Plan is informed by NICE guidelines relating to maximising uptake of childhood and flu vaccinations[4,5,6]. Although no additional funding is made available in Wales to support full delivery of NICE guideline recommendations, development of the detailed action plans that will sit alongside this Strategic Plan take them into consideration. Another important national policy driver includes the Wellbeing of Future Generations (Wales) Act 2015, in particular the ways of working it advocates. In seeking to improve the uptake of vaccinations amongst eligible groups, the Act encourages us to:

- think long term in our planning and aspirations, to prevent the spread of vaccine preventable disease wherever possible,
- take a whole system approach to vaccination by integrating planning and the delivery of services,

[1] Immunisation against infectious disease: The Green Book
[2] Joint Committee on Vaccination and immunisation: code of practice, June 2013
[3] BCUHB (2018). 3 Year Plan (2018-2021)
[4] NICE (2009). Immunisations: reducing difference in uptake in under 19s [PH21]
[5] NICE (2018). Flu Vaccination: increasing uptake [NG103]
[6] NICE (2017). Vaccine Uptake in under 19s: Quality Standards [QS145]

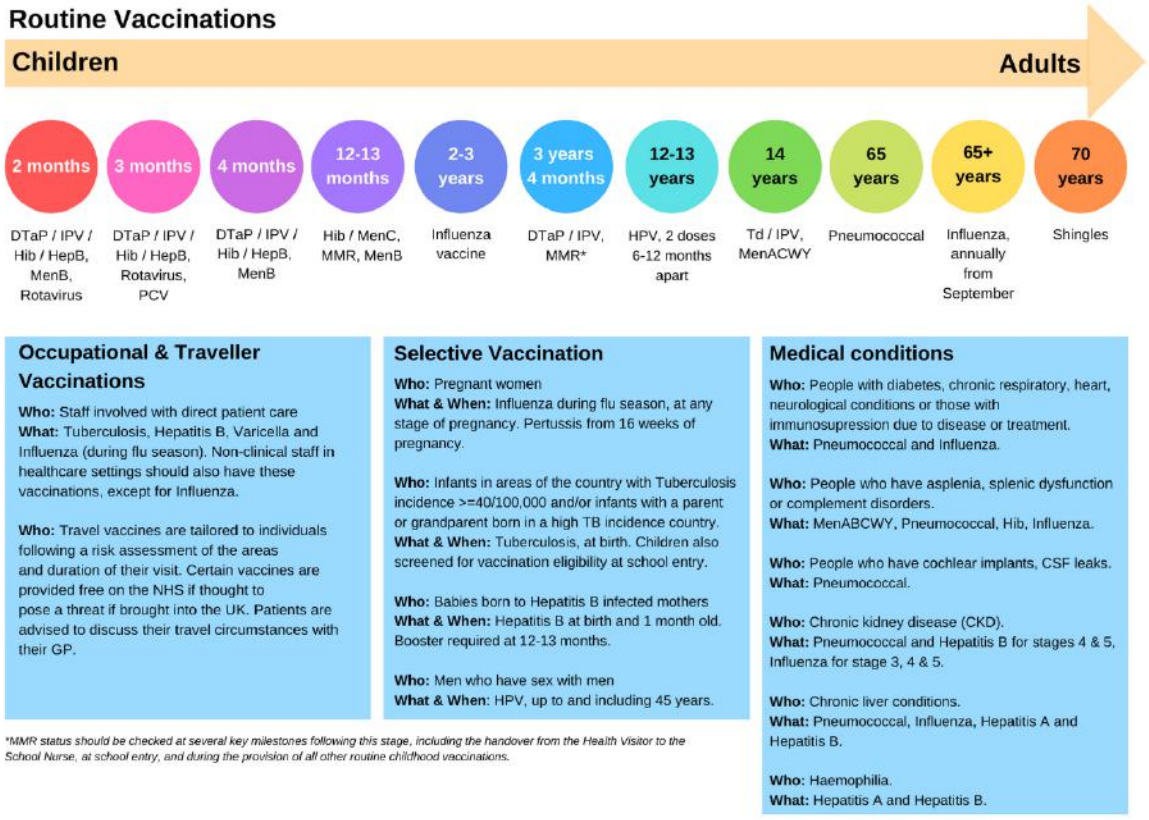
- encourage further collaboration with and involvement of key stakeholders to secure improvement.

Low immunisation uptake increases the risk of an outbreak. Maintaining high levels of uptake is the responsibility of BCUHB. The response to an outbreak is the shared responsibility of a multi-agency Outbreak Control Team as defined in the 'Communicable Disease Outbreak Plan for Wales'. BCUHB staff involved in immunisation may be required to assist in delivering outbreak response activities. Adequate staffing levels are therefore necessary to continue routine activities while also contributing to responding to outbreaks.

4 Immunisation Programme Schedule

Figure 1 presents a summary of the vaccination programmes that are being delivered by the Health Board and primary care contractors for the population of North Wales[7]. It is based on the detailed vaccination checklists outlined in Public Health Wales' Vaccine and Preventable Disease Programme webpages[8], including routine, selective, travel and occupation vaccines across the life course. Note that guidance relating to the frequent checking of MMR status at key milestones following the scheduled second dose at 3 years and 4 months is reflective of current good practice across BCUHB. This is not highlighted in national guidance.

Figure 1: Summary Schedule of Routine, Selective, Medical and Occupational & Traveller Vaccinations



[7] Please note that this schedule is not exhaustive and is subject to changes in line with Welsh Government vaccination directives

[8] http://www.wales.nhs.uk/sitesplus/888/page/43510

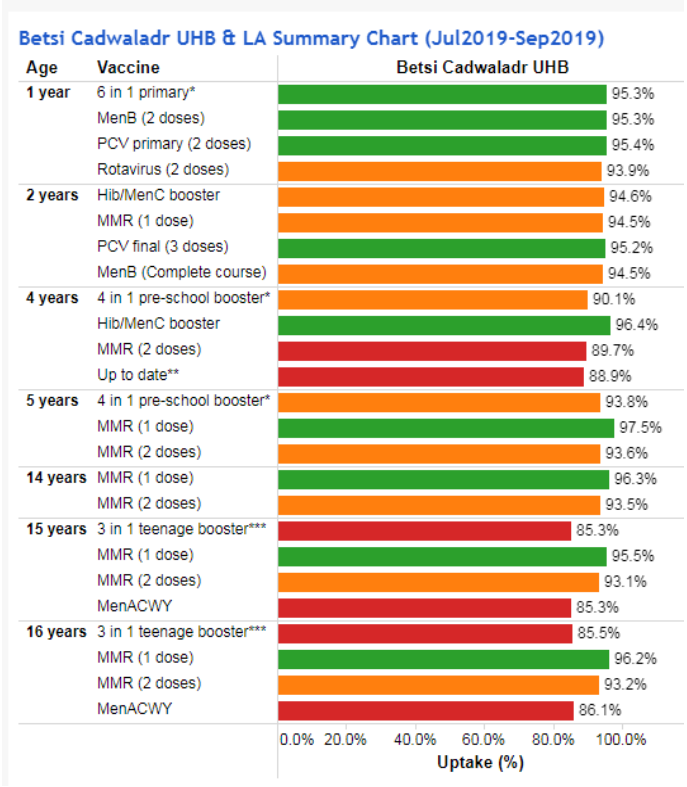
5 Benchmarking

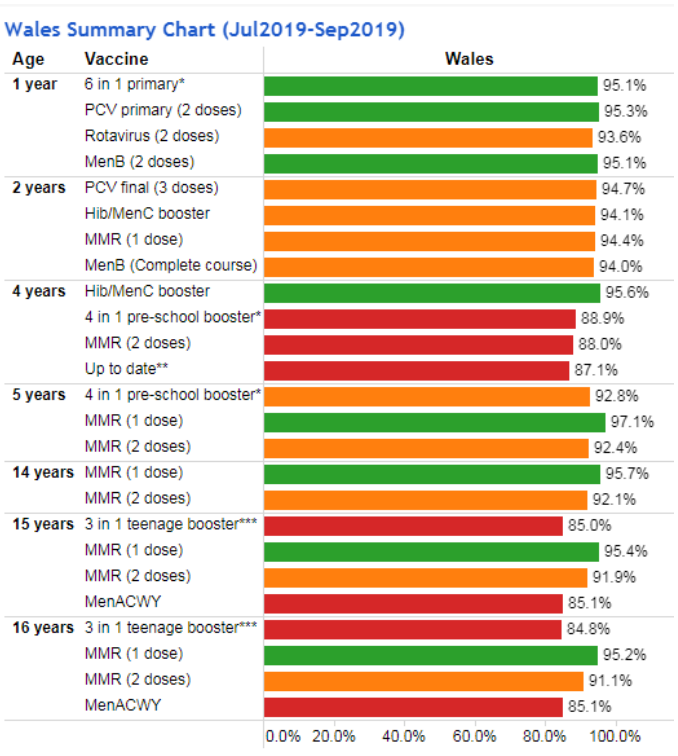
This benchmarking chapter provides a narrative summary of the uptake of routine and selective vaccinations, specifically for children, adults and flu (across the life-course). Further detail can be found via the links to the data sources referenced as footnotes, and in Appendix 1 which includes an overview of child, adult and travel & workplace vaccines.

5.1 Childhood Immunisations

BCUHB has historically performed better than the national average for uptake of most childhood immunisations. The most recent data[9] shows vaccine uptake in young infants remaining high and stable. However, as outlined in Figures 2a & 2b, uptake rates[10] generally reduce from infancy through to later childhood, and there is variation based on geographical area (see section 5.1.2 for MMR variation by Cluster).

Figures 2a & 2b: BCUHB & Wales Childhood Vaccination Uptake (July-Sept 2019)

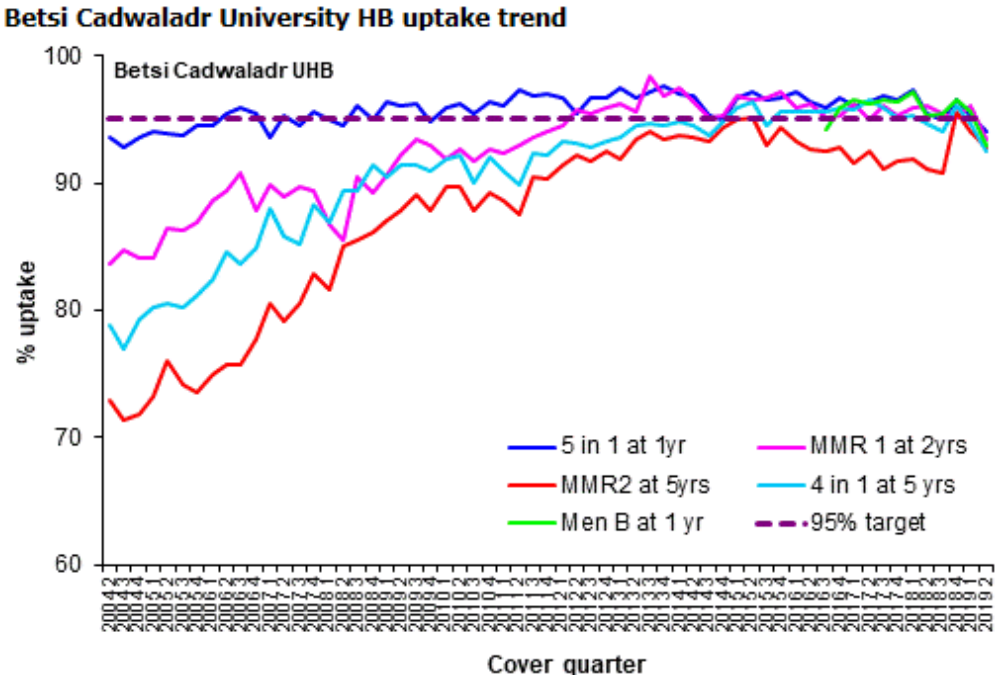




[9] Childhood immunisation uptake data (called COVER data) is provided by the Public Health Wales Vaccine Preventable Disease Programme (VPDP): http://nww.immunisation.wales.nhs.uk/cover (data access may be limited to non-NHS computers)

[10] Key: Green = uptake meets or exceeds 95% target; Yellow = uptake between 90%-94.9%; Red = uptake below 90%

Figure 3: BCUHB Uptake Trend of Key Childhood Vaccinations, 2004-2019



Uptake of the second dose of MMR at age 5 shows a decline from 2014/15 until mid-2018/19, which was a cause for concern.

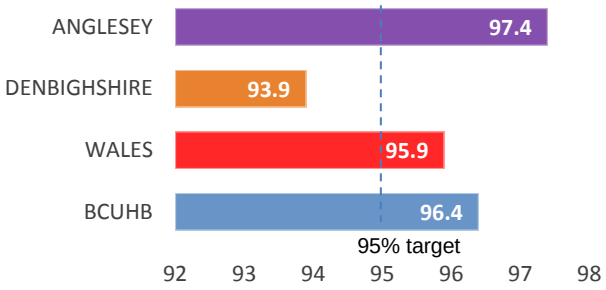
However, recent COVER trend data (Figure 3) illustrates a sharp increase in uptake during Oct-Dec 2018. This was due to a review and rectification of data as part of a national quality assurance project; historical data will not be adjusted for this correction.

Whilst this latest data rightly recognises the positive impact of the collective system efforts in supporting a high uptake of MMR uptake, there remains geographical variation at Area, Local Authority, Primary Care Cluster and GP Practice levels (see Section 5.1.2 below for further details). There is also a general decline in the selected routine childhood immunisations over the most recent 2-3 quarters (Figure 3). This illustrates the need to continue to prioritise optimal uptake of routine childhood vaccinations in order to maintain the high immunisation levels required in order to protect child health and wellbeing in north Wales.

5.1.1 6 in 1 Vaccine

In 2017/18 all Local Authority areas exceeded the 95% target for the 6 in 1 vaccination before 1st birthday, except Denbighshire at 93.9%.

Figure 4: 6 in 1 by 1st birthday 2017/18



5.1.2 Measles, Mumps and Rubella (MMR)

12-13 months

Hib / MenC, PCV, MMR, MenB booster

3 years 4 months

DTaP / IPV, MMR*

BCUHB uptake of the first dose MMR vaccine in two-year-old children was above the 95% target (95.5%) and also above the national average (94.5%) during the most recent full year that data is available (2018-2019). At Local Authority level, Wrexham, Flintshire, Anglesey and Gwynedd remained above the target (Anglesey equal highest in Wales at 97%). However, Conwy and Denbighshire were below at 94.1% and 93.7%, respectively. Overall, BCUHB has constantly remained above the target since 2014.

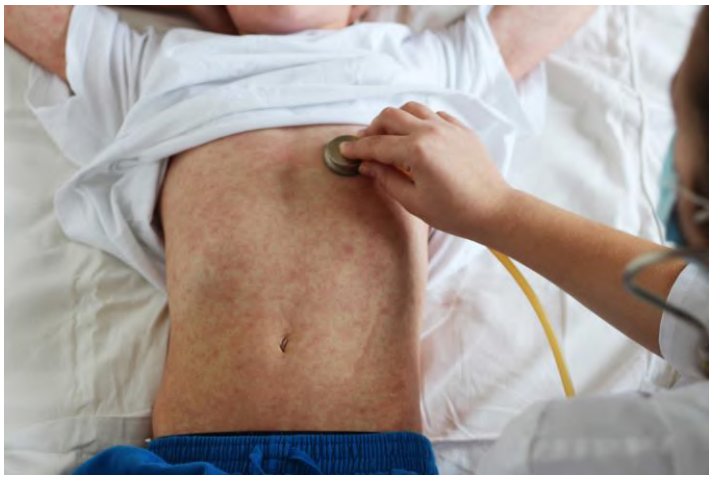


Figure 5: Uptake of two doses of MMR at age 5 years by BCUHB Primary Care Cluster

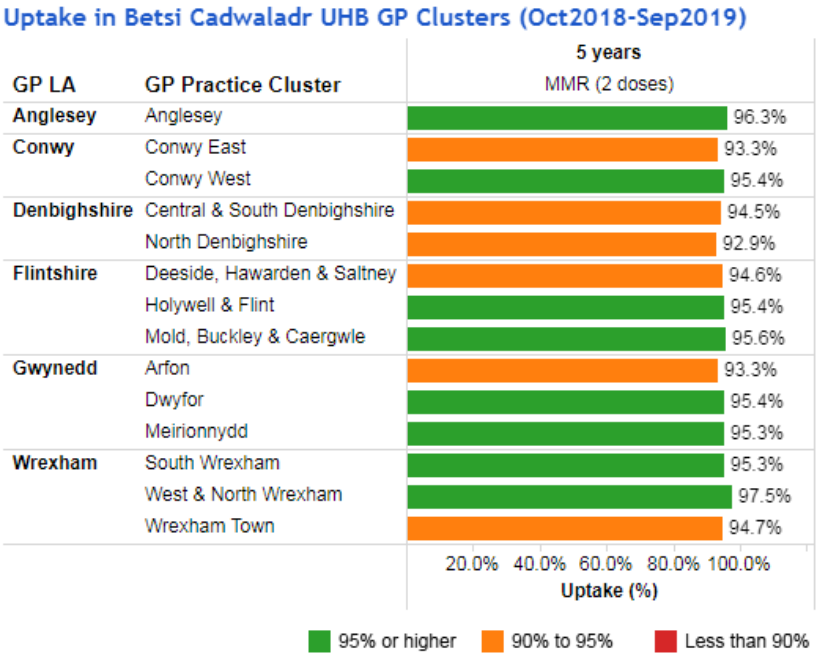
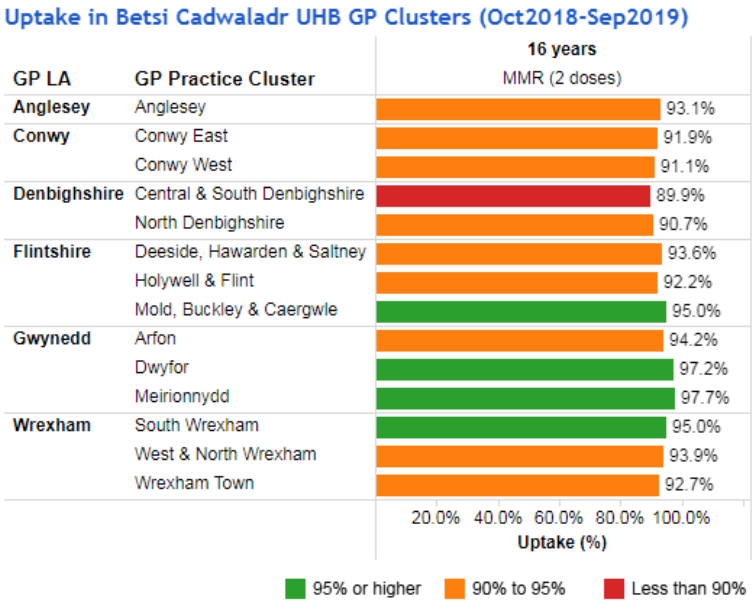


Figure 5 illustrates the most recent uptake data of two doses of MMR by age 5 in Primary Care Clusters (October 2018-September 2019). It is worth noting that:

- 8 out of the 14 Clusters achieved the 95% uptake target
- At least one Cluster in each Local Authority area achieved the 95% target except for Denbighshire
- Highest uptake was in West & North Wrexham (97.5%) and Anglesey (96.3%)
- Lowest uptake was in North Denbighshire (92.9%)

Figure 6: Uptake of two doses of MMR at age 16 years by BCUHB Primary Care Cluster



The proportion of children achieving an uptake of two doses of MMR at age 16 is notably lower than at age 5, which represents an increased risk of potential measles outbreaks in this current cohort older children. The lower uptake is likely due to number of factors, including historical parental attitudes to vaccination and the effectiveness of the system in identifying and following up children who missed a vaccination. Again there is notable variation across the Primary Care Clusters:

- Four Clusters achieved the 95% uptake target with Dwyfor and Meirionnydd achieving particularly high uptake (97.2% and 97.7% respectively)
- Lowest uptake in Denbighshire, with Central and South Denbighshire achieving just under 90%

A three year Measles and Rubella Elimination Action Plan was published by Public Health Wales in 2019[11]. It makes recommendations for system-wide interventions at national and Health Board levels to support achieving high uptake of the MMR vaccination, including establishing catch up programmes in schools and general practice for young people 16-24 years of age. The Health Board is establishing an action group to ensure that the relevant recommendations are taken forward locally, along with supporting a number of other measures to secure continual improvement in MMR uptake.

5.1.3 Up to date by 4th birthday

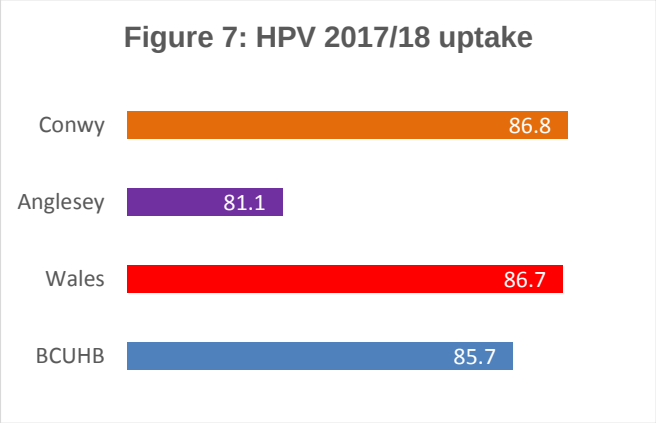
Local Authorities are measured by the proportion of resident children that are 'up to date' with their immunisations by their 4th birthday. This indicator is a composite measure of completion of the '4 in 1' preschool booster, the Hib/MenC booster and second MMR dose and, as such, there is no uptake target. The uptake for BCUHB has been higher than the Wales average since 2014. At Local Authority level, Anglesey and Flintshire are generally highest with Denbighshire and Conwy having consistently lower uptake.

[11] Wales Measles and Rubella Elimination Task Group Action Plan 2019-2021. Available from: http://nww.immunisation.wales.nhs.uk/opendoc/500141

5.1.4 Human Papilloma Virus (HPV)

12-13 years

HPV, 2 doses 6-12 months apart**

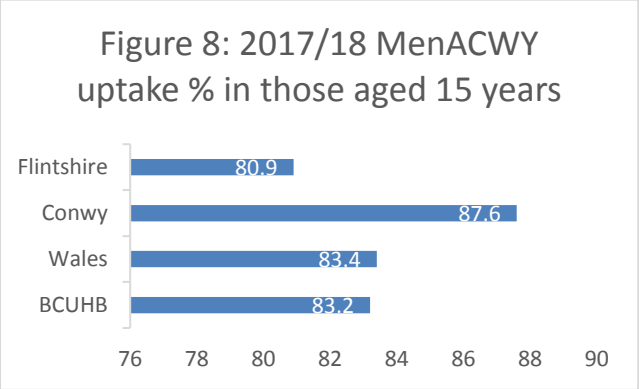


A summary of uptake of a complete course of HPV vaccine (two doses for girls reaching their 16th birthday) in 2017-2018 can be seen in figure 7. The trend has been a decline of 1.6 percentage points over the previous two years in BCUHB (87.3% in 2016/17 vs 85.7% in 2017/18).

5.1.5 Meningococcal ACWY (MenACWY)

14 years

Td / IPV, MenACWY



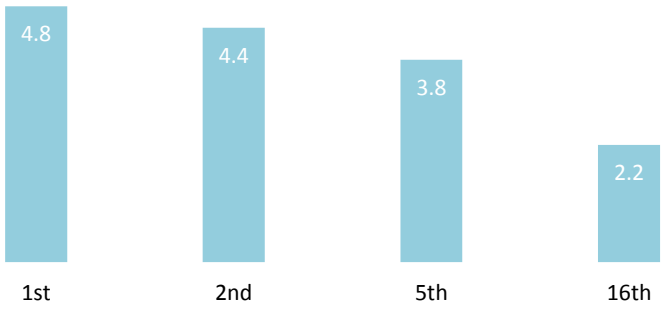
Since 2015, young people aged 13/14 years and new university students have been offered the MenACWY vaccine. This is in response to a rise in cases of meningitis and septicaemia caused by meningococcal W. Uptake in 15 years olds is measured. Rates are variable as can be seen by figure 8, with BCUHB levels similar to all Wales uptake since 2016.

5.1.6 Hepatitis B

An all-Wales database to support the appropriate monitoring and follow up of vaccination of babies born to mothers with hepatitis B infection has been developed by Public Health Wales. In BCUHB, uptake of three doses in children by their first birthday who were at risk of perinatal infection was 100% in 2017/18. Uptake of four doses in children who were at risk of perinatal infection by their 2nd and 5th birthdays was also both 100% in 2017/18.

5.1.7 Bacillus Calmette-Guérin (BCG)

Figure 9: Percentage of children at respective birthday's immunised with BCG in BCUHB Q3 2018.



The uptake data in figure 9 is based on BCG immunisations recorded in the National Community Child Health Database. The proportion of children in each age group being vaccinated for BCG is increasing from early age, although the causes of this are unclear. Only children who are eligible due to risk factors are immunised with BCG. At Local Authority level, Wrexham had the highest proportion of children given BCG, specifically 8% and 6.1% of children reaching their first and 2nd birthday, respectively. More information on geographical variation by age, and eligibility for BCG, can be found in Appendix 1.

5.2 Adult vaccinations

5.2.1 Human Papilloma Virus (HPV)

The HPV vaccination programme for men who have sex with men (MSM) has been offered since April 2017. In Wales, Health Boards offer sexual health services through integrated sexual health clinics. The vast majority of MSM who are in regular contact with sexual health clinics are seen at consultant led (level 3) sexual health clinics.

Public Health Wales provide quarterly reports on uptake to service providers and to Welsh Government.

5.2.2 Pneumococcal

65 years

Pneumococcal

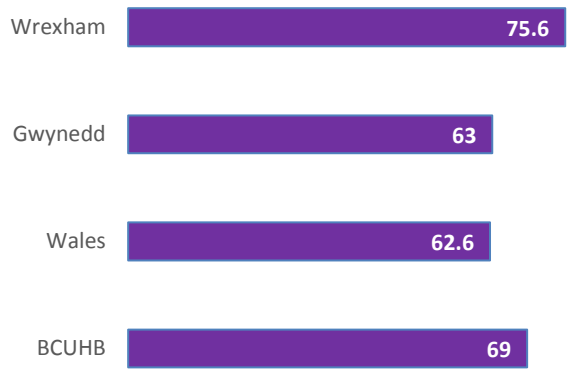
People are eligible for pneumococcal vaccination if 65 years and over, or aged 6 months to 64 years with 'at risk' conditions. People usually receive just one dose for life unless they have chronic kidney disease, no spleen or splenic dysfunction which requires vaccination every five years. Vaccination uptake data has only been produced on an ad hoc basis since the programme commenced; the most recent data is for 2006, and the scheme has been hampered by national vaccine supply issues for several years. There is no specific target for this vaccination programme.

5.2.3 Shingles

70 years

Shingles

Figure 10: Percentage uptake of Shingles in eligible individuals aged 73 years on 1st Sept 2018



Individuals are eligible for shingles vaccination from age 70-80 years. GP practices are required to provide data to Public Health Wales (PHW) sufficient to carry out surveillance and monitoring of the shingles vaccination programme. There is no specific uptake target and it is important to note that there will be a significant proportion of the eligible population that are contraindicated due to disease or treatment. The uptake for those aged 73 years from the 1st September 2018 for BCUHB, is in the graph, particular variation can be seen between Wrexham and Gwynedd. More information on the shingles programme in BCUHB can be found in Appendix 1.

5.3 Seasonal Flu Vaccination Programme

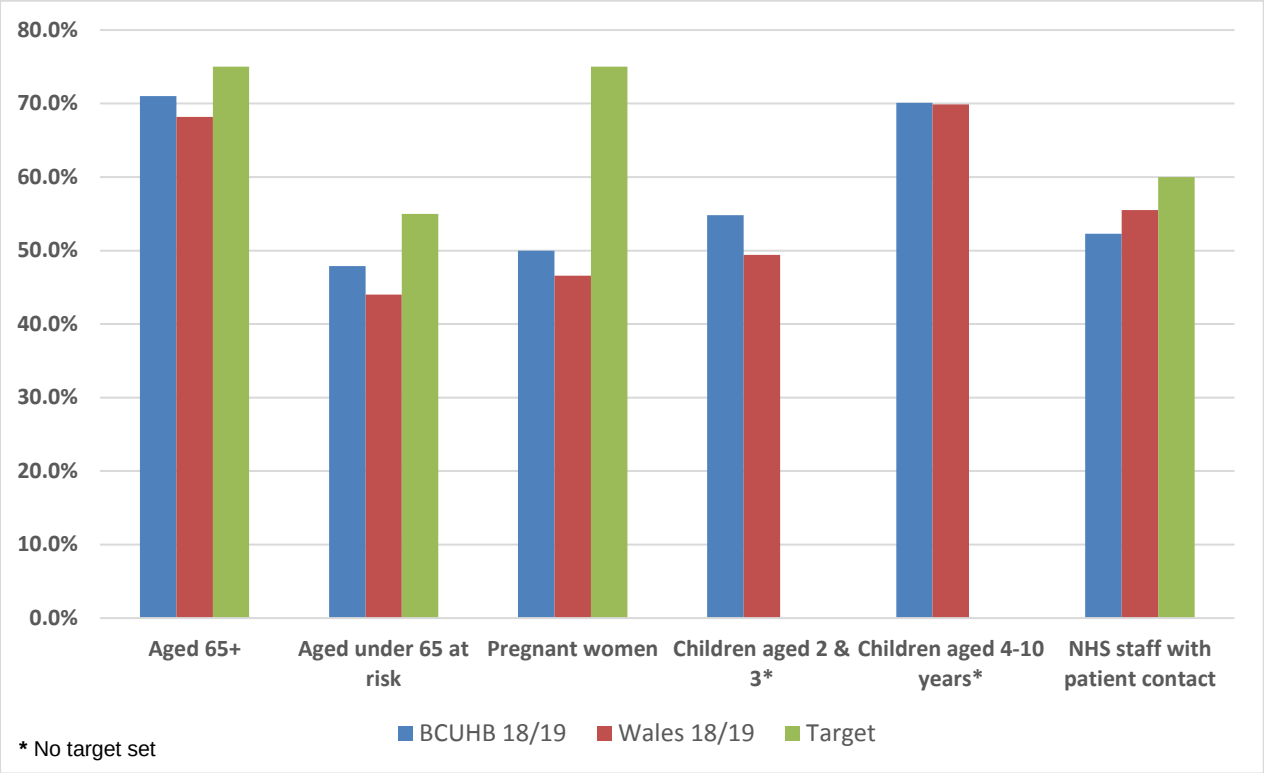
Flu vaccination is available every year on the NHS to help protect adults and children at risk of flu and its complications. The Flu vaccine uptake targets for 2018/19 were:

- 75% uptake for those aged 65 years and older and pregnant women
- 55% uptake for those aged six months to 64 years in clinical risk groups
- 60% uptake for health care workers providing direct patient care.

The long-term aim for all eligible adults is that a minimum 75% uptake rate is achieved, as recommended by the World Health Organisation. Specific targets for the children's programme have not been set. The expectation is that uptake across the children's programme will improve on the previous season.

Figure 11 summarises the uptake of the 2018/19 flu vaccination amongst eligible groups (including the targets) for BCUHB and Wales.

Figure 11: 2018/19 Flu Vaccine uptake by Eligible Group: BCUHB, Wales and Target



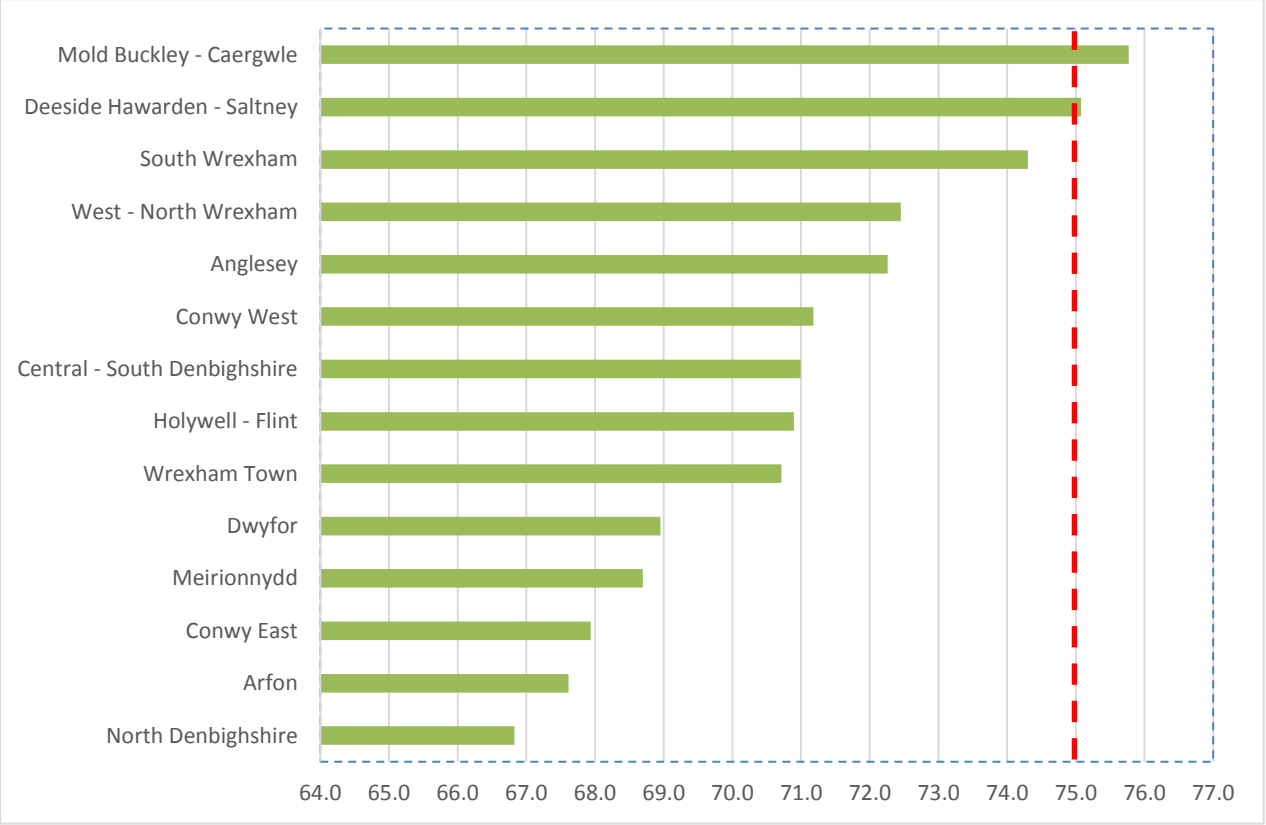
Although the uptake targets were not met for 2018/19, BCUHB has consistently been performing well compared to other Health Boards in Wales. However, as with Childhood Immunisations, there remains considerable variation in flu vaccine uptake for all eligible groups across geographical areas in north Wales. Figures 12, 13 and 14 highlight the 2018/19 flu vaccine uptake at Primary Care Cluster level for people aged 65+ years, clinical risk patients aged 6 months–64 years, and children aged 2&3 years, respectively[12].

The uptake target for people aged 65+ was met by two Clusters (Mold, Buckley & Caergwrle, and Deeside, Hawarden and Saltney); the target for at risk groups aged 6 month – 64 years was not met by any Clusters. In terms of the magnitude of variation between the Clusters with the highest and lowest uptake, there was an 8.9% point difference in uptake for people aged 65+, 12.4% point difference in uptake for people with an at risk condition, and a notably large 26.6% point difference in uptake for children aged 2 & 3 years.

[12] Vaccine Preventable Disease Programme, Public Health Wales (data by request)

Public Health Wales provides weekly flu vaccine uptake reports during the flu season via the Influenza Vaccine Online Reporting (IVOR) platform. These are accessible to NHS staff via the Vaccine Preventable Disease Programme (VPDP[13]) webpages. Data is available at Health Board, Cluster, and individual GP Practice levels. It was not appropriate to include the most up to date uptake data for the 2019/20 flu season at the time of writing this plan (end of January 2020).

Figure 12: 2018/19 season flu immunisation % uptake in patients aged 65+ in BCUHB Primary Care Clusters (red line denotes the 75% uptake target)



[13] http://nww.immunisation.wales.nhs.uk/ivor

Figure 13: 2018/19 season flu immunisation % uptake in clinical risk patients aged 6 months–64 years in BCUHB Primary Care Clusters (red line represents 55% uptake target)

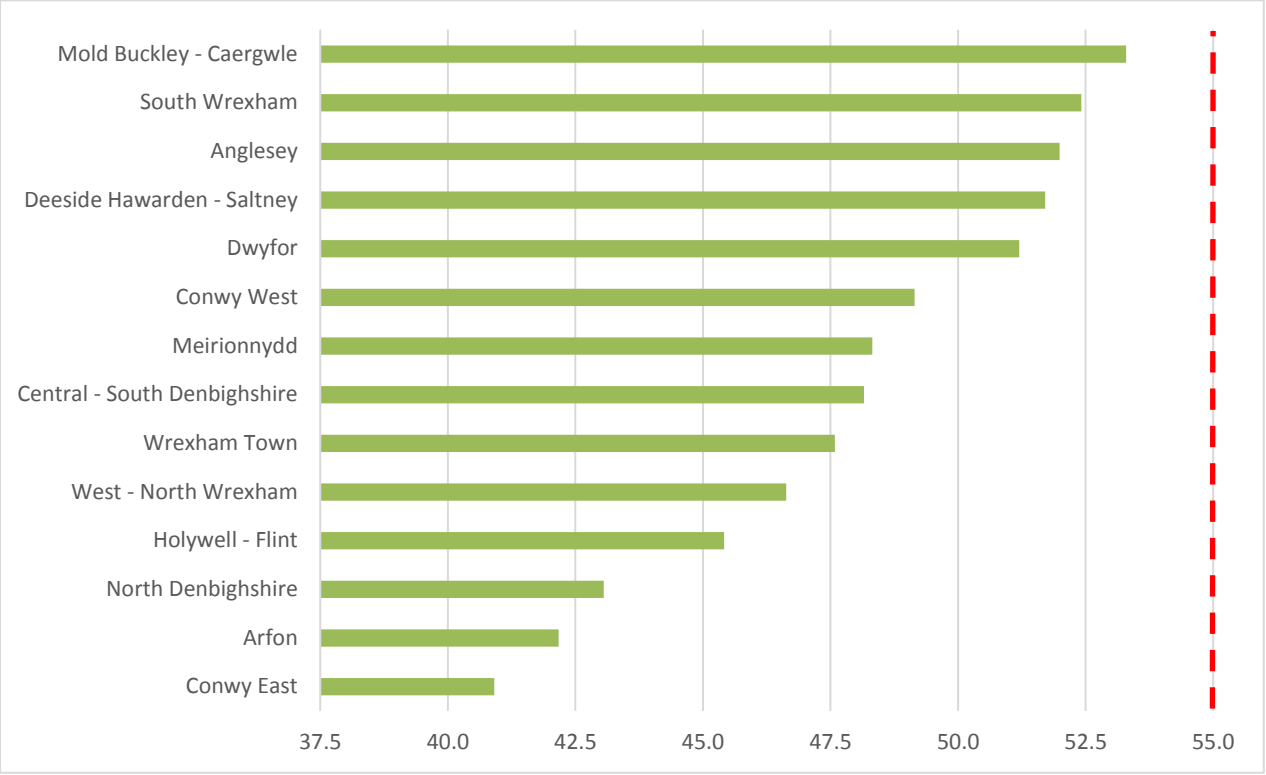
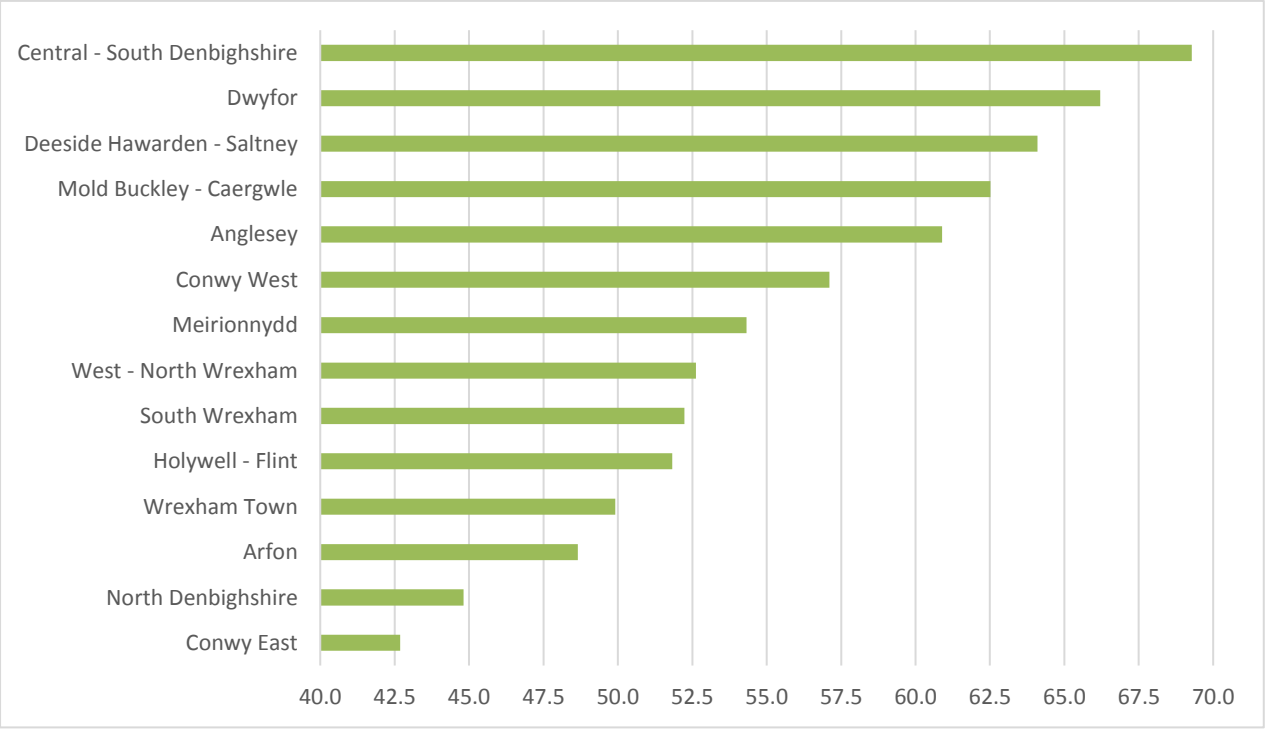


Figure 14: 2018/19 season flu immunisation % uptake in children aged 2 & 3 years in BCUHB Primary Care Clusters (no uptake target set for this group)



5.4 Selective Vaccines

5.4.1 Travel Vaccines

Travel vaccinations are required to protect health when travelling abroad[14]. The NHS must provide certain travel vaccinations, others are available via private services. For more details see Appendix 1.

5.4.2 Workplace Vaccines

Employers need to have an effective immunisation programme in place to protect their employees from some infectious diseases such a Hepatitis B, measles, or influenza. The employer has an obligation to arrange and pay for this service. No data is collected on the uptake of vaccines apart from influenza in the NHS.

5.4.3 Medical Conditions

A range of medical conditions require extra protection through vaccination, see routine immunisation schedule diagram in Section 4.

Primary care keep records of who is eligible and are responsible for inviting patients and administering vaccinations to those with qualifying medical conditions. BCUHB only collects data on influenza vaccination uptake for those with medical conditions.

6 Equality

As defined in the Public Sector Equality Duty (2011), BCUHB is required to demonstrate how it has paid due regard to the potential impact of this Strategic Immunisations Plan on groups sharing the protected characteristics[15]. An integrated Equality and Health Impact Assessment screening exercise was undertaken by a task and finish group on a draft version of this Plan[16]. No significant negative impacts were identified, although the assessment highlighted a number of opportunities to improve how vaccination programmes are delivered and promoted in order to improve access and uptake amongst priority eligible groups. A summary of these improvements is provided below, which will be addressed as part of the detailed action plans to take forward the Improvement Priorities (Section 7).

[14] NHS Travel Vaccines: https://www.nhsdirect.wales.nhs.uk/travelhealth/TravelVaccines/

[15] Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. Impact on the Welsh Language is also considered.

[16] A detailed report on the Health and Equality Impact Assessment is available on request.

- Need identified to develop a comprehensive engagement and communication plan for key groups to improve awareness and uptake of immunisations. This work to include close collaboration with representatives from children and young people (and their parents & guardian), those with transport, language or communication difficulties, and those with physical or learning disabilities. Ensuring provision of up-to-date information in a variety of formats on the benefits of immunisation against vaccine-preventable infections tailored for different communities and groups, according to local needs.

- Strengthen our existing collaborative working arrangements with both NHS service providers and external agencies. Working collaboratively, in particular with, third sector and local authority social care and education services, to inform strategic approaches to promoting and facilitating access to vaccinations for priority eligible groups. This to include maximising existing assets that are already effectively engaging with identified groups.

- Improve the quality of GP Practice coding relating to health and disease status, in order to facilitate more accurate vaccination uptake data (e.g. pregnancy and chronic conditions)

- Targeting geographical areas with known lower vaccination uptake rates, not all of which are associated with socio-economic deprivation

7 Priorities for Improvement

As outlined in Section 2 (Introduction), the aim of this Strategic Plan is to protect and improve the health of the population through maximising uptake of vaccines for eligible groups across the life course. In order to achieve this aim, a number of vaccination improvement priorities have been identified due to their:

a) Risk to health i.e. what would be the risk to the health of those eligible for the vaccination if vaccine uptake was sub-optimal
b) Scale of impact i.e. the proportion of the population that would be negatively impacted due to sub-optimal vaccine uptake
c) Welsh Government vaccine uptake targets, which have been identified in relation to both a) and b) above, and against which BCUHB performance is measured
d) Potential impact to public services, in particular health and social care, due to sub-optimal vaccine uptake and subsequent increased risk of vaccine preventable disease outbreaks

The priority vaccines have been grouped into three themes (Figure 15), alongside a rationale for their inclusion. They have been described as the **'What'**. The lower section of Figure 15 describes the **'How'**, which is represented by six improvement areas that are informed by the Public Health Wales Quality and Impact Framework[17].

Tables 1-6 provide further detail on each of the six improvement areas. The Strategic Immunisation Group will lead the development of detailed action plans to take forward each of these for 2019/20-2021/22.

Year 1: Apr 2019-Mar 2020

Year 2: Apr 2020-Mar 2021

Year 3: Apr 2021-Mar 2022

[17] Public Health Wales Quality and Impact Framework: http://www.wales.nhs.uk/sitesplus/documents/888/FINAL%20PHW%20Quality%20and%20Impact%20Framework%20E%284%29.pdf

Figure 15: Improvement Priorities: What we are going to achieve, and how will it be done (defined under six improvement areas)

Tables 1-6: How the Strategic Plan will lead the work across the six improvement areas

1. Transforming Culture		
What will we do?	**How will we deliver this?**	**Who is responsible and by when?**
Strengthen the governance and accountability structures for vaccinations and immunisations in the Health Board.	Review and agree the governance structure for vaccinations and immunisations within BCUHB to ensure accountability and effective reporting & escalation mechanisms, clarity of roles and responsibilities, consistency of approaches, and improved communication between groups.	SIG (Year 1)
	Refine the terms of reference for the Strategic Immunisation Group (SIG), Area Operational Immunisations Groups and other immunisation groups within the Health Board. This work to also consider opportunities for strengthening the link with Primary Care Clusters in relation to their role in promoting and delivering vaccination programmes across the life course.	SIG (Year 1)
	Clarify the financial arrangements for Area Teams, and regularly review these budgets, in order to facilitate the ongoing implementation of all vaccination and immunisations programmes. Maintain close collaboration with finance teams to ensure effective financial planning for new vaccination programmes, in line with expected corresponding Welsh Health Circulars.	BCUHB Area Finance Leads (Year 1)
	Undertake an annual review of all BCUHB Immunisation Plans (and associated documents) that are currently in place, and ensure that the development of any new plans are informed by and fit with this Strategic Immunisation Plan.	SIG (Year 1, 2, 3)

	Develop a formal system of reporting BCUHB activities related to immunisation. Agree activities to be monitored by immunisation managers, Area Operational Immunisations Groups and SIG to ensure expected programmes and ad-hoc activities are being delivered.	SIG (Year 1)
Consolidate and strengthen Senior Leadership in the Health Board in order to drive improvements against the Plan's Outcomes.	Maximise the role of Board members in advocating for and securing improvements for key vaccination programmes, in support of the Director of Public Health as the Executive lead. Identify and increase the visibility of Clinical Leaders in both Primary and Secondary Care in relation to vaccinations, and agree the most effective way of seeking their ongoing engagement in informing the planning and monitoring of vaccination uptake for both staff and the public.	SIG (Year 1, 2, 3) SIG (Year 1, 2, 3)

2. Strengthening the Workforce		
What will we do?	**How will we deliver this?**	**Who is responsible and by when?**
Ensure that the workforce has the right knowledge, skills and capacity to effectively deliver vaccination programmes. Encourage BCUHB staff to be vaccinated (particularly flu) in order to protect themselves and their patients, families and communities.	Undertake an annual immunisation workforce review of BCUHB staff, ensuring staffing capacity and competencies are appropriate and implementing any necessary changes. Develop an immunisation training plan to address any training needs identified in the above review and to also include non-BCUHB immunisation colleagues. Include promotion of the FluOne training module in included in the training. Implement plans to build awareness of immunisation into the BCUHB induction process for both clinical and non-clinical staff.	Immunisations Coordinator (Year 1, 2, 3) Immunisation Coordinator (Year 1) Immunisation Coordinator (Year 1, 2)

Maximise the role of Primary Care services in delivering vaccination programmes across the life course.	Review of Service Level Agreements (SLAs) with GP Practices in the East Area for the delivery of childhood immunisations in order to increase capacity of GP Practice staff to deliver vaccinations. In line with Improvement Area 1, scope opportunities for maximising the role of Primary Care Clusters in supporting improvement in vaccine uptake.	East Area Health Visitor Management AOIGs

3. Monitoring Impact		
What will we do?	**How will we deliver this?**	**Who is responsible and by when?**
Establish robust monitoring and scrutiny arrangements within the immunisation governance framework, in order to maximise vaccination uptake and reduce inequities in uptake.	In line with Improvement Area 1, develop mechanisms within AOIGs and the SIG for regular monitoring of vaccination uptake and variation. Develop effective mechanisms for updating key stakeholders on progress, including frontline BCUHB teams.	SIG (Year 1) BCUHB Communications Team (Year 1, 2, 3)
Recognise risks of outbreaks and potential health harms from low uptake, and target activities to reduce the risks.	Maintain high levels of data accuracy in relation to immunisation uptake and monitoring of circulating vaccine preventable disease. Ensure clear risk management and escalation systems in place.	Immunisations Coordinator, AOIGs, BCUHB Infection Prevention and Control Team (Year 1, 2, 3)
Monitor the processes and systems of immunisation programmes without routinely collected uptake data, in order to ensure a high quality and equitable service across the Health Board.	Work in partnership with those delivering programmes for non-routine immunisations / programmes with variable demand, in order to develop a detailed understanding of processes and provision across the Health Board.	Immunisations Coordinator (Year 1, 2)

4. Raising Standards, Achieving Impact and Outcomes		
What will we do?	**How will we deliver this?**	**Who is responsible and by when?**
Maximise uptake of key vaccinations, in particular childhood immunisations and flu, and reduce variation across BCUHB geographies and within specific groups known to have lower uptake.	Review data accuracy through audit and review of immunisation recording processes. Make recommendations if necessary for improvements. Regularly scrutinise uptake data, including information on inequalities, in order to inform action on addressing low levels. Develop robust systems to enable the deployment of resources to respond to identified need. Strengthen plans and policies for targeting areas or groups of low uptake, agreeing for each immunisation, at what uptake level they are to be implemented. Respond to the findings of the Equality Impact Assessment and develop an ongoing plan of engagement with priority groups in the population to improve access to and uptake of vaccinations. Strengthen consistency in high outcomes across BCUHB, whilst supporting a flexible approach to meeting local needs.	Immunisation Coordinator (Year 1, 2, 3) SIG & AOIGs (Year 1, 2, 3) AOIGs (Year 1, 2, 3) SIG & BCUHB Communications Team (Year 1, 2, 3) SIG & AOIGs (Year 1, 2, 3)
Ensure the work of BCUHB is informed by evidence based guidelines.	Regular review of NICE guidance and Welsh Health Circulars / CMO Letters against BCUHB activity, and implementing changes where necessary.	Immunisations Coordinator & BCUHB Public Health Team (Year 1, 2, 3)

5. Measuring Improvement and the Quality of our work		
What will we do?	**How will we deliver this?**	**Who is responsible and by when?**
Utilise quality improvement (QI) methodology where appropriate to enable the effective planning, delivery, and evaluation of tests of change.	Identify opportunities e.g. specific improvement projects, to use QI methodology. Ensure robust evaluation considered as a core part of planning test of change, and facilitate the sharing of learning in the system.	AOIGs, Immunisations Coordinator, BCUHB Public Health Team (Year 1, 2, 3)
Strengthen Child Health Systems to continue delivering accurate and timely surveillance information for children's immunisations.	Undertake quality assurance activity around data in the BCUHB Child Health System, in partnership with Child Health System colleagues.	Immunisations Coordinator & Child Health Team (Year 1, 2, 3)
Ensure the continued safe and prudent delivery of vaccine programmes.	Develop more robust methods for scrutinising data in relation to medication errors. Ensure relevant learning included and shared in clinical training.	SIG SIG

6. Working Collaboratively		
What will we do?	**How will we deliver this?**	**Who is responsible and by when?**
Secure meaningful engagement with and insight from key external stakeholders around vaccination uptake, including groups in the population.	Undertake an external stakeholder analysis in relation to priority vaccination programmes. Work collaboratively to develop an insight based communications plan to address areas or groups with low uptake and reduce variation. This work to also identify stakeholders who can influence attitudes and cultures around immunisations in order to positively affect immunisation uptake.	BCUHB Communications Team, Immunisations Coordinator, BCUHB Public Health Team (Year 1, 2, 3)

	Identify opportunities to secure ongoing engagement with key settings and management groups in external agencies, including the offer of joint training e.g. Early Years settings, Social Care Services, Third Sector Services. In line with reviewing the governance arrangements (see Improvement Area 1), identify methods for effective collaboration with Primary Care Clusters to develop approaches to sharing learning and reducing local variation in uptake across all vaccination programmes.	BCUHB Communications Team, Immunisations Coordinator, BCUHB Public Health Team (Year 1, 2, 3) AOIGs
Secure improved engagement and communication with NHS service providers across Primary and Secondary Care to inform robust immunisation planning and monitoring activity.	In collaboration with colleagues in Primary and Secondary Care services, develop an internal communications plan that raises the profile of immunisations across the life course, outlines roles and expectations of staff at all levels, and identifies opportunities for improvement. Identify more effective and sustainable ways of securing input from colleagues in Primary and Secondary Care in informing the planning, monitoring and evaluation of immunisation programmes.	BCUHB Communications Team (Year 1, 2, 3) SIG, AOIGs, BCUHB Communications Team (Year 1, 2, 3)

8 Funding the Plan

All vaccination programmes are funded through Welsh Government allocations. These are updated through the publication of Welsh Health Circulars for new vaccination initiatives, guidelines, or changes to eligible groups, and are reviewed annually.

As part of developing this Plan, a comprehensive piece of work is being undertaken to review existing allocations and expenditure for all vaccination programmes in order to consolidate to an overall current baseline. This will then form the basis for delivering the plan over the next three years, including ensuring equitable allocation of both staff and vaccination resources across the Health Board to support the delivery of identified priorities.

The work will include reviewing the financial governance controls that are in place at Area level, and establishing regular monitoring and reporting of expenditure to the Strategic Immunisations Group. In addition, evidence will be collated as to the benefits realised in terms of expenditure against vaccination uptake performance, in order to inform future planning and improvement.

9 Risks

There is a risk that:	Controls in place:
The health and wellbeing of the population could be adversely affected by vaccine preventable diseases. This may be caused by sub-optimal uptake of vaccinations amongst eligible groups across the life-course, which could present as variation at a geographical level or between specific groups in the population. This could lead to increasing the risk of avoidable illness, disability and preventable excess deaths. It could also lead to increased avoidable demand on health care and other public services.	**Strategic Controls for all Immunisation Programmes** 1. Strategic Immunisation Plan and monitoring in place. 2. Responsibility for operational delivery confirmed under lead of Area Director (West), with Area Operational Immunisation Groups (AOIGs) in place in each Area. 3. Key BCUHB Immunisation roles identified, namely Immunisation Co-ordinator Senior Nurse for Immunisation.
	Childhood Immunisation Specific Controls: 1. "COVER" reports circulated to AOIGs. Immunisation regularly reported as item on the Clinical Advisory Group (that reports to the BCUHB Children's Transformation Group). 2. Regular auditing of compliance with the MMR Welsh Health Circular. 3. Raising awareness of the uptake of two doses of MMR on an individual school basis with Heads of Education services. 4. Regular checking and recording of Immunisation status on Child Health System for Looked After children. 5. Identifying children not in mainstream education/privately educated or educated in England to establish immunisation status 6. Detailed epidemiological report developed and disseminated on variation in uptake of key childhood immunisations, in order to support more targeted improvement action. 7. School nurses routinely ensuring MMR is offered with Teenage booster or other school years e.g. HPV Year 8. 8. Ongoing data cleansing in relation to pupils entering secondary schools.
	Influenza Specific Controls: 1. Flu Planning Group established with membership from across the Health Board. Group meets frequently from April to the commencement of delivery in October. Planning has been informed by the

	Flu Debrief to capture learning from the 2018/19 season and outline how priority areas will be improved. 2. Specific uptake improvement activities identified for priority eligible groups for 2019/20, including staff flu vaccine uptake 3. Flu Monitoring Group established meeting frequently from October to March to monitor uptake during the flu season. 4. Weekly WHO report received via Public Health Wales and distributed during the season, along with weekly coverage data for Wales to inform local actions. 5. Consolidating the work from 2018/19 for the provision of flu vaccine to pregnant women attending Antenatal Day Units 6. Resources identified to support delivery of comprehensive Internal and External Flu Communications Plans 7. Bespoke Flu planning sessions offered to Primary Care Clusters to support local improvements and reduce variation in uptake.

10 Governance, Monitoring and Evaluation

This section summarises the governance structure for delivering the Strategic Immunisations Plan, including monitoring and evaluation arrangements.

- The Health Board lead for immunisations will be the Executive Director of Public Health.
- Overall co-ordination and monitoring of the Strategic Immunisations Plan lies with the Strategic Immunisation Group (SIG), who will oversee the development, implementation, and monitoring of detailed operational actions plans to implement the Plan over 2019-2022. The SIG will also monitor and scrutinise vaccination uptake data in line with Welsh Government Targets, and seek to provide assurance to the Health Board on progress, risks and mitigating actions.
- Oversight of the operational delivery of all routine and selective vaccination programmes at an Area level will be provided by the Area Operational Immunisation Groups (AOIGs), which report directly to the SIG. The role of the BCUHB Immunisations Sub-group, which currently provides clinical input into immunisation policy development, will be reviewed in line with the strengthened function of the AOIGs.
- The SIG reports to the Quality and Safety Group, which reports to Quality, Safety and Experience Committee. This arrangement is illustrated in Figure 16.
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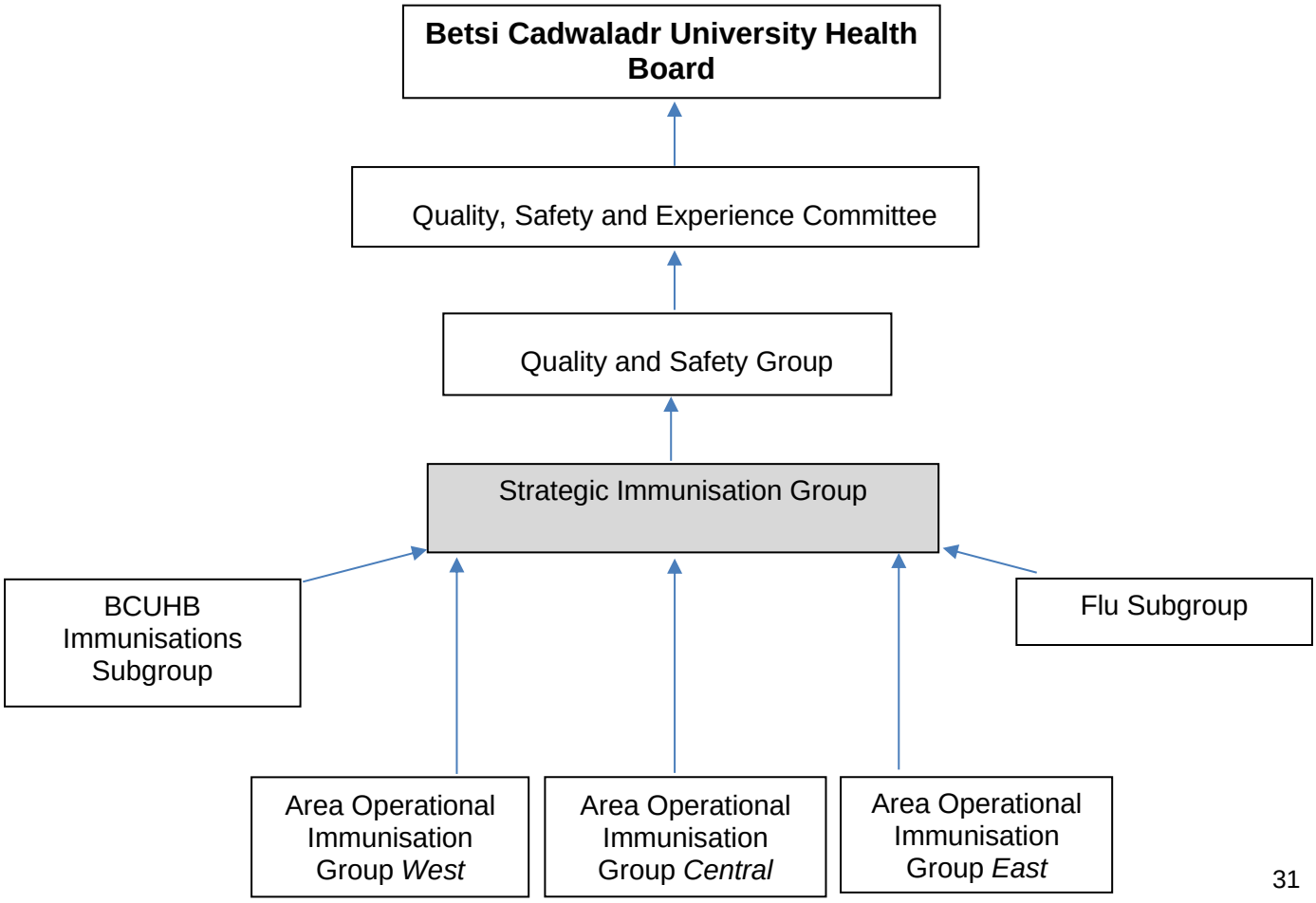
Figure 16: BCUHB Immunisation Governance Structure



Appendix 1: Additional details on BCUHB immunisation programmes

1 Childhood Immunisations

1.1 Human Papilloma Virus (HPV)

BCUHB uptake of a complete course of HPV vaccine (two doses for girls reaching their 16th birthday) in 2017-2018 was 85.7%, which is slightly lower than the Welsh average at 86.7%. At Local Authority level, Conwy had the highest uptake (86.8%), closely followed by Gwynedd (86.7%), Denbighshire (86.4%), and Flintshire (86.2%). Wrexham and Anglesey had the lowest uptake at 85.3 % and 81.1% respectively. Overall, there was a 1.6% decline over the previous two years in BCUHB (87.3% in 2016/17 vs 85.7% in 2017/18). It is expected that a HPV vaccination programme for boys will be launched in Wales during 2019/20.

1.2 Bacullus Calmette-Guerin (BCG)

In Wales, as in the rest of the UK, BCG is offered to babies and children under 16 years of age who are more likely than the general population to come into contact with someone with Tuberculosis (TB). This could be due to them having lived in a country with high rates of TB, or that their parents or grandparents came from a country with high rates of TB and are at potentially increased risk of exposure to contracting the disease.

The uptake data is based on BCG immunisations recorded in the National Community Child Health Database. Within BCUHB, BCG has been received by 4.8%, 4.4%, 3.8%, and 2.2% of children reaching their first, second, fifth and 16th birthdays (respectively) during quarter three of 2018. At Local Authority level, Wrexham had the highest proportion of children given BCG, specifically 8% and 6.1% of children reaching their first and 2nd birthday, respectively. Conwy had the highest proportion of children given BCG by 5 years of age (5.7%), and Denbighshire had the highest proportion of children given BCG by 16 years of age (2.7%). Child and adult BCG vaccinations are coordinated and led by different staff in the three areas. Three specialist respiratory nurses, one for each area lead clinics for high risk adults. Clinics are necessary for BCG to avoid wastage, as the vaccine only comes in a ten dose vial. There is no individual with responsibility for BCG vaccination in BCUHB, and no data is collected by the health board on the uptake rate for adult vaccination.

2 Adult Vaccinations

2.1 Human Papilloma Virus (HPV)

The HPV vaccination programme for men who have sex with men (MSM) has been offered since April 2017. In Wales, Health Boards offer sexual health services through integrated sexual health clinics. The vast majority of MSM who are in regular contact with sexual health clinics are seen at consultant led (level 3) sexual health clinics.

These clinics offer a full course of HPV vaccination to the following eligible groups when they are accessing services for sexual health care: all MSM up to and including those 45 years of age; transgender men and women, HIV positive men who are not MSM, HIV positive women, and sex workers. It is not intended that vaccination should be offered to all attendees in these groups but to those who may individually benefit. Clinics are not required to arrange separate HPV vaccination sessions or to proactively identify and contact eligible clients who have previously attended the services. The programme is not offered via Primary Care services.

2.2 Shingles

The shingles vaccination programme for people aged 70-79 years was introduced in Wales in September 2013. The introduction was phased with those aged 70 and 79 years eligible in the first year. Eligibility was defined by an individual's age on 1st September of each year, and they may receive the vaccine from the 1st April that year. Now all those aged between 70 and 80 years are eligible. Those who have received shingles privately are not recorded on the national statistics. There is no robust call and reminder system in place for shingles vaccination in Wales.

2.3 Pneumococcal

The pneumococcal vaccination programme was introduced in Wales in 1992 for adults deemed to be at risk of developing complications or severe disease. The programme has had several changes since then so that now adults aged 65 years and over are eligible and also people aged 6 months to 64 years with at risk conditions such as asplenia or if they have a cochlear implant.

3 Selective Vaccines

3.1 Travel Vaccines

Travel vaccinations are required to protect health when travelling abroad[18]. A risk assessment is conducted by a practice nurse in a General Practice following a request by the patient. This risk assessment will determine, if any vaccines are required for travel abroad. There are three categories of travel immunisations:

1. Those that must always be given as part of NHS provision including Hepatitis A (first and second /booster dose (6-12 months after the first dose); combined hepatitis A and B; Typhoid (first and any booster doses); combined hepatitis A; typhoid and Tetanus, diphtheria and polio (as given in the combined Td/IPV vaccine), and Cholera.
2. Those that cannot be given as an NHS service including Yellow Fever, Japanese B encephalitis; Tick borne encephalitis and Rabies.
3. Those that can be given as either NHS or as a private service including hepatitis B (single agent) any dose and Meningitis ACWY (quadrivalent meningococcal meningitis vaccine; A, C, Y and W135).

3.2 Workplace Vaccines

Employers need to have an effective immunisation programme in place to protect their employees from some infectious diseases such a Hepatitis B or influenza. The employer has an obligation to arrange and pay for this service. No data is collected on the uptake of vaccines apart from influenza in the NHS.

3.3 Medical Conditions

A range of medical conditions require extra protection through vaccination. Conditions such as diabetes, chronic liver disease and those on some cancer treatments are included (see routine immunisation schedule diagram in Section 4). Some vaccinations are needed more often than others, for example Hepatitis B is only needed once in a lifetime, whereas the flu vaccine is an annual immunisation.

Primary care keep records of who is eligible and are responsible for inviting patients and administering vaccinations to those with qualifying medical conditions. As conditions such as asthma and pregnancy change over time, if records are not updated regularly, GP lists may not be completely accurate. Measures are not recorded centrally by BCUHB or Wales of who is being invited or vaccinated in these medical groups, other than for flu. To find further details on the vaccination status of those with medical conditions the records of each GP surgery would need to be analysed.

[18] NHS Travel Vaccines: https://www.nhsdirect.wales.nhs.uk/travelhealth/TravelVaccines/

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 2nd November 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quality Governance Self-Assessment Action Plan
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Acting Associate Director of Quality Assurance Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Committee is asked to note the report and update of the Quality Governance Self-Assessment Action Plan.

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

Following submission of the Quality Governance Self-Assessment to Welsh Government on 07 January 2020, an action plan was developed that recorded each action identified in the submission and a lead officer and target date.

This update is being provided for assurance to the Committee that ongoing delivery and monitoring is continuing. This work should be considered in the context of the imminent Welsh Audit Office Review of Quality Governance which will supersede this plan, the ongoing Corporate Governance Review, the professional support from the Good Governance Institute and Stronger Together organisational development work which all commenced post this action plan.

Cefndir / Background:

Following well publicised events at Cwm Taf Morgannwg University Health Board, the Royal College of Obstetricians & Gynaecologists (RCOG) was commissioned by the Welsh Government to undertake an external review to investigate the care provided by the Health Board's maternity services. The review took place on 15-17 January 2019, and at the request of Welsh Government,

the resulting report and its findings/recommendations informed a local benchmarking exercise involving Health Boards across Wales. Each Health Board was asked to consider its own maternity services in the context of the recommendations of the report and to provide assurances on the safety of those services. The Women's Directorate in the Health Board undertook this benchmarking exercise and submitted the outcome to Welsh Government in May 2019. Some areas for ongoing improvement were identified and have been taken forward as part of the Directorate's learning culture and service development.

In November 2019 Healthcare Inspectorate Wales and the Wales Audit Office issued a report titled 'A review of quality governance arrangements at Cwm Taf Morgannwg University Health Board'. The Minister for Health and Social Services requested that all Health Boards and NHS trusts in Wales assess themselves against the recommendations of the review and provide plans for future review of their arrangements and/or the necessary action to be undertaken. The self-assessment was required to include a narrative of current arrangements and the current level of assurance as high, medium or low.

The Board held an extraordinary workshop session in December 2019 as part of its process for determining its self-assessment response. The approved version of the response was submitted to Welsh Government on 07 January 2020 and reported to the QSE Committee that month.

The self-assessment response sets out the Health Board's current position across 7 areas:

- Strategic focus on quality, patient safety and risk
- Leadership of quality and patient safety
- Organisational scrutiny of quality and patient safety
- Arrangements for quality and patient safety at directorate level
- Identification and management of risk
- Management of incidents, concerns and complaints
- Organisational culture and learning

Levels of assurance, based on the current position, were allocated, based on the following definitions: 'a self-assessment of 'high' indicates substantial assurance on the effectiveness of the quality governance arrangement in question, with few or no matters requiring attention. 'Medium' indicates reasonable assurance, with some matters requiring management attention. 'Low' indicates limited or no assurance, with more significant matters requiring management attention'.

Asesiad / Assessment & Analysis

The achievement of the actions in this plan will help strengthen governance arrangements within the Health Board. The Corporate Quality Assurance Teams continues to monitor this plan and collate evidence against each completed action (which is being stored in a central file directory).

A number of actions are rated as Amber and in these cases target dates have been amended. These changes are due to the COVID-19 pandemic and need to prioritise clinical service delivery, alongside the various significant changes in organisational improvement work identified earlier in the report. Previous updates have been sent to the QSE Committee and Joint Audit and QSE Committee.

For ease, only those open actions are included in the update below:

Actions (aggregated)	Lead	Target Date	Update
Engagement, development, approval, and implementation of a new Quality Strategy	Associate Director of Quality Assurance	31/03/2022	Target date to be updated due to delays in engagement and capacity limitations as a result of the pandemic. Proposal accepted to take forward a one year strategy.
Engagement, development, approval, and implementation of a new Clinical Strategy	Executive Medical Director	TBC	Target date to be finalised in line with Living Heathier Staying Well (LHSW) refresh, development of the Integrated Medium Term Plan (IMTP) refresh and Stronger Together.
Deploy a single improvement system and establish Clinical Summits to lead on clinical pathway improvements	Executive Medical Director	TBC	These actions, as originally proposed, will be superseded by the Stronger Together work and the creation of the new BCU Pathways work as part of the new Transformation and Improvement Directorate.

Since the last update a number of actions have been closed:

- Implementation of the governance review of Board committees
- Implementation of the new complaints process and associated training
- Implementation of a new Quality Dashboard.

It is proposed that these remaining, outstanding actions be integrated into the improvement plan following receipt of the Welsh Audit Office Review of quality governance, thus creating a new single improvement plan covering quality governance reflecting current organisation priorities.

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered - Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

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

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

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

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 2nd November 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quality Assurance Review – Morfa Ward, Llandudno General Hospital
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO
Awdur yr Adroddiad Report Author:	Lead Author: Reena Cartmell, Associate Director of Nursing Investigation team members details in the full report
Craffu blaenorol: Prior Scrutiny:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO Matthew Joyes, Acting Associate Director of Quality Assurance
Atodiadau Appendices:	1. Full Quality Review Report 2. Terms of Reference 3. Levels of Care Definition 4. Professional Escalation Timeline

Argymhelliad / Recommendation:

The Quality, Safety and Experience Committee is asked to receive this report for assurance.

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

Sefyllfa / Situation:

Following concerns raised by student nurses into alleged poor clinical practice, poor patient experience and matters of safeguarding concern on Morfa Ward, the Executive Director of Nursing and Midwifery/Deputy CEO, commissioned a quality assurance review designed to provide the service with an honest and supportive assessment of quality with a focus on the following domains: safe care; effective care; dignified care; individual person centred care; staffing and leadership.

In commissioning this review, the Executive Director of Nursing and Midwifery/Deputy CEO set out clear expectations that the report will be publically published in-line with the Health Board's refreshed commitment to openness and candour, and that in preparation of the report

a multi-disciplinary approach is needed that brought in external objectivity and expertise including expertise by experience. The Health Board is grateful to the individuals, internal and external, who have contributed to this review.

This review is aimed at issues of leadership, governance and culture as they relate to clinical practice and patient experience. Separate workforce processes are underway.

Cefndir / Background:

The quality assurance review was commissioned by the Executive Director of Nursing and Midwifery/Deputy CEO and its process designed to provide the service with a supportive assessment of its current arrangements and care outcomes in relation to patient safety and patient and carer experience. The primary aim is to drive improvement and to facilitate the sharing of best practice. A secondary purpose is to provide the Health Board with assurance on the quality within the service.

The methodology for the review adopted a blended approach with a primary aim to assess the current baseline undertaken in two parts. The design was tailored to address the situation that prompted the review.

The review comprised of:

Part 1

- Desktop review of quality data - Review period of January 2020 to June 2021
- Case Note Review
- Unannounced Ward Accreditation visit
- Leadership walks

Part 2

Focused on a Qualitative review in two phases:

- Phase A. In-depth full review of all inpatient wards on the Llandudno General Hospital (LLGH) site including the ward of concern Morfa Ward (July – August 2021).
- Phase B. Shorter ‘headline’ reviews of Health Board community hospital inpatient wards (August 2021).

It is important to note a further in-depth full review of all community hospital wards was completed by the end of September 2021 by the Dementia Nurse Consultants. These additional reviews identified no significant new issues to what had been identified previously during a recent peer review of all community hospitals.

<u>Design</u>

The design has permitted in-depth analysis of a range of relevant factors.

In Part 1, the following was examined:

- Safeguarding
- Workforce
- Supervision
- Escalation
- Learning environment
- Training and education
- Staff concerns regarding performance previously registered
- Staff support from Occupational Health
- Ward accreditation

In Part 2, using a full bespoke review tool in Phase A and a short bespoke review tool in Phase B the following was considered.

- Staff wellbeing
- Support for patients and families
- Environment and enablement
- Communicating care
- Supporting patients with distressed behaviours
- Mental capacity
- Safety and risk management
- Education and understanding
- Culture and confidence to speak up and escalate
- Safety and safeguarding

Analysis

For both parts of the review, the following quality ratings were applied to the domains:

- Significant Issues - A rating of 'Significant Issues' indicates the service is performing poorly against the Health and Care Standards for that domain, with potentially significant risks to quality.
- Improvement Needed - A rating of 'Improvement Needed' indicates the service is not meeting all the Health and Care Standards for that domain, however there are clear improvement plans which can be evidenced and limited risk to patients, staff and the organisation.
- Good Practice - A rating of 'Good Practice' would indicate the service is meeting the Health and Care Standards for that domain.
- Outstanding Practice - A rating of 'Outstanding Practice' would indicate the service is meeting and exceeding the Health and Care Standards for that domain and has areas of exceptional practice.

These ratings are in-line with the Quality Governance Reviews now underway.

Asesiad / Assessment & Analysis

A copy of the full report is provided for the Committee at Appendix 1.

In summary:

Whilst this report focuses on areas of improvement needed, there are clearly dedicated staff working hard to deliver high quality care to patients and good practice highlighted and shared.

A number of recommendations have been made to support both the local service and wider Health Board with improvement. Many of these actions require support from the Health Board to drive consistency of standards and build on the work of the Health Board to drive compassionate and collective leadership, creating the conditions to involve, listen to both our patients and staff and learning from patient experience. Furthermore, the introduction of Shared Governance as a framework to advance professional nursing practice, including a robust evaluation of the chosen model will support the drive for consistency of standards.

There are Health Board wide recommendations outlined in this report due to the consistent findings across the Health Boards' wider community hospital services.

Overall from the 5 domains within the review (Safe Care; Dignified Care; Individual Person Centred Care; Staffing and Resource; Leadership and Escalation) the review panel reported a rating of 'Improvement Needed'.

The management team of the site provided an initial action plan in response to the review; however, recommendations within this report will build on the local actions taken for further assurance.

It is important to note however that improvements are already in place as "make safe" immediate actions were taken whilst the review was underway.

On behalf of the North Wales Safeguarding Adult Board, a nominated member has provided an independent review of the report's findings and has concluded this is an honest and fair report and would not recommend any changes.

The Review Panel extends its gratitude and appreciation to the leaders and staff who have engaged with this review, and to the corporate teams who have provided data and analysis in support of the review. Further thanks goes to our University partners and expert by experience (carer) reviewers.

This appreciation is even more heartfelt due to the unprecedented impact on services from the COVID-19 pandemic and the hard work and dedication of staff across the service to prepare and respond to the challenges, which are continuing. It is recognised that the pandemic will have impacted upon the service and its staff.

Due to the issues identified and the need to provide robust assurance to the Health Board, a re-visit is recommended in 6 months to report on progress.

Strategy Implication – Not applicable. Paper does not relate to strategic or business plans.

Options considered - Not applicable. Paper is not an options appraisal.

Financial Implications – Not applicable. Paper does not relate to financial expenditure.

Risk Analysis – This is contained within the report.

Legal and Compliance – This is contained within the report.

Impact Assessment – Impact assessments are not required for this report.

Appendix 1

Quality Assurance Review

Division/Site:	Llandudno Hospital – Morfa Ward
Date of Review:	July – August 31st 2021
Lead Reviewer:	Reena Cartmell, Associate Nurse Director of Nursing
Quality Governance Lead for Review:	Matthew Joyes, Acting Associate Director of Quality Assurance
Version	1.0

INTRODUCTION

The purpose of this report is to provide an overview of quality assurance, patient safety and patient experience following the commissioning by the Deputy Chief Executive/Executive Director of Nursing and Midwifery of an internal independent quality assurance review of Morfa Ward, Llandudno Hospital. The review will consider whether the Health and Care Standards for Wales and the Health Board vision, values and policies have been followed, in particular the provision of:

- a safe environment;
- individualised, dignified and person centred care;

- effective leadership and professional clinical practice at all levels;
- a culture of openness, integrity and responsiveness to concerns.

The review lead was requested to prepare a draft report for consideration by the commissioning Executive Nurse Director by late August 2021.

During the review, any immediate or urgent concerns identified would be escalated without delay to the commissioning executive and through the appropriate internal/external governance processes.

Concerns reported or identified relating to staff capability affecting safe care will be handed over to the Associate Nurse Director Workforce for further investigation.

The report presentation will enable public disclosure and will include findings of the review and recommendations for improvement.

RATIONALE FOR THE REVIEW

Following concerns raised by student nurses into alleged poor clinical practice, poor patient experience and matters of safeguarding concern, the Executive Nurse Director / Deputy CEO commissioned a quality review designed to provide the service with an honest and supportive assessment of quality with a focus on safe care; effective care; dignified care; individual person centred care; staffing and leadership.

The primary aim is to drive improvement and to facilitate the sharing of best practice. A secondary purpose is to provide the Health Board with assurance on quality governance within the service, complementing other internal arrangements (such as clinical audit, ward accreditation) and independent or external arrangements (such as internal audit, Healthcare Inspectorate Wales inspections).

ABOUT THE SERVICE

Ysbyty Llandudno is a community hospital in Llandudno, Conwy. It is one of six community hospitals sites within the Central Area Division of the Health Board, all of which provide inpatient services apart from the Royal Alexander Hospital, Rhyl, Denbighshire.

Ysbyty Llandudno currently provides a range of services. These include inpatient beds across three wards namely Beuno, Morfa and Llewelyn Ward, providing care for patients under the specialism of Care of the Elderly and Rehabilitation.

The Minor Injury Service, Intravenous Therapy Suite, Primary Care Treatment Unit and North Wales Bone Unit are also on the Llandudno Hospital Site and the Central Area Management Team manages these services, along with inpatient wards.

A Community Hospital Matron, supported by a Deputy Head of Nursing and Head of Nursing for Intermediate Care and Specialist Medicine, provides the nursing leadership of these services. The Central Area Management Team consists of a triumvirate model, Area Director, Area Nurse Director and Area Clinical Director. The Assistant Area Director for Intermediate Care and Specialist Medicine also supports the nursing structure and services.

Outpatient Child & Adolescent Mental Health Services (CAMHS) are also available at the Llandudno site but supported by the Head of Nursing for Children's Services.

The West Secondary Care division currently manages General Outpatient services, operating theatres and day case surgery. Services on the site such as Physiotherapy, Radiology, Cardiology and British Pregnancy Advisory Services are part of separate directorates or divisions.

Morfa Ward is currently a 19-bedded ward, which cares for Care of the Elderly patients who require further nursing or medical care, but do not need to be cared for in an acute hospital setting. These patients include those needing nursing and medical intervention for a range of conditions. This includes those requiring intravenous medication or fluid replacement, oxygen therapy and enteral feeding. A significant cohort of the patients are frail and/or living with dementia.

A Ward Manager supported by a Deputy Ward Manager, overseen by a Matron and Head of Nursing provides the Ward Nursing Leadership Team. At the time of escalation there were interim posts in place.

The nursing team comprises registered nurses, health care support workers, a housekeeper and a dementia support worker.

Therapy input is provided on a daily basis by occupational therapy and physiotherapy staff who are based in Ysbyty Llandudno. Other therapy services such as speech and language therapists and dietician attend when required and provide remote advice.

Medical care is overseen by a Consultant in Care of the Elderly medicine supported by a team of advanced nurse practitioners and nurse practitioners who provide 7 day a week cover although not ward-specific.

Morfa Ward also provides a level of inpatient rehabilitation with support from therapy services based on the site.

The ward care for patients who are either 'stepped-up' from the community setting, transferred from the acute hospital or patients who are receiving palliative or end of life care. Patients can also be cared for on Morfa Ward who are medically optimised. This is the point at which care assessment could be continued at home or in a non-acute setting or the patient is ready to go home, but may still require care services and safe discharge planning which is a clear focus of the ward's clinical workload.

REVIEW TEAM

An Associate Director of Nursing, who is independent of any services involved, led the review. A review team including the following, all of whom have had no prior involvement in this case, supported the lead:

- Senior medical and therapy expertise
- Safeguarding Team
- Corporate Nursing Team – Improvement Lead
- Nurse Consultants Dementia
- Corporate Nursing Team – Associate Nurse Director Regulation and Education
- Quality Assurance Team
- Corporate Governance Lead

A representative of Bangor University also participated in the review.

For the main ward of concern, two family members (unconnected to the review) were identified with the support and engagement of the Community Health Council. The family members were prepared and supported to join part of the review, to approach patients, ask questions about their experience and observe the ward environment and care delivery. Following a de-brief meeting, feedback was elicited for the review which has been verified with the family members.

Age Cymru have been invited to act as a 'critical friend' in reviewing the proposed action plan arising from this review.

North Wales Safeguarding Adult Board have been approached by the Health Board requesting a Safeguarding Board member to support the Quality Review working with the Health Board to provide and evidence independence, transparency and appropriate challenge.

The review lead and review panel members collectively gathered and considered the evidence available.

Lead of this review was Reena Cartmell, Associate Nurse Director Corporate Services.

Quality Governance Lead for this review was Matthew Joyes, Acting Associate Director of Quality Assurance (substantively Assistant Director of Patient Safety and Experience) with the support of BCUHB Head of Quality Assurance.

METHODOLOGY

The methodology for the review adopted a blended approach with a primary aim to assess the current baseline undertaken in two parts. The design was tailored to address the situation that prompted the review.

The review comprised of:

Part 1

- Desk top review - Review period - January 2020 to June 2021
- Case Note Review
- Unannounced Ward accreditation visit
- Leadership walks

Part 2

Focused on a Qualitative review in two phases:

- Phase A. in-depth full review of all inpatient wards on the Llandudno General Hospital (LLGH) site including the ward of concern Morfa Ward (July – August 2021).
- Phase B. shorter 'headline' reviews of Health Board community hospital inpatient wards (August 2021).

It is important to note a further in-depth full review of all community hospital wards was completed by the end of September 2021 by the Dementia Nurse Consultants. These additional reviews identified no significant new issues to what had been identified previously.

Design

The design has permitted in-depth analysis of a range of relevant factors.

In Part 1, the following was examined:

- Safeguarding
- Workforce
- Supervision
- Escalation
- Learning environment
- Training and education
- Staff concerns regarding performance previously registered
- Staff support from Occupational Health
- Ward accreditation

In Part 2, using a full bespoke review tool in Phase A and a short bespoke review tool in Phase B the following was considered.

- Staff wellbeing
- Support for patients and families

- Environment and enablement
- Communicating care
- Supporting patients with distressed behaviours
- Mental capacity
- Safety and risk management
- Education and understanding
- Culture and confidence to speak up and escalate
- Safety and safeguarding

Analysis

For both parts of the review, the following ratings were applied:

- Significant Issues - A rating of 'Significant Issues' indicates the service is performing poorly against the Health and Care Standards for that domain, with potentially significant risks to quality.
- Improvement Needed - A rating of 'Improvement Needed' indicates the service is not meeting all the Health and Care Standards for that domain, however there are clear improvement plans which can be evidenced and limited risk to patients, staff and the organisation.
- Good Practice - A rating of 'Good Practice' would indicate the service is meeting the Health and Care Standards for that domain.
- Outstanding Practice - A rating of 'Outstanding Practice' would indicate the service is meeting and exceeding the Health and Care Standards for that domain and has areas of exceptional practice.

Once checked for factual accuracy and approved by the Executive Lead, the report will be presented to the Patient Safety and Quality (PSQ) Group and to the Quality, Safety and Experience (QSE) Committee of the Health Board with the approved improvement plan.

Actions within the improvement plan will be monitored by the Corporate Quality Assurance Team and reported to the PSQ Group through the Quality Assurance Report, and onwards thereafter to the QSE Committee.

The process was designed to provide the service with a robust, honest and supportive assessment of its arrangements and outcomes in relation to the governance of quality covering patient safety, patient and carer experience.

The primary purpose was to provide the Health Board with assurance on quality and safety governance within the service, complementing other internal arrangements (such as clinical audit, ward accreditation) and independent or external arrangements (such as internal audit, Healthcare Inspectorate Wales inspections). The secondary aim was to drive improvement and to facilitate the sharing of learning and best practice across the Health Board.

This process and this report makes no critical comment about or towards individuals. Its focus is on the quality for our patients, carers, and staff and identifies system-level

management and governance issues, which are needed for improvement. Furthermore, opportunity to highlight good practice have been noted.

The Review Panel extends its gratitude and appreciation to the leaders, staff, service users, lay reviewers and Bangor University who have engaged with this review, and to the corporate teams who have provided data and analysis in support of the review.

The findings relate to Morfa Ward unless otherwise stated.

The period of desktop quality review was January 2020 – June 2021.

Terms of Reference for the Review can be found in Appendix 2.

SAFE CARE

The review panel rated this domain as: Improvement needed

Quality Governance

Quality Audits undertaken within BCUHB are in line with standards of care and inform staff where their service is doing well, and where there could be improvement. BCUHB Matron Quality Ward Audits are locally managed and overseen by Operational Heads of Nursing and Operational Nurse Directors who review compliance and scoring on a monthly basis as part of their local Quality and Safety meetings.

The Service Head of Nursing acknowledged the value of undertaking the Matron Quality Ward Audit and acknowledged these ward audits were required to be undertaken monthly and peer reviewed.

At the onset of the pandemic, the 'peer' element of the audit process was paused across the Health Board in an effort to reduce footfall across hospitals to avoid potential infection transmission, however Matrons expected within the Health Board to continue to audit their own clinical wards areas.

From the onset of the pandemic, the Matron Quality Ward Audit was not undertaken and did not restart until May 2021. In addition, there was no Matron on the LLGH site from February 2021 to May 2021 due to sickness absence, which also accounts for some of the omissions. The appointment of a temporary Matron in May 2021 resulted in the resumption of the Matron Quality Audit and subsequent compliance.

Corporate collation of the Matron Quality Audit is not presently in place to monitor compliance or themes however, with the development of the Health Board Quality Nursing Dashboard, there is opportunity for collation, assurance and learning.

The Ward Manager has continued to undertake the Ward Accreditation Monthly Audit and compliance on the ward has been high until very recently when the leadership of the ward changed. This has resulted in one omission. The Interim Ward Manager is now aware of the audit schedule and has provided assurance audits will be consistently completed.

The Head of Nursing has reported 'satisfactory' findings from both Matron and Ward Manager audits and these have shown some areas of good practice however reports the need for more training and awareness of caring for patients with dementia. This includes communicating with patients with cognitive impairment and planning their care.

'What Matters' documentation has not been completed robustly and there is currently no previous monitoring of the use of the 'This is Me 'document. The Head of Nursing has confirmed Matrons and Wards Managers have been asked to ensure that these are completed early in the patients' care assessment.

Nursing staff appear to use a risk-based approach to planning care with a range of risk assessments to use during care-planning including falls, pressure ulcer r and infection control risk assessment, however these were not always fully completed and variably acted upon suggesting further training needed. Opportunities to promote patient independence utilising a risk-based approach was also less evident.

Alongside the clinical leadership team there is the support of the Central Area Site Governance Team to drive forward patient safety responses and improvements however, there is a potential for over reliance on their contribution and this requires further consideration in terms of the engagement and accountability of the nursing team and the wider Multi-Disciplinary Team (MDT).

Findings:

The ‘What Matters’ documentation needs to be consistently monitored for completion and this activity needs supporting with staff education and training.

Thorough patient assessment and care plan completion is required and needs reinforcing with supported staff education and training.

Implementation of person centred care is limited. Long term planning earlier in the patient and carer journey is required to inform person centred care and promote independence utilising a risk-based approach.

Ward Manager and Matron overseen by the Head of Nursing are to maintain a robust schedule of quality audits with reporting and escalation through to the Central Area Quality and Safety Meeting.

The Quality Corporate Nursing Team would support compliance assurance and thematic learning with the introduction of a central monitoring process.

Safeguarding

Safeguarding Ambassadors:

Across the organisation there are 111 Safeguarding Ambassadors, these positions have been implemented since National Safeguarding Week in November 2019 to embed safeguarding practice at operational level and to ensure information and best practice is shared and available for ward staff and colleagues.

There is currently no identified Safeguarding Ambassadors at LLGH.

It has been agreed a minimum of 8 members of staff are to be identified and encouraged to participate and attend Safeguarding Ambassadors training specifically for LLGH.

Deprivation of Liberty Safeguards (DoLS**):**

Table 5 identifies there have been 37 applications for a DoLS from the ward within the reporting period with the highest applications noted in April 2021.

Table 5: *DoLS Applications by Month*

DoLS Applications	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21
Reports	0	1	4	0	2	4	5	2	1	2	2	0	2	2	2	7	1	0

Seven (7) applications were granted. However 28 were withdrawn due to the patients either being discharged or deceased. Two (2) applications were not authorised a DoLS due to the patient being identified as having mental capacity.

It is noted that ten (10) of the applications had document errors with the applications. These issues included:

- Missing details regarding communication and medical information
- Poor/wrong decision on the capacity forms
- No capacity forms completed and submitted
- Sections within the application Form were not completed correctly

Such omissions run the risk of delay in the authorisation of a DoLS, and potential for patients being unlawfully detained and possible harm.

Safeguarding Training Compliance:

The compliance for June 2021 is provided in Table 6. The compliance under the Health Board' required target of 85% is highlighted.

Table 6: *Safeguarding training Compliance for June 2021 by Staff Group*

Morfa Ward	NMC Reg. Staff	Other Clinical Staff
Number of Staff	12	17
MCA - Level 1	91.6%	70.5%
MCA - Level 2	83%	71%
Adults - Level 1	100%	94.1%
Adults - Level 2	92%	88%
Children - Level 1	83.3%	94.1%
Children - Level 2	83%	82%
VAWDASV	58%	65%

The compliance data is relatively positive. With exception to Adult at Risk (AAR) training there is room for improvement in all other modules, however the reduction in face-to-face training due to the pandemic may have resulted in challenges relating to the interpretation and application of risk and harm and the contributory factors. Mandatory training is supported by a number of IT platforms, which is offered using different methodologies to support training and learning. Face-to-face training enables discussion and welcomes challenge, which aids wider learning.

There have been non-compliance issues identified in the DoLS processes and evidenced in the applications from the ward. This may correlate to areas of training reduced training compliance in particular for Mental Capacity Act (MCA) Level 1 & 2.

Additional Safeguarding training has been recommended and the Central Area Management Team has agreed an additional face-to-face training plan for both mandatory and bespoke subject-specific training.

Safeguarding Supervision:

Corporate Safeguarding are actively supporting the ward to achieve compliance through sharing training information, group supervision and monitoring of compliance rates.

Adult Safeguarding supervision session has been provided to the ward staff on the 17th June 2021 in response to the concerns raised. Further dates are agreed and supported by the Central Area Management Team.

A Safeguarding Improvement Action plan has been agreed with the Llandudno Senior Leadership Team for immediate implementation. This to be monitored within the Central Area internal processes in addition to the Central Safeguarding Forum.

The key main themes of the plan include:

- Leadership
- Communication
- Quality of practice
- Practice in line with legislation and the Wales Safeguarding Procedures

The Safeguarding plan includes bespoke training in Escalation, MCA and DoLS training, and Group and Individual Safeguarding Supervision. There will also be continued engagement and visibility of the Corporate Safeguarding Team to provide support and responsive supervision.

Risk Management

The Datix system (the Health Board's concern management system) held two risks, both closed in February and July 2021.

The first risk recorded in April 2019 was supported with a risk assessment and supporting evidence. Despite communications to the handler, no update was provided until further contact in July 2021, whereby it was confirmed that a swipe card installation had been completed and therefore was no longer an issue.

Whilst the action and target risk score was achieved and closure of the risk was appropriate, the process was not followed for updating the system.

The second risk was correctly articulated and in line with the requirements of the Risk Management Strategy and placed on the register in April 2019 with supporting risk assessment documentation. Despite communications to the handler, it had not been updated. The risk was closed by the Central Area Risk Manager in February 2021, however completion of further actions to reduce the risk score or evidence of achievement of the target risk score is not clear and there does not appear to be following of the appropriate risk management strategy and procedure requirements.

Further review of the wider Central Area Community Hospital risks held on the Datix system noted 6 open risks.

Whilst all risks are appropriately recorded within the Tier and scoring structure in line with the Risk Management Strategy requirement, two risks have been recorded on the system since 2015 and were still classed as high risk one of which is 'nurse staffing levels'.

In this 6 year period, mitigations and controls should have been recorded and in place to support the local risk to reduce the score. If the risk cannot be managed locally, there should be documented evidence of escalation.

Five (5) risks were currently scoring between 9 and 12 and should be reviewed bi-monthly. Only one (1) risk had been reviewed in June 2021 and was in date, 4 were out of date and have not been reviewed since February 2021.

Key information was missing from the Datix system, for example no Risk Lead identified, and no next review date or target risk date.

Findings:

Following the information shared as part of this quality review regarding the challenges to meet consistent safe nurse staffing levels, a local risk assessment for the ward is required linked to the wider Central Area risk and wider Corporate Nurse Staffing Risk.

Clear roles and lines of accountability for the management of risk on the ward needs to be reaffirmed and documented.

Refresher training is required by all those responsible for creating and managing risks to ensure compliance with the requirements as set out in the Risk Management Strategy and Policy.

Incident Processes

Datix Risk Management System Reporting:

With the exception of the Datix incident report relating to the incident which instigated this quality review, it has been identified from the Datix system that only one (1) incident was recorded with the 'Safeguarding Incident' flag ticked as 'Yes' in the last 12 months.

This incident was reported February 2021 which related to a pressure ulcer noted on admission and reported that the patient had suffered a fall prior to admission. No AAR report was submitted.

There have been no Datix incidents in relation to patient-on-patient harm in the reporting timeframe. Given only two flagged safeguarding incidents were recorded within the system during the review period there is the potential for under reporting and additional bespoke training is required for assurance.

During the period January 1st 2020 and May 31st 2021, 274 incidents were reported via Datix in relation to Morfa Ward. Of these, a small proportion were staff affected incidents. The highest reported category of incident, by staff in relation to themselves,

was categorised as abuse of staff by patients, this was then followed by incidents that reported positive COVID-19 results amongst staff.

Patient affected incidents totalled 214.

A small number of incidents were categorised as resulting in major or catastrophic harm; these incidents were all in relation to harm caused by potential healthcare acquired COVID-19 and will be included in the Health Board's wider COVID-19 investigation.

The majority of incidents reported during this period were categorised as negligible i.e. no harm. The top three reported incidents during this period are as follows:

1. Slips, trips, falls and collisions
2. Administration or supply of a medicine from a clinical area
3. Pressure sore/decubitus ulcer

Within these categories, a number of incidents were found to be have affected a patient multiple times, for example, one patient had more than one fall/medication error. The majority of these incidents were not linked on the Datix system. By linking incidents, staff can identify whether the factors contributing to the incident are a new problem or risk, part of an existing problem (trend) or help evaluate the effectiveness of interventions or controls initially put in place.

Within the data, when identifying lessons learned, of those with a lessons code applied to the incident the main categories referred to 'a complex patient group' and 'breakdown or lack of communication'. A proportion of incidents had no identified lessons stating lessons 'not applicable'.

The incident report submitted on the 22nd June 2021, which initiated this review, was categorised as negligible on the reporting system, provided very little detail and locally closed. The incident did not identify any patients or staff affected but did indicate an investigation was ongoing. Closure was found to be premature as the investigation remains ongoing and lessons learned and actions require inputting, prior to closure.

Falls:

Within the review reporting period, there have been 80 Datix reported incidents on the ward in relation to slips, trips, falls and collisions. These account for 28% of Datix incidents. It has been identified that 13 patients experienced more than one fall.

Fig 1: *Number of falls per individual patient*

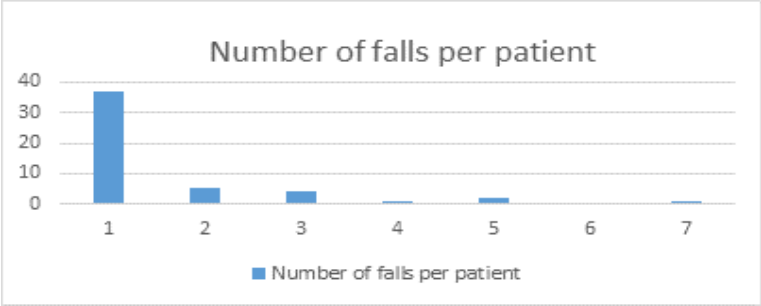


Figure 1 highlights that thirty seven (37) patients fell once. Five (5) Patients have fallen twice. A further four (4) fell three times. One (1) patient fell four times and two (2) patients fell five times with another one (1) patient having fallen seven times.

Medication incidents:

Within the reporting period Table 1 identifies there have been 49 Datix incidents on the ward in relation to medication, with the majority of these incidents relating to medicine not administered. The second most reported issue is within the 'other incident' category. Without further analysis, it is uncertain as to the nature and severity of those incidences.

Table 1: *Categorisation of medication incidents*

	2020	**2021**	**Grand Total**
Adverse Event			
Administration of Medicine Delayed	2	1	3
Expiry date wrong, omitted or passed		1	1
Formulation of medication was wrong	1		1
Frequency for taking of medication was wrong	1	1	2
Medicine not administered	19	2	21
Mismatch between patient and medicine	2		2
Omitted medicine or ingredient	1	2	3
Other medication incident	5	4	9
Patient information leaflet wrong or omitted	1		1
Wrong drug / medicine	2	2	4
Wrong quantity		1	1
Wrong route for administration of medication		1	1
Grand Total	**34**	**15**	**49**

Fig 2. *Number of medication incidents per individual patients*

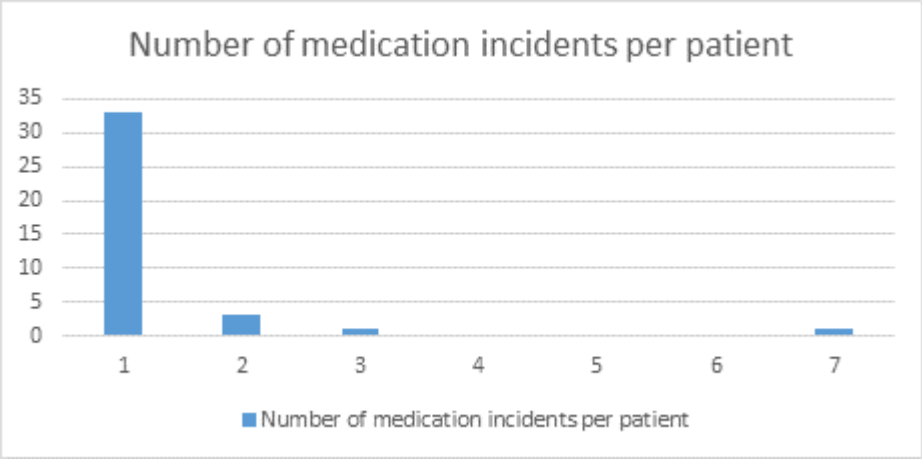


Figure 2 identifies that five (5) patients have been noted to have had more than one medication incident recorded. Three (3) patients have two (2) medication incidents, one (1) patient has three (3) incidents and one (1) patient has seven (7) incidents recorded.

For those patients who had multiple incidents reported, it is identified that omission of medication were either critical medication, controlled medication and/or antibiotics.

Antibiotics were recorded as unavailable, however it was not stated as to what action was taken to ensure future administration. Medication errors were associated with controlled drugs.

Ten of the 18 multiple incidences highlighted were within the period of September 2020 to December 2020. Further scoping is required to identify if there are any themes and trends associated with staffing factors or if any impacted on reported harm, as this cannot be identified within the reported Datix incidents.

All except one (1) incident were marked as negligible in severity with the result recorded as one of the following:

- No injury, harm or adverse outcome
- Near Miss – With intervention
- Near Miss – No intervention

One incident was marked as minor recorded in May 2021 whereby medication was not administered to the patient. The result recorded was personal injury with communication failure as a contributory factor.

Table 2: *Medication incidents contributory factors*

	2020	**2021**	**Grand Total**
Contributory Factor			
Behaviour - Patient Uncooperative	1		1
Communication Failure	5	5	10
COVID Pandemic	7		7

Dispensing Error - Pharmacy	1		1
Documentation Inadequate	2		1
Failure to Follow Procedure	4	2	6
Prescription Error	1	0	1
Not recorded	13	8	21
Grand Total	**34**	**15**	**49**

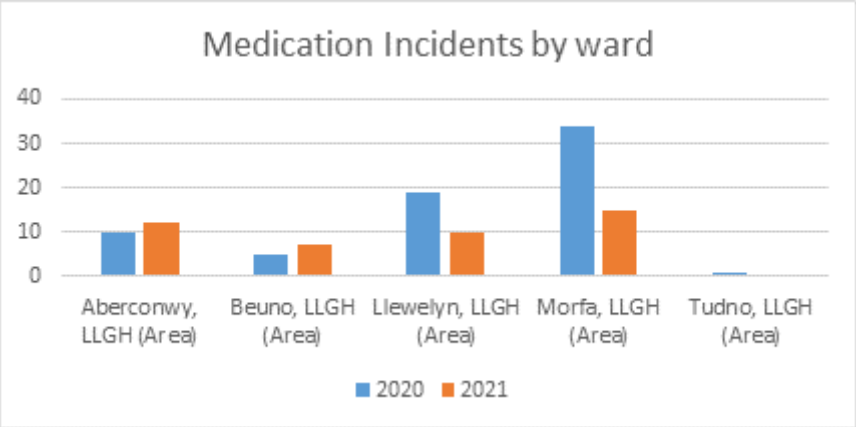
Table 2 identifies that in 2020 the highest number of incidences related to medicine not being administered. Communication failure is consistently the highest recorded contributory factor in 2020 and 2021; however, there is a high number of medication incidents where no contributory factor is recorded in both 2020 and 2021.

Table 3 and Figure 3 indicate that the ward has had the highest number of incidents reported relating to medication compared to the other LLGH wards in both 2020 and 2021 accounting for almost half of the incidents reported since January 2020.

Table 3: Medication Incidents LLGH wards

Ward	2020	2021	Grand Total	Percentage
Aberconwy, LLGH (Area)	10	12	12	19.47%
Beuno, LLGH (Area)	5	7	17	10.62%
Llewelyn, LLGH (Area)	19	10	29	25.66%
Morfa, LLGH (Area)	34	15	49	43.36%
Tudno, LLGH (Area)	1		1	0.88%
Grand Total	**69**	**44**	**113**	

Fig 3: *Medication incidents by ward*



Medication Safety:

Review of incidents reported during the review period identified that the second highest reported incidents were classified as 'administration or supply of a medicine from a clinical area'.

Following falls, 'medication not administered' was the highest reported adverse event. These incidents were in relation to critical medicines.

Prior to 2020, pharmacy staff were actively identifying the issues surrounding patient medication omission on all in-patient wards in LLGH. The pharmacy team worked with the LLGH wards with a concerted improvement initiative and subsequently, the number of critical medication omissions decreased. The initiative included all prescribed medication omissions recorded and monitored by pharmacy staff.

All omissions of medication deemed "critical medications" were escalated via Datix.

Pharmacy support was withdrawn due to COVID-19 pandemic pressures in March 2020 when the 8am medication round pharmacy support was withdrawn. Ward based pharmacy support was vastly reduced due to Covid restrictions and maintaining the workforce was the priority focused on supply services.

Findings:

Following a review of a small sample of prescription charts, it was felt that, whilst single incidents of omissions were, in the main, recorded and managed appropriately, there remains concern regarding the number of times that the omissions were categorised as 'medication refused', with some instances covering weeks of non-administration.

Currently data is collected on 'omissions of medication' as part of the Safety Thermometer tool, but it is unclear whether staff access this information to inform any improvement needed.

There appeared to be a lack of positive decision making when faced with multiple instances of non-administration, with no documented plan or discussion about how long it is appropriate for a patient to refuse a medication without alternative routes/stopping considered. Medical Consultants reported being unaware of instances

of omissions covering weeks however, it was noted that Advanced Nurse Practitioners and junior medical staff might possibly be more sighted on these events.

During the qualitative on-site review, ward observation of medication administration demonstrated good person centred care, which supported staff commitment to avoiding sedation by trying non-pharmacological approaches first.

It is recommended that an in-depth review be undertaken to fully understand the reasoning behind multiple omissions where the patient is unable to receive/no access or patient refuses medication. This should not be limited to Morfa Ward, but encompass other Older Peoples' Wards across the Health Board where patients may have difficulty with taking medications.

Pressure Ulcers

Between January 2020 and June 2021 there have been 27 Datix incidents in relation to pressure ulcers. Sixty-six percent of these incidents relate to pressure ulcers noted upon admission.

Table 4: *Pressure Ulcer incidents*

Pressure sore / decubitus ulcer	2020	2021	Grand Total
Delay or failure to monitor	-	3	3
Extended stay / episode of care	1	-	1
Pressure ulcer noted on admission	9	9	18
Simple complication of treatment	3	2	5
Grand Total	**13**	**14**	**27**

Out of the 13 incidents in 2020 three (3) were confirmed as a HAPU (Healthcare Acquired Pressure Ulcer).

Out of the 14 incidents recorded in 2021, five (5) were confirmed as a HAPU.

The Corporate Safeguarding Team is unable to confirm if the All Wales Pressure Review Tool and root cause identified 'avoidable' or 'unavoidable' for those pressure areas recorded as healthcare acquired, due to the unavailability of the information. There were no AAR reports submitted for any of the HAPUs.

One (1) incident reported in February 2021 has the 'Safeguarding Incident' flag ticked as 'Yes'. A pressure ulcer was noted on admission and it was reported that the patient had suffered a fall prior to admission. No AAR report was submitted.

Findings:

Further analysis and the triangulation of information relating to repeated falls, pressure ulcers and repeated medication errors is required to identify if there were missed safeguarding opportunities. An example of this would be for the patient who fell 7 times.

DIGNIFIED CARE

The review team rated this domain as: Improvement Needed

Privacy & Dignity:

Staff confirmed privacy was maintained as much has possible in a limiting physical environment. Some dementia-friendly adaptations were needed on the ward despite a comprehensive environmental audit in 2017 (for example; clock in view for all patients, good handrails, Reception signs at the nursing station and toilet signs projecting out into the corridors), which reflects the picture in a large number of other wards reviewed. Patients were nursed in male or female bays and offered personal hygiene care in the bathroom for privacy. Patients appeared to be treated with respect for example the provision of pressure area care offered with discretion. Patients are given choices where possible such as the option for a male or female staff member to care for their personal care needs.

Staff expressed challenges to having time to read care plans and the 'This is Me' tool appeared more readily used during the review visits to inform care. Handovers were the main means of communicating care rather than care plans, which were viewed by some as a 'paper exercise'. The design of the care plan documentation in use was observed to be less than ideal, which limits its utility, yet this could be mitigated with the provision of person centred care training. This finding was strongly representative of most other wards' approach to communication.

Patients can choose to go to bed according to their preferences yet it was said that breakfasts are at 7 30am, so it was usual to have patients up and ready for these. One interviewee expressed pressure from day staff to give morning medications but they refused to wake people. Another said night staff were asked to do the ward weekly risk assessments yet may not be best placed to do so.

Families were supported to stay in contact by phone during the pandemic to keep them informed. Family members are supported to come in at night if a patient's condition is poor. Staff promote patients transfer to the ward at night to arrive before 10 30pm.

Patients are encouraged to wear their own clothes and asked how they wish to be addressed. Good use is made of tools to aid communication such as hearing cards and photographs of food by the Dementia Support Worker to help with making menu choices.

Staff consistently reported having little time for meaningful occupation with patients and had previously relied heavily on their Dementia Support Worker, however at the time of review only one ward had a Dementia Support Worker in post (Beuno Ward) due to vacant posts. Not all wards in the wider community hospitals had a dedicated Dementia Support Worker per ward but it was usual in practice to have access to the role weekdays only. Several interviewees made a strong case for a seven-day Dementia Support Worker.

Whilst not an issue on Morfa Ward, several other hospital wards were observed to use falls alarms which could potentially cause distress to patients when set to emit a startling audible alert. At interview, several staff demonstrated a lack of knowledge of falls management and did not seem to fully understand positive risk assessment and management, preferring to keep patients restricted.

Wards had various crockery and utensils in use, some of which were undignified (feeder cups/beakers). During mealtime observations on the ward, a couple of missed opportunities were noted to better support and encourage patients with eating and this was also noted during the lay review.

An example of good practice on the ward was staff taking time to read a lengthy letter from a patient's friend detailing their life. Another was a story of how a Health Care Support Worker supported a suddenly ill patient superbly throughout the incident. On St David's Day staff worked with a student to make it an event for patients including bingo, decorations and cakes. To make patients on one ward more comfortable with chair-based exercises, staff created an Olympics activity to make the activities inclusive for all, fun and engaging.

The findings around Dignity were similarly reflected across all community wards reviewed.

Findings:

Ward areas can be enhanced through standardisation of technologies and crockery/utensils to support patient care.

Environments need reviewing to ensure visibility of dementia and other patients and to promote dementia-friendly environments.

Nursing documentation and its completion was not always effective in helping nurses to assess patients and plan individualised care. Care planning through assessment early in the care process is necessary for good quality care and outcomes. Implementation and promotion of person centred care will further help prepare staff to balance risk with personal preferences and needs.

Parity in Dementia Support Worker provision is needed.

INDIVIDUAL PERSON CENTRED CARE

The review team rated this domain as: Improvement Needed

Individualised & Person Centred Care:

Amongst the staff interviewed, there seemed to be varied understanding of person centred care. One staff said person centred care was less practiced at night time, another said it was variable amongst staff. All staff said they would be happy for a

relative of theirs to be cared for on the ward. This finding around person centred care reflected the general situation on all of the wards reviewed.

The Dementia Support Worker role on all wards that previously or currently had one was highly praised. This role was successful at engaging families, supporting patients with dementia and cognitive impairment, completing or updating 'This is Me' documents and providing meaningful occupation to patients.

Family engagement was not encouraged with personal care but families were especially welcome at mealtimes on the ward, if they could assist their relatives to eat. Whilst all wards had taken steps to help families keep in contact with patients as best they could during the pandemic, there was generally a missed opportunity across all wards to engage fully and work in close partnership with families, suggesting a lack of knowledge about family engagement.

One interviewee reported limited availability of TV and radio and the pandemic had meant sharing a TV in the day room was not permitted along with magazine use, which limited patients' meaningful occupation. On wards that had one, the Dementia Support Worker would instead focus on activities with individuals rather than group activities. Use of a mobile TV is made on the ward but there is limited technology available for patients such as ipads, RITA (Reminiscence Interactive Therapy Activities technology - which was available but not used) and radio to occupy them, especially at a time when social contact is limited due to the pandemic.

When asked about managing patients who are distressed, interviewees said some staff were more capable than others and they need support as some patients were very "aggressive" and they were not mental health trained. Some staff referred to patients as being ''abusive", "aggressive" and "difficult".

A small range of techniques were suggested such as distraction or sitting with the patient, although the latter had at times been for very prolonged periods (6 hours) instead of staff rotating more frequently. Some staff had good knowledge evidenced by them trying to identify the cause of distress such as hunger or pain. Dementia training undertaken by staff was very limited (mandatory awareness) with one interviewee having had no dementia training and another having had none in several years. There was a strong preference for face-to-face training as online training was not seen to be as effective.

Interviewees said there had been no team meetings for many months and handover was used as the main mechanism for communication about new policies, changes in practice and so on. This reflected the situation across most hospital wards reviewed.

In all community wards reviewed, mental capacity was generally not well understood, with a few notable exceptions. The Mental Capacity Act requirements appear to be paperwork driven rather than a person centred care approach.

Staff on the ward showed considerable compassion for patients. An example of good practice was staff playing film videos to help engage a dementia patient. Another was a staff member who adopted a different name to suit a patient with dementia who believed it was her real name.

Lay review:

Lay reviewers described patients as happy in general. The word "wonderful" was used with the majority of patients being very appreciative of the nurses' efforts. A missed opportunity to support a patient with drinking was observed when seemingly confused by the choice of soup in a cup and two drinks placed in front of him.

A minority of patients spoken to expressed staff having been abrupt on occasion. One patient said there had been an occasion her when her request for the toilet had not been responded to quickly enough which had upset her. Another patient said she felt chastised once when ringing her bell for another patient in need of assistance.

It was noted that there was no staff identity board, 'my name is' badges or visible poster for visitors and patients on how to make a complaint or compliment. One patient had left his meal and family asked for an update on Speech and Language Therapy involvement. Staff said a gentleman did not like soup but he very much did like soups, suggesting they did not know his preferences. The same patient was waiting for assistance to the toilet during lunchtime for quite a few minutes until staff were free.

Lay reviewers identified that some patients felt lonely and noted the absence of a Dementia Support Worker. Another was medically fit for discharge but was not aware of any discharge plans imminent. Reviewers identified a lady who was concerned about her sore finger which was reported. It was noted that not all signage was dementia-friendly and toilet seats, handles and grab handles were not in a contrasting colour. No Reception sign was in use at the Nursing station and no exit sign was visible to help wayfinding. Access to the TV in a shared lounge was limited due to the pandemic.

For adequate patient observation and safe care, lay reviewers felt strongly that dementia patients ought to be in line of sight of the Nursing station if at all possible.

The ward was observed to be very clean.

Patient and Carer Experience

Complaints:

Within the review period, three complaints were made in relation to care received on the ward. The complaints describe dissatisfaction with communication, hospital treatment, staff attitude and discharge planning. Two complaints were responded to formally through the 'Putting things Right' process, with one currently being investigated by the Public Services Ombudsman for Wales. The third complaint was resolved after a telephone call with the patient and her family.

The Patient, Advice and Liaison Service (PALS) received three enquiries during the review period. One of the enquiries escalated to a complaint (as noted above) and the remaining enquiries related to Continuing Healthcare funding and discharge communication.

Communication, especially in relation to discharge planning, appeared as an area of dissatisfaction within four of the seven concerns submitted by families and carers

Patient and Carer Experience:

During the period under review there was limited patient experience feedback collated: 24 returns in total. These were collected during the months of December 2020, and April and May 2021.

Generally, the Health Board receives only a small proportion of real-time feedback from LLGH and the Patient Experience Team supplement this with consented face-to-face interviews called 'Care2Share'. Due to COVID-19 and the restriction in access for non-clinical staff and visitors this has meant that both the use of a paper survey and Care2Shares has been further limited.

Due to the low numbers and interrupted frequency of reporting, it is difficult to identify any themes or trends in relation to the patient experience. Of the 24 responses collated from patients and carers:

- 70% staff 'always' introduced themselves
- 58% felt that they were 'always' listened to
- 54% felt they were 'always' given all the information they needed
- 79% 'always' received assistance when needed
- 50% were 'always' involved as much as they wanted to be in decisions about their care
- 75% felt that staff 'always' took time to understand what mattered to them as a person
- 14% could 'always' speak welsh to staff if they wanted to

The Director of Nursing Central Area Division following the escalation of student concerns requested the Patient Experience Team undertake 'Care2Share' interviews with a sample of patients on the ward.

A total of six interviews were completed in July 2021 which are summarised as follows:

- One patient mentioned that she had been humiliated and embarrassed by a member of staff. She expressed that she was also unhappy during her stay, however since these initial issues had been addressed, the situation had improved with no further such reported incidences. The patients expressed that their privacy was poor on the ward, but that this was not due to the staff, but rather attributed to the ward being a busy environment. It was so busy, that one patient said that she felt that she was a nuisance to the staff. One patient said that she did not feel safe at the beginning of her stay, but this had improved, and was considerably better now. She did feel that the staff looked after her although some staff could be a bit brisk.

- The Night staff were reported as being noisy at times and talking loudly. The food had been poor and cold when arriving, but this is now improved.
- Most of the staff were reported as being good, and the previously reported instances were isolated, attributed to 1 or 2 staff members only. All the other staff members were reported as being very kind. One particular nurse was reported as being especially kind. Relatives felt well supported and commented that the staff were kind.

Following Care2Share feedback, the Central Area Nurse Director held discussions with the Matron and Head of Nursing.

The Care2Share poster was shared will all staff and displayed on the notice board, shared within the ward staff safety huddle and further assurance provided with the introduction of monthly reviews with the team.

The Central Area Nurse Director requested further Care2Share opportunities across the wider Central Area Community Hospitals for assurance.

Length of Stay (LoS)

Morfa Ward average LoS of 24 days is slightly lower than the average LoS for LLGH wards. Benchmarked against the wider Health Board community hospitals Morfa Ward length of stay is less.

Comparison annual AVLOS per month by financial year with heat map

	Centre						East				West					
	Morfa	Lland	C/Bay	Denb	H/Well	Ruthin	Chirk	D/Side	Mold	Penley	Allt	Bryn B	Dolg	Eryri	Pen RS	Tywyn
201920	27.63	28.3	29.84	33.76	37.76	27.89	43.53	31.69	38.06	39.57	28.93	28.75	26.21	33.78	38.08	40.6
202021	24.01	25.5	24.98	25.84	32.02	25.22	34.4	28.51	32.98	32.27	24.14	29.35	21.59	33.14	35.36	37.2
202122	24.08	25.4	29.21	25.95	35.28	25	29.35	32.06	38.89	36.06	28.17	36.17	23.64	34.92	43.05	40.1

Findings:

Training on family engagement, customer relations, mental capacity and managing patients with distressed behaviours is indicated.

Policies and practices around patient observations and managing patients at risk of falls need appraising, including how these are managed with reduced staffing levels.

Ward communications need examining including reinforcing team meetings and communication with families.

Criteria led discharge is required to plan for patient discharge in partnership with the health care team, including the patient and/or their carer.

STAFF AND RESOURCES

The review panel rated this domain as: Improvement needed

Safe Staffing

LLGH Hospital site is included in the Central Area Intermediate Care safety huddle which considers safe nurse staffing and is attended by matrons (or ward managers in their absence), The Deputy Head of Nursing and /or the Head of Nursing and Central Area Quality Nurse provides representation from every site each day.

All wards in the LLGH site and Central Area are using SafeCare (electronic acuity reporting tool). The information shared at the Intermediate Care safety huddle, held every morning reviews patient acuity and nurse safe staffing compliance. There is a further safety huddle held at the end of the working day.

Following a risk assessment, beds were reduced from 23 to 19 in June 2020 to allow for social distancing and to ensure a 2.6m minimum bed spacing. The roster system was reviewed by the leadership team to bring it in line with changes in bed numbers.

Vacancies:

Workforce data shows a budgeted workforce of 29.82 Whole Time Equivalent (WTE) and contracted workforce of 25.83 WTE (Month 4). Registered nurses are budgeted at 12.93 WTE and contracted 10 WTE, whilst Unregistered nurses are budgeted 16.89 WTE and contracted 15.83 WTE. Vacancy percentage of Registered Nurses over the period has averaged at 18% and for Non-Registered Nurses it is 11%.

The service has actively advertised vacancies and Morfa Ward successfully recruited a total of 4 new starters (2 Registered Nurses and 2 Health Care Assistants) between June 2020 and February 2021.

A number of newly qualified nurses have been recruited through the All Wales recruitment streamlining process with start dates September 2021.

During the first part of 2021 there was significant absence of Dementia Support Workers within LLGH due to sickness and vacancies. The vacant posts are currently in the recruitment process.

A review of the available acuity and staffing data from SafeCare during the period June 2020 to 30th June 2021 indicates the following:

Data Entry:

Acuity data is being recorded and entered, however some census periods have been missed which affects the quality of data reported. The Red Flag data entry appeared low and requires further investigation by the clinical team.

Skill Mix:

In terms of Registered Nurse staffing, both January and February 2021 had more Registered Nurse staffing shifts filled than the planned requirement however, March to June 2021 there was an increase in the planned demand and the number of Registered Nurse shifts filled was less than required for each of these months.

For Non-Registered nursing staff the number of shifts filled has been greater than the planned requirements each month. For the months that the Registered nursing workforce was below planned staffing, it is likely that the ward covered Registered nursing shifts with a Non-Registered nursing workforce.

A Clinical leadership walk, undertaken on the ward by the Associate Nurse Director and Head of Nursing 11th August 2021 noted the current layout of the ward and the reduced visibility of patients. This observation was supported with staff feedback.

Further assessment is required to determine the possible modifications to the ward layout or work sub stations to increase patient visibility and also inform the ward nurse staffing review.

Further reported challenge is the ability for the Ward Manager / Shift Leader to provide oversight and supervision due to providing direct care when the team experiences staffing shortfalls.

Ward observation during the qualitative review of the ward supports the need for adequate staffing to safely oversee patient care in all areas of its unhelpful layout. This was also noted during the lay review. Furthermore, several staff raised cleaning duties as a distraction to the giving clinical care to patients (especially dishes and cups due to the ward domestic being off sick) and cleaning toilet raises.

Temporary Staffing:

Overall, the ward have used high levels of temporary staffing across each month reviewed within this report. The higher levels of temporary staffing are indicative of substantive staffing shortages within the ward due to vacancies or staff absence or responding to patient acuity.

For Registered nursing staff the temporary bank staffing use has been between 9% and 23% of the overall staffing. The use of agency staff is minimal at between 1% to 2% in all but one month.

For the Non-Registered nursing staff the use of temporary bank staff has been between 28% and 52% of the overall staffing.

During qualitative review of the ward, two staff highlighted inflexibility around staffing that affected adequate cover. One described the variation in external nurse agency pay and the unfortunate impact on the ability to cover their own ward's shortfall. Another said that the Health Board does not currently award staff permanent night duty contracts, which they believed affectes retention.

Acuity Data:

The ward has reported high levels of patient acuity at Level 3 and also significant reporting of Levels 4 and 5.

The acuity data should be reviewed to establish if the trends recorded are accurate for the anticipated ward activity. There is a staff perception that acuity has risen due to more complex patients coming from the main hospitals due to pandemic pressures. This requires further analysis in the context of acuity versus patient dependency.

Levels of Care Definition (see Appendix 3)

Medical Cover:

The ward has Consultant Physician cover with cross cover arrangements during periods of annual leave and sickness provided by a Consultant Physician peer. It has been noted that Consultant Physicians often have to stretch to cover these working arrangements and often this requires coverage across different hospital sites.

There is only one allocated junior medical staff member for the entirety of LLGH a GP trainee with no cross cover.

Advanced Nurse Practitioners are available who cover the wider LLGH site, however as they are not based on one specific ward, continuity of medical care is provided by the Consultant Physicians alone.

Patient length of stay is routinely mapped and monitored by the local medical team. The impact of medical staff annual leave and sickness appears to be a contributory factor to a longer patient length of stay.

Turnover:

Overall turnover for the ward nurse staffing in the last 12 months is moderate. There have been 4 (headcount) leavers during that time, with reasons for leaving reviewed by the Workforce Team and the Central Area Management Team. The Llandudno Site Nursing Leadership Team due to various circumstances has not been consistent and this can be expected to have had an adverse impact on the continuity and delivery of quality services.

Sickness:

Sickness rates on the ward have been variable over the last 6 months as follows:

January	10.18%
February	8.45%
March	6.20%
April	2.26%
May	6.5%
June	11.18%

Sickness reasons vary (Covid and non-Covid related) and are a mix of short-term and long-term absence. With respect to recorded work-related stress over the last 12 months, 852 days of absence lost was recorded due to S10 (Stress, Anxiety, Depression). The ward has the highest recorded stress-related absence within LLGH and across community hospitals in the Central Area. One other community hospital in the Central Area lost 723 days of absence due to S10

Support for staff to maintain their well-being and reduce stress across the Health Board includes Web Based Cognitive Behavioural Therapy programme, free Health for Health Professionals Wales Service and within LLGH the Chapel was changed into a breakout/support room with refreshments available for staff.

Across wider community hospital wards, nursing staff reported that limited staffing impinges on the ability of nursing to provide person-centred care. Several interviewees expressed that individual staff and teams had lasting damage to their health and wellbeing by the personal and workplace impact of the pandemic upon them, often working in very difficult circumstances.

Mandatory Training:

Mandatory training compliance overall for the ward is 89.89% (for all subjects).

Compliance by level and subject is included below:

Compliance by staff group overall is as follows:

Registered Nurses 78%

Non-Registered nurses 72%

Where compliance for individual staff members is below the Health Board standard of 85%, the Central Area Management Team are currently reviewing reasons and agreeing plans to increase compliance.

Appraisals:

Compliance with appraisals (as of July 2021) was 100%.

Leadership Team Support:

Due to various circumstances, leadership cover within LLGH has been variable with substantive staff absences resulting in a mixture of cover which potentially has had an adverse impact on the continuity and delivery of quality services. Leadership cover is in place currently for both the ward and LLGH site, however this needs to be stabilised for consistency and accountability.

Speak Out Loud:

During qualitative review on the ward, a degree of fear about speaking up was expressed by one participant for fear of consequences, yet another felt supported and able to raise concerns. The former interviewee perceived no action would be taken.

Staff morale and therefore their ability to give safe effective care had reportedly improved in the weeks preceding the review. There was a very strong sense of shame, reputational damage and feeling punished for the alleged mistakes of others.

Interviewees from other wards expressed feeling able to raise concerns and some gave examples of when they had.

University Learning Environment Audits:

The last full Placement Learning Environment (PLE) audit was undertaken in December 2018 (all PLEs are audited every two years) and a Once for Wales pandemic audit was completed 11.06.20. Previous student evaluations for the ward from August 2018 - August 2019 were rated overall as 'good' indicated by an overall satisfaction score of 85%.

The university, in partnership with the Central Area team are in the process of updating the full PLE audits for Llandudno Hospital

It was noted in a minority of community hospital wards reviewed, that opportunities to provide educational activities for students were missed when they were over-utilised for patient observations or predominantly placed on night duty.

Findings:

Based on the SafeCare information, consideration should be given to whether the ward has specific issues in terms of covering the late shift and whether this is an area that requires further support.

The Red Flag data entry on the SafeCare system appears low and should be investigated further by the clinical team. Datix training needs to precede the scheduled new version of Datix due for introduction January 2022.

The service needs to undertake a wider workforce review including medical staffing and the non-nursing workforce. The nursing review need to include a skill mix and acuity review to ensure both the skill mix and establishments are set correctly. This includes undertaking a review of the ward layout and safe visibility of patients and the potential to modernise the ward workforce.

Nursing leadership needs strengthening and stabilising for consistency and accountability, with an emphasis on promoting 'compassionate leadership'. It is important to note the temporary Ward Manager is proving very capable and rising to the challenge, bringing forward their professionalism and experience of community care however, stability is required. Current substantive ward staff are also compassionate and keen to deliver best possible care but require a stable nursing leadership team.

Where mandatory training compliance for individual staff members is below the Health Board standard of 85%, the Central Area Management Team need to review the reasons and agree, monitor and plan to increase compliance.

As the ward has the highest recorded stress-related absence within LLGH and across community hospitals in the Central Area, a local staff wellbeing risk assessment needs to be undertaken.

Across all community wards, a review of administration support roles will be helpful to understand the current cover and the hours required to standardise across all ward areas and free up nursing time.

LEADERSHIP AND ESCALATION

The review panel rated this domain as: improvement needed

The Professional Escalation Timeline can be found in Appendix 4.

Leadership

As reported in the Workforce section of this report, the LLGH Hospital Site Nursing Leadership Team has experienced a lack of stability amongst key leadership roles including Head of Nursing, Matron and Ward Manager. The importance of maintaining consistent strong visible clinical leadership within all clinical areas cannot be over-emphasised. Leading with compassion and engagement will reduce cynicism, burnout, and is essential to building a culture of person centred care.

Across the wider community wards reviewed, ward staff had praised the support of Matrons and Heads of Nursing. However, large number of interviewees felt under-supported during the pandemic by senior leaders who were said to have had insufficient presence.

Common across community wards was the view that staff were under-supported during the pandemic.

University Escalation:

The process for university escalation and subsequent action is shared between the School of Medicine and Health Sciences, Bangor University and the Health Board. The joint Practice Education Quality Assurance Group (PEQAG) meeting and regular placement meetings have been held since the start of the pandemic to successfully support students to return to placement areas and to act on any placement escalations of concern.

The Nursing & Midwifery Council (NMC) reported evidence of good relationships and partnership working practices with Health Board colleagues in recent programme approval reports.

Information about escalation actions and changes or improvements to placement learning processes (ensuring confidentiality) is reported to the University at the School of Medical and Health Sciences Teaching and Learning Committee, the School Board of Studies, and the main University Professional, Statutory and Regulatory Body Sub-Group, which reports to the University Quality Assurance and Validation Unit.

Concerns and escalation are reported by exception to the NMC using their reporting criteria using a partnership approach between the School and Health Board Nurse Education Team.

Student Placement and Escalation:

The ward first year pre-registration nurse students on placement from the School of Medical and Health Sciences, Bangor University during the periods of 3rd January 2021 until 29th February 2021 and 8th March 2021 until 28th May 2021.

One student requested a meeting with the Programme Lead, Adult Field, on 12.05.21 during a routine online course meeting with students. The student indicated in this meeting that the concerns were primarily about the placement learning environment culture. The Practice Learning Environment (PLE) Link Tutor became involved at this point to support students.

A written statement was received from the student on 25.05.21 and all students were subsequently withdrawn from the placement on 27.05.21; all were due to complete placement on or by 28.05.21.

The University Programme Lead emailed the Associate Nurse Director Professional Regulation and Education on 2nd June 2021 to notify the Health Board of the escalation of concerns and action however due to annual leave this was not picked up until 7th June 2021. In addition, the Link Tutor notified the Ward Manager on the 2nd June 2021, which was escalated internally by the Matron at LLGH.

Health Board - Professional Escalation:

Following the Link Tutor notification to the Ward Manager on the 2nd June 2021, the Ward Manager notified the Central Area Nurse Director the same day, who escalated the concerns to the Area Director, also on the 2nd June 2021. An AAR referral was also made on the 2nd June 2021, with a Safeguarding meeting held on 3rd June 2021.

On 7th June 2021 the Health Board Corporate Education Team convened a placement meeting for the 8th June 2021 whereby the Associate Nurse Director, School NMC Lead (Nursing) Head of Nursing, and Link Tutor commenced the joint University/Health Board placement escalation process.

A joint placement risk assessment was completed on the 16th June 2021, in line with the agreed process for removal of students from clinical placement. The actions agreed within the risk assessment remain under review with a risk assessment review completed end of Sept 2021. Students remain removed from the ward.

An online meeting was held on the 10th June 2021 with the Programme Lead, Adult Field, Link Tutor and Head of Nursing Central Area and nine pre-registration nurse students There was a delay in receiving the transcript due to lack of admin support. The Central Area Nurse Director, having reviewed the transcript, escalated to the Secondary Care Nurse Director (acting for the Executive Nurse Director) on 25th June 2021

On the 6th July 2021 following Health Board notification from Health Inspectorate Wales the Executive Nurse Director was informed of the events and instigated an urgent meeting.

Findings:

Within the Health Board, there was a clear delay concerning the escalation of professional concerns. This will require further assurance across Nurse Leadership Teams to the Executive Nurse Director to prevent further events.

The University has informed the Health Board that a review of the publicly available School escalation of concerns process and Quality Assurance process, which started prior to this episode, will be ongoing with multidisciplinary involvement and will include the Health Board's Education Team and Safeguarding Team.

The initial student contact stage of the escalation process will also be reviewed to ensure students are asked explicitly if the concern they are raising is specifically learning related and if there are any concerns about patient care or safeguarding.

The Executive Nurse Director has written to the Head of the School of Nursing, Bangor University to note the delay in the Health Board Executive Nurse Director being made aware of students' concerns and the withdrawal of students from clinical placement. The Head of School has indicated that in future the Executive Nurse Director will be informed of all significant concerns as soon as they are reported. This will ensure the Health Board can quickly put in place necessary safeguards to protect patients, staff and students and ensure a safe, harm-free learning and patient environment.

The Health Board have recently launched the Speak Out Safely Campaign, which provides the option for staff to have an anonymous conversation with a member of the Speak Out Safely Team, or our Speak Out Safely Guardian. Details were enclosed in the communication for dissemination to staff and students in the University.

The University Practice Education Facilitators (PEFs) have recommenced monthly student forums within the Health Board. The forums offer an opportunity for students to explore effective practice learning strategies, challenges, share learning experiences and identify further learning needs. An update on themes emerging from the forums will be provided at the next Practice Education Quality Assurance Group, membership which includes University and Health Board education and clinical senior nurses, which will also offer an opportunity to review the forums to ensure they meet students, practice supervisor and assessor needs.

In partnership, the process of reviewing placement escalation processes is required with our university providers to ensure a consistent process is in place across North Wales. This will include a direct notification of concerns relating to patient safety or a sub optimal learning environment to the Executive Nurse Director.

Processes for Personal and Safeguarding Link Tutors identifying concerns about the learning experience and or wellbeing issues during placements will enhance the early escalation process and support.

Acknowledging the professional escalation within the Health Board was delayed, further assurance is required

Adult at Risk Reporting and Escalation:

Between the 1st of January 2020 and the 30th of June 2021 there have been eight (8) AAR reports submitted by the ward. All of the AAR Reports were submitted in June 2021.

The first Report was submitted on the 2nd of June 2021, the Local Authority received the remaining seven (7) submitted Reports, on the 22nd of June 2021 and all Reports related to the same concern.

The initial Report on the 2nd June referenced the ward in its entirety due to allegations received from the workforce. No patients were identified as an AAR, as defined in the Social Services and Well Being (Wales) Act 2014, the Local Authority duly noted the concern and advised that if/when an individual AAR was identified, individual Reports should be submitted.

The Area Nursing Leadership Team prompted the initial AAR Report to be completed and submitted to the Local Authority, recognising the limitation of the information, but with an objective of transparency. The appointed investigator completed individual interviews on the June 10th 2021 and as a result, seven (7) patients and allegations relating to Health Board employees had been identified.

On the 22nd June the Area Nursing Leadership Teams submitted seven (7) AAR Reports. The timescale and submission of the seven (7) AAR reports to the Local Authority was determined by the availability and content of the information shared by the University. This resulted in a delay in the submission of the AAR Reports to both the Local Authority and health Board Corporate Safeguarding Team. The AAR process was instigated by the Local Authority and process continues to be followed in line with the All Wales Safeguarding Procedures (2019) in support of the Social Services and Well-being (Wales) Act 2014

Initially the Local Authority closed each of the Reports as the seven (7) patients identified were no longer patients on the ward and therefore were not deemed to be ‘at risk’. Following due process the Local Authority within a multiagency forum (strategy meeting) reviewed all associated information relating to each patient and although the patients were no longer deemed to be at risk and did not meet the AAR threshold, the Section 5 Position of Trust process was followed for each professional allegation.

It is difficult to assess the trend or themes of the quality of the AAR Reports as these Reports were submitted at the same time and no reports were made in the previous 18 months.

The Central Area Nursing Leadership Team acted swiftly upon receipt of the limited information from Bangor University on the 2nd June 2021 and contact was made with the Health Board’s Corporate Safeguarding Team and an initial risk assessment for the ward was completed. The Corporate Safeguarding Team contacted the Local Authority on the same day highlighting the concerns raised. On the 2nd June 2021 the Local Authority advised the current allegation did not meet the AAR threshold and recommended for it to be considered a whistle blowing issue. If individuals were

identified as being at risk due to this process it was agreed they were to be reported following the AAR reporting process.

On the 3rd June 2021 a meeting was convened between the Corporate Safeguarding Team and the Central Area Nursing Leadership Team. Assurance was obtained from the Central Area Nurse Director to Safeguarding that that the professional concern had been directly escalated to the Corporate Nursing Team.

As part of a formulated risk assessment, the initial plan to mitigate the risks included senior presence and visits onto the ward however, the Safeguarding Team considered the initial plan could have been strengthened. Upon receipt of the risk assessment, the Corporate Safeguarding Team highlighted areas where additional assurance was required and further assurance was requested on the 4th June 2021.

Findings:

Strengthened internal escalation of concerns is required relating to professional conduct and safeguarding allegations.

A need to provide opportunity to express safeguarding concerns in a safe environment with the Corporate Safeguarding Team if an individual is unable to express these concerns at ward level.

The Health Board's Standard Operating Procedure (SoP) incorporating the National Guidance and Working Together to Safeguard People Section 5 – Position of Trust, will support and strengthen the governance and the role and responsibilities of the workforce and the Central Area Nursing Leadership Team, when professional allegations and concerns are highlighted. The new Welsh Government Guidance to support any escalation of Professional Safeguarding Concerns, is awaiting ratification. This has resulted in the delay of the ratification and implementation of the Health Board's SoP.

To support this activity, the Corporate Safeguarding Team have identified immediate safeguarding supervision and training, which incorporates the reiteration of the escalation of concerns, and the Professional / Position of Trust process and procedures.

CONCLUSION

Whilst this report focuses on areas of improvement needed, there is clearly dedicated staff working hard to deliver high quality care to patients and good practice highlighted and shared.

A number of recommendations have been made to support the service with improvement. In addition, there are Health Board wide recommendations outlined in this report due to the consistent findings across the Health Board's wider community hospital services.

The Review Panel extends its gratitude and appreciation to the leaders and staff who have engaged with this review, and to the corporate teams who have provided data and analysis in support of the review. Further thanks goes to our University partners and lay reviewers.

This appreciation is even more heartfelt due to the unprecedented impact on services from the COVID-19 pandemic and the hard work and dedication of staff across the service to prepare and respond to the challenges, which are continuing. It is recognised that the pandemic will have impacted upon the service and its staff.

RECOMMENDATIONS

Following the Quality Assurance Review, the following recommendations are made:

Morfa Ward and Llandudno Site

Immediate Actions:

LLGH nursing leadership to be strengthened, stabilised and supported for consistency and accountability with emphasis on compassionate and collective leadership.

Area Director of Nursing along with the Head of Nursing and Matron to provide enhanced frontline leadership visibility and engagement, fostering a culture of relationship focused leadership with staff, patients and families.

Dementia Care Support Worker to be allocated consistently to the ward roster.

Standardisation of dementia-friendly crockery and utensils, dementia care signage, toilet seats and clocks to be introduced.

Undertake a review of patient visibility within the ward lay out, identifying opportunities and adaptations to support bay nursing.

A local nurse staffing risk assessment for the ward is required linked to the wider Area risk register and wider Corporate Nurse Staffing Risk. This provides the necessary detail for the Central Area Management Team to provide targeted intervention, mitigation, escalation and leadership support.

Establish clear roles and lines of accountability for the management of risk on the ward needs to be reaffirmed and documented.

Risk management refresher training is required for ward staff and the local leadership team to include clear ownership of process and accountability. This needs to dovetail with person centred care training. The use of Datix to support and record incident management requires training and educational support.

Indirect patient safety and quality activity/workload for example Datix reporting, quality auditing, nursing documentation is required to gain an understanding of its impact on care provision and for non-compliance with supportive corrective action.

Safeguarding Ambassadors to be identified with assurance that attendance at the training is supported.

The 'What Matters' and 'This is Me' documentation needs to be consistently monitored for completion supported with staff education and training.

Early and thorough patient assessment and care plan completion is required and needs reinforcing with supported staff education and training.

Ward Manager and Matron overseen by the Head of Nursing to maintain a robust schedule of quality audits with reporting and escalation through to the Area Quality and Safety Meeting.

Review ward organisation, communication and escalation with increased clinical engagement helping nurse leaders position themselves to facilitate greater collaboration and inquiry to support staff.

The Safeguarding Improvement Action plan agreed with the Hospital Nursing Leadership Teams for implementation to be closely monitored within the Area's quality reporting arrangements in addition to the Area Safeguarding Forums.

Longer Term:

Undertake a patient dependency, acuity and skill mix review with the potential to develop a workforce plan to modernise the workforce.

Review technology available to patients to provide meaningful occupation and connection with family and friends and technology used to manage risk (falls alarms).

Provide stand-alone person centred care training for all clinical ward staff, to include promoting independence utilising a risk-based approach.

Criteria led discharge promoted to plan for patient discharge in partnership with the entire health care team, including the patient and/or their family carer.

Further analysis and triangulation of information relating to repeated falls, pressure ulcers and repeated medication errors / omissions is required including training to identify if there are missed safeguarding opportunities within the reporting procedures.

Health Board Wide

Immediate

Standardisation of dementia-friendly crockery and utensils.

Dementia training refreshed, designed to deliver to staff in patient-facing roles.

Awareness raising to understand distressed behaviours expressed in people living with dementia and change use of powerful and stigmatising language. This to include the avoidance of the terms 'violent' or 'aggressive' to a more positive person-centred language.

Commission an in-depth review to establish the actions taken to manage medication omission and organisation wide learning.

Health Board to work with the Universities to ensure the Escalation of Concerns Process incorporates direct escalation to the Executive Nurse Director and Midwifery alongside the escalation to the Associate Nurse Director Regulation and Education.

Internal professional escalation to the Executive Nurse Director to be strengthened and reinforced.

Good practice and learning identified during this review to be communicated and celebrated.

Within 12 months

A model of person centred care implemented throughout the Health Board to improve holistic assessment to inform the nursing process and enhance patient and family care experience.

Stand-alone person centred care training for all clinical staff to include promoting independence utilising a risk-based approach.

The introduction of Shared Governance as a framework to advance professional nursing practice, including a robust evaluation of the chosen model, which will support the drive for consistency of standards.

Customer care and family engagement training for patient facing roles.

A review of the Dementia Support Worker resource and parity in its provision needs undertaking alongside provision of a Health Board network for role-holders.

Dementia Champion roles refreshed and increased in number.

Wards need to repeat King's Fund Dementia Friendly Environments audits previously undertaken in 2017.

Options to enhance the built ward environments/patient visibility within wards. These need appraising along with options for developing outdoor 'dementia friendly' space for patients where these are absent.

Standardisation of dementia care signage, toilet seats and clocks.

A review of technology available to patients to provide meaningful occupation and connection with family and friends and technology used to manage risk (falls alarms).

The 'What Matters' and 'This is Me' documentation needs to be consistently monitored for completion supported with staff education and training.

Early and thorough patient assessment and care plan completion is required and needs reinforcing with supported staff education and training.

Criteria led discharge is required to plan for patient discharge in partnership with the health care team, including the patient and/or their carer.

Appendix 2

Terms of Reference

Quality Assurance Review Morfa Ward, Llandudno Hospital

1. Background

The Deputy Chief Executive/Executive Director of Nursing and Midwifery has commissioned a quality assurance internal review into Morfa Ward, Llandudno Hospital following concerns raised by student nurses into alleged poor clinical practice, poor patient experience and matters of safeguarding concern.

2. Internal Investigation objective

The review will consider whether the Health and Care Standards for Wales and the Health Board vision, values and policies have been followed, in particular the provision of:

- a safe environment;
- individualised, dignified and person centred care;
- effective leadership and professional clinical practice at all levels;
- a culture of openness, integrity and responsiveness to concerns.

3. Internal Investigation Team Composition

The review will be led by the Associate Director of Nursing who is independent of any services involved.

The lead will be supported by a review team including the following, all of whom will have no prior involvement in this case:

- Senior medical and therapy expertise
- Safeguarding Team
- Corporate Nursing Team – Improvement Lead
- Corporate Nursing Team – Dementia Nurse Consultants Expert advisors
- Quality Assurance Team

A representative of the University will also be invited to participate.

In addition, a suitably prepared and supported family member / carer will work alongside Nurse Consultants as part of the review process.

4. Methodology

The review will include the following methods to enable a triangulated, evidence-based view of the ward:

- Interviews with staff, patients and carers;
- Documentation review including case note review;

- Review of quality (safety, experience, effectiveness), nursing and workforce data;
- Unannounced quality assurance visit using the ward accreditation framework.
- Clinical Governance desk top review

5. Reporting Mechanisms

The review lead will prepare a draft report for consideration by the commissioning executive by late August 2021.

During the review, any immediate or urgent concerns identified will be escalated without delay to the commissioning executive and through the appropriate internal/external governance processes.

The report will be written in such a way that enables public disclosure of the report and will include findings of the review and recommendations for improvement.

The report, once checked for factual accuracy and approved by the Chair of the review will be presented to the Patient Safety and Quality (PSQ) Group alongside the improvement plan and also to the Quality, Safety and Experience (QSE) Committee of the Health Board. Actions within the improvement plan will be monitored by the Corporate Quality Assurance Team and reported to the PSQ Group through the Quality Assurance Report, and onwards thereafter to the QSE Committee.

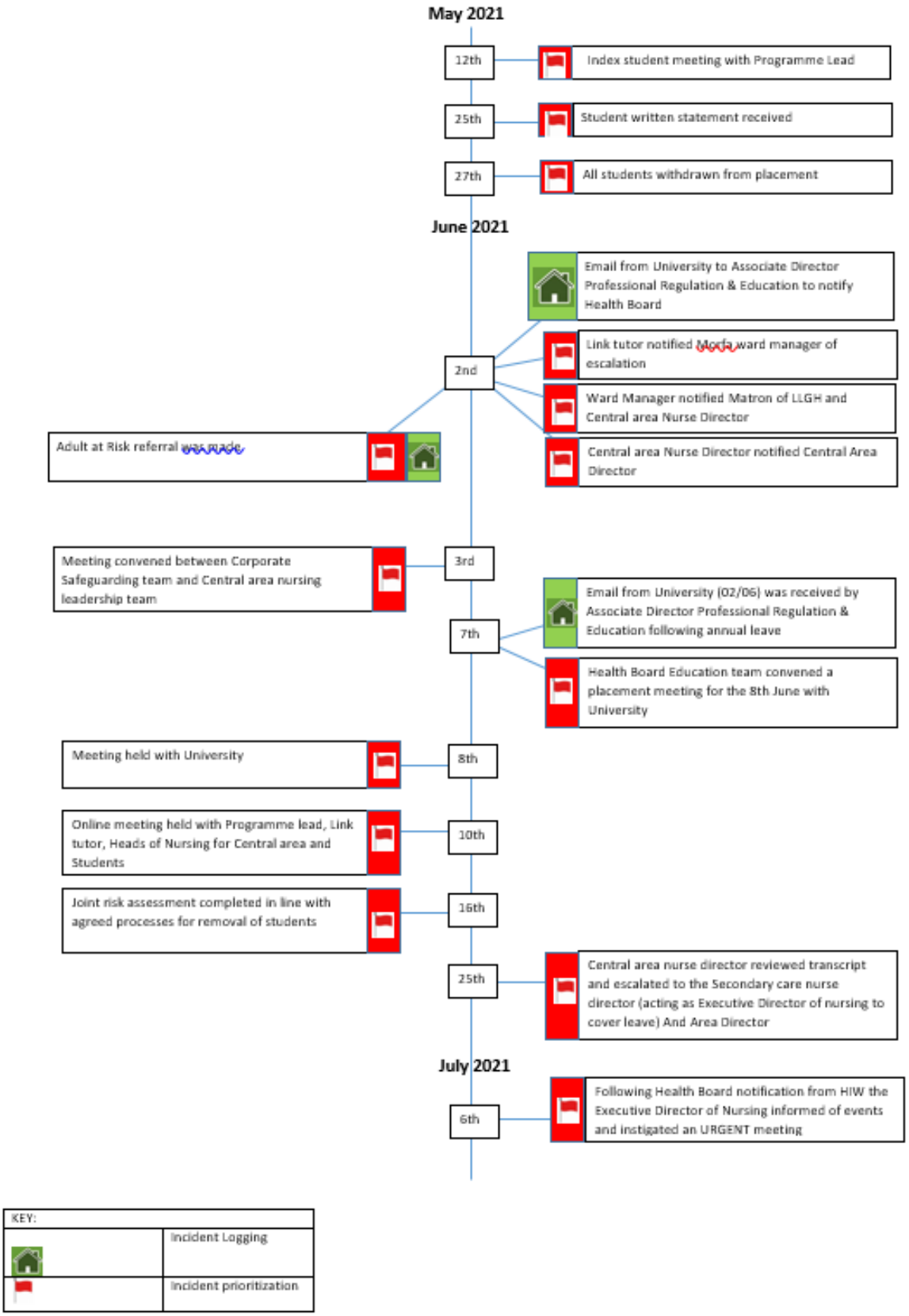
Appendix 3

Levels of Care Definition

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.

Appendix 4

Professional Escalation timeline



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 2nd November 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Welsh Ambulance Services NHS Trust - Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Acting Associate Director of Quality Assurance Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO
Atodiadau Appendices:	1. Healthcare Inspectorate Wales (HIW) Report 2. Management / action plan response

Argymhelliad / Recommendation:

The Committee is asked to note the attached HIW report and the Health Board's action plan response.

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

As part of the Healthcare Inspectorate Wales annual review programme for 2020-21, HIW committed to undertake a review of the Welsh Ambulance Services NHS Trust (WAST). This was due to concerns identified with long handover delays during a previous WAST local review carried out in 2019-20, where HIW explored how the risks to patients' health, safety and well-being were being managed, whilst they were waiting for an ambulance to arrive.

This review set out specifically to consider what the impact of ambulance waits outside of Emergency Departments is having on the overall experience of patients, which included their safety, care, privacy and dignity. HIW considered the period between 1 April 2020 and 31 March 2021.

This report sets out HIW findings and recommendations for improvement. It is HIW's expectation that the recommendations are considered at a system level and are taken forward in the context of broader improvement work underway to tackle the challenges faced in this area over recent years.

Cefndir / Background:

WAST responds to more than 1800 emergency calls a day across the country. It operates 24 hours a day, 365 days a year, and provides emergency medical services, advice and appropriate signposting to other healthcare services. In addition to emergency transport, WAST also provides a Non-Emergency Patient Transport Service (NEPTS), as well as hosting the 111 service, which consists of the NHS Direct Wales and clinical triage elements of the GP out-of-hours services.

The workforce is made up of over 3,500 staff who contribute to the delivery of patient care across Wales. In addition, it has over 300 vehicles based in 90 ambulance stations across Wales which work collaboratively with the three Emergency Medical Service Clinical Contact Centres (EMSCCCs) in Wales. WAST ambulance crews are highly skilled professionals who are able to treat and stabilise patients before taking them, if necessary, to the most appropriate hospital. The ambulance vehicles hold a wide range of emergency care equipment including oxygen, a defibrillator, advanced life-saving equipment and emergency drugs including pain relief.

As part of the review, HIW also engaged with all Health Boards across Wales providing emergency care.

The pandemic introduced unique and unprecedented pressures on the healthcare system; in view of this, HIW considered patient experiences between 1 April 2020 and 31 March 2021 in order to understand what impact the pandemic had on this issue.

To review the areas detailed above, HIW requested relevant documentation and issued a self-assessment document to WAST and each Health Board. HIW also considered local and national performance data and statistics. HIW held interviews with a variety of WAST staff, and conducted a survey for both WAST and Health Board staff. In addition, HIW conducted a survey of people who used the emergency ambulance service in the 12 month period highlighted above.

Asesiad / Assessment & Analysis

The HIW findings are detailed in the attached report which has been published. Recommendations can be found on page 41 and 42. In response, the Health Board has developed (in partnership with WAST) an action plan in response to the findings. This action plan has been shared with HIW and is also attached.

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered - Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

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

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

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

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Welsh Ambulance Services NHS Trust

Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

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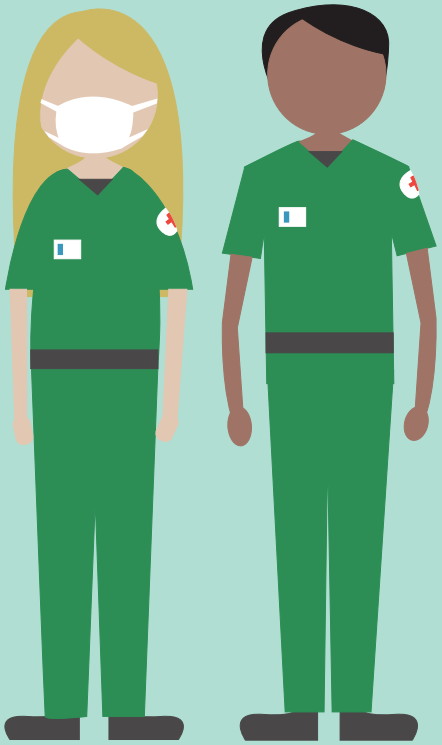
Website: **www.hiw.org.uk**



Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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Contents

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

Our purpose

To check that people in Wales receive good quality healthcare.

Our values

We place patients at the heart of what we do.

We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

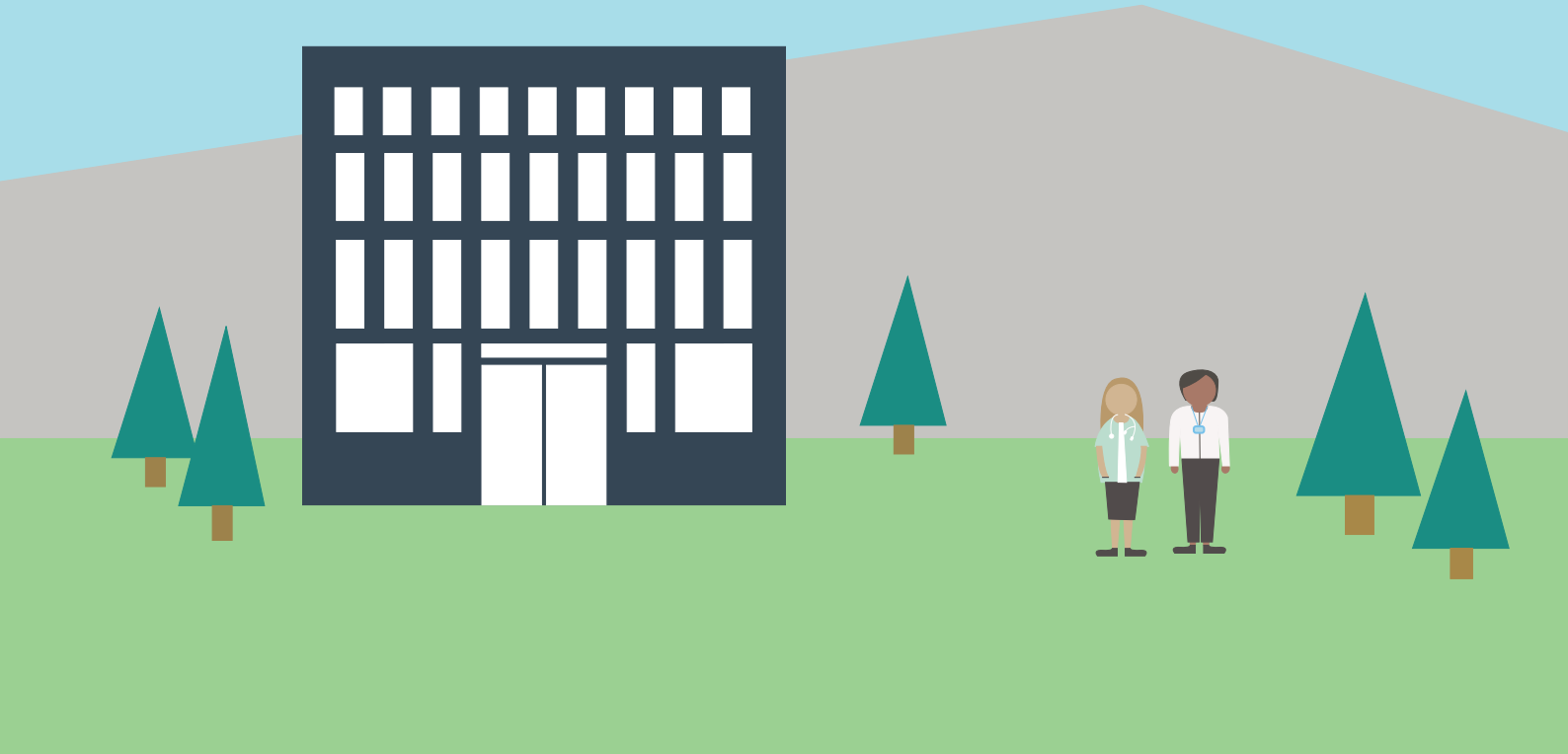
Our priorities

Through our work we aim to:

Provide assurance:
Provide an independent view on the quality of care.

Promote improvement:
Encourage improvement through reporting and sharing of good practice.

Influence policy and standards:
Use what we find to influence policy, standards and practice.



Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. We are responsible for inspecting, reviewing and investigating NHS services and independent healthcare services throughout Wales against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. In our role, it is important that we maintain an overview of each of the NHS health boards and Trusts in Wales.

The COVID-19 pandemic has introduced unique and unprecedented pressures on the healthcare system, however, it is our continued commitment and goal to check that people in Wales are receiving good quality care, which is provided safely and effectively, in line with recognised standards.

As part of the HIW annual reviews programme for 2020-21, we committed to undertake a review of the Welsh Ambulance Services NHS Trust (WAST). This was due to concerns identified with long handover delays during a previous WAST local review carried out in 2019-20, where we explored how the risks to patients' health, safety and well-being were being managed, whilst they were waiting for an ambulance to arrive. A copy of this report can be found on our website[1].

This review set out specifically to consider what the impact of ambulance waits outside of Emergency Departments is having on the overall experience of patients, which included their safety, care, privacy and dignity. We considered the period between 1 April 2020 and 31 March 2021.

This report sets out our findings and recommendations for improvement. It is our expectation that our recommendations are considered at a system level and are taken forward in the context of broader improvement work underway to tackle the challenges faced in this area over recent years.

We would like to express our thanks to all of the patients who helped inform our review by completing our survey and sharing their experiences with us. We also convey our gratitude to staff working within WAST and health boards across Wales who participated in this review, which included completing our professional surveys and participating in interviews with the HIW review team.

In addition, we wish to thank the Community Health Councils[2] in Wales, which provided their support in developing our questionnaire and with obtaining patient views.

1 www.hiw.org.uk/sites/default/files/2021-09/20200923WASTReviewFinalENG.pdf – WAST Review

2 Community Health Councils (CHCs) are independent bodies who listen to what individuals and the community have to say about the health services with regard to quality, quantity, access to and appropriateness of the services provided for them. They then act as the public voice in letting managers of health services know what people want and how things can be improved.

Summary

This report highlights the findings of our review of the experience of patients waiting on board an ambulance outside emergency departments during delayed handovers. The key findings of our review are outlined below.

It is clear from our review that the issue of prolonged handover delays is a regular occurrence outside Emergency Departments (ED) across Wales. Whilst patients were positive about their experience with ambulance crews, it is clear that handover delays are having a detrimental impact upon the ability of the healthcare system to provide responsive, safe, effective and dignified care to patients.

Whilst there are clear expectations and guidance for NHS Wales[3] in relation to hospital handovers, and a clear and apparent will to meet and achieve these, there are substantial challenges inhibiting the ability of the NHS in Wales to do so. The problem of delayed handovers is symptomatic of the wider issue of patient flow throughout the NHS, with consequent increased risks to patients associated with prolonged waits on ambulance vehicles outside EDs, impacting the ability of WAST to coordinate responses for patients waiting in the community for an ambulance.

Our review has noted that whilst work is ongoing to try and tackle this issue, with various approaches and initiatives in progress at a national level, such as the development of a National Quality and Delivery framework for Emergency Departments in Wales[4], which commenced in 2018, it is unclear how effective these activities have been to date. This is not a problem that WAST can resolve by itself, it is a challenge that requires WAST, health boards, and Welsh Government to work together and consider whether a different approach is required to ensure reinvigorated, strengthened and concerted action is taken to make sure that these issues are overcome.

Whilst we found that overall, handover processes at EDs across Wales are broadly similar, some variations exist in processes between individual EDs within health board areas. This was due to a number of local joint Standard Operating Procedures (SOPs) being in place within WAST and EDs, due to geographical layouts of ED environments, staff roles and levels of staffing available. This inconsistency can introduce risk, with our findings indicating that some WAST staff may be unfamiliar with SOPs specific to the ED that they are handing over to.

Further to this, feedback suggests that local handover processes can differ from day to day, depending sometimes on the clinician and or member of ED staff being dealt with. Again, we are concerned that this inconsistency could have a detrimental impact on patient care and safety and requires attention.

It is concerning that our review found that only 41% of WAST staff clearly understood who has responsibility and accountability for the patient at all times. This is despite three quarters of ED staff reporting that they clearly understood who is responsible for the patient. Ensuring absolute clarity over who has responsibility for patient care on board an ambulance following triage, until transferred in to the ED, is an important issue requiring attention to ensure safety of care.

Some health boards have introduced specific roles with the purpose of improving handover processes, such as Ambulance Patient Flow Co-ordinators or Hospital Ambulance Liaison Officers (HALO); these have reportedly had a beneficial impact on handover, and on patient experience by ensuring better coordination of the process. However, these roles are not in place across all EDs, and we believe that all health boards should consider the benefits that these roles may bring.

3 Wales Hospital Handover Guidance 2016 https://gov.wales/sites/default/files/publications/2019-07/nhs-wales-hospital-handover-guidance.pdf

4 The Emergency Department Quality & Delivery Framework Programme www.nccu.nhs.wales/urgent-and-emergency-care/framework/

Attention is required from WAST and health boards regarding some of the specific operational challenges faced by staff during the handover process. This includes the need to address some of the procedural challenges associated with timeliness of handover process. There is also a need to ensure that procedures to provide timely investigations, such as blood tests and X-rays, for patients on board ambulances awaiting handover are strengthened. This would have the benefit of enabling ambulance crews to be released, to undertake their primary role of providing on scene urgent or emergency care.

We found there are appropriate processes in place to escalate a deterioration in a patient's condition to ED staff. It was disappointing to find however, that only 49% of staff we engaged with felt there was a robust process in place. More work is required from WAST to ensure the escalation process is clearly communicated to and understood by its staff.

WAST also needs to ensure that its workforce is adequately supported, and that staff wellbeing is maintained, when they wait for long periods on board an ambulance due to delayed handovers. Some approaches have improved the situation, for instance the introduction of the Duty Operational Manager which has facilitated crews to take their allocated breaks, and to finish their shift on time wherever possible, by taking over the care of patient. However, work remains on WAST's behalf to ensure that it adopts a consistent approach across Wales to support its workforce.

Improvements are also needed to strengthen collaborative working between WAST and health boards in relation to communication and the management of serious incidents arising from delayed handover. This includes the need to ensure health board representatives attend WAST Serious Clinical Incident Forum (SCIF) meetings, to enable timely management of concerns, development of action plans and ensure learning via feedback throughout the organisations.

Concerns were also highlighted to us around the consistency of feedback from incident reporting within WAST. Our findings highlight the need for WAST to identify more effective processes for sharing feedback and learning from incidents with ambulance crew following incident investigations, to improve quality and safety of patient care. In addition, WAST needs to do more to ensure that its staff feel confident that any concerns they raise would be addressed.

Patients were generally positive about their experiences and provided good feedback about ambulance crews, particularly in relation to their kindness, overall communication and management of distressing situations. Patients reported that they were treated with dignity and respect by ambulance crews, and felt safe and cared for. Patients also indicated that they were satisfied with the care and treatment from ED staff. Overall, our findings indicate that the severe impact of the pandemic did not negatively affect the experience of patients who used emergency ambulances services across Wales, and that on the whole patients were satisfied with the care provided.

Whilst patient feedback has been positive, this should not detract from the issues associated with delayed handover. It is clear that there are genuine frustrations held by WAST and health board staff regarding their inability to effectively carry out their roles as a consequence of this issue. The positive experiences shared by patients should also not detract from areas of concern regarding patient care, including the difficulties in facilitating patients to access a toilet during their wait, the risk to patients of sustaining skin tissue pressure damage, and the problems faced in providing them with food and drink. In addition, a number of staff raised concerns about their ability to appropriately achieve and appropriately maintain high standards of hygiene and infection, prevention and control measures on board the ambulance.

We have found that whilst WAST has developed clear systems, which identify risks, provide mitigation and escalate concerns, it is clear that these systems alone are not enough and more collaborative work between WAST and health boards is required to resolve the issue of prolonged handover delays.

Context

WAST is the primary frontline service delivering ambulance transport in Wales. The Trust was formed in 1998, and serves a population of around 3.2 million people across seven health boards in Wales.

WAST responds to more than 1800 emergency calls a day across the country. It operates 24 hours a day, 365 days a year, and provides emergency medical services, advice and appropriate signposting to other healthcare services. In addition to emergency transport, WAST also provides a Non-Emergency Patient Transport Service (NEPTS)[5], as well as hosting the 111[6] service, which consists of the NHS Direct Wales[7] and clinical triage elements of the GP out-of-hours services[8].

The workforce is made up of over 3,500 staff who contribute to the delivery of patient care across Wales. In addition, it has over 300 vehicles based in 90 ambulance stations across Wales which work collaboratively with the three Emergency Medical Service Clinical Contact Centres (EMSCCCs) in Wales.

WAST ambulance crews are highly skilled professionals who are able to treat and stabilise patients before taking them, if necessary, to the most appropriate hospital. The ambulance vehicles hold a wide range of emergency care equipment including oxygen, a defibrillator, advanced life-saving equipment and emergency drugs including pain relief.

A range of information sources indicate that ambulance waiting times, outside hospital EDs, can be excessive, particularly when the healthcare system is under pressure. These information sources include Welsh Government ambulance monthly performance indicators, Serious Incident notifications to Welsh Government, intelligence held by WAST, media reports, and discussions between HIW and senior staff within both WAST, and health boards. In addition, delays in the handover process with EDs resulting in reduced ambulance availability, were highlighted during HIW's local review of WAST during 2019-20, and within the Amber Review report publised by the Emergency Services Committee in 2018[9].

In response to these issues, our review set out to consider the impact of ambulance waits outside of EDs on patient safety, privacy, dignity and overall experience. The review set out specifically to consider the impact that ambulance waits outside EDs are having on the overall experience of patients, and considered the period between 1 April 2020 and 31 March 2021.

As part of our review, we also engaged with all health boards across Wales providing emergency care. This included Aneurin Bevan, Betsi Cadwaladr, Cardiff and Vale, Cwm Taf Morgannwg, Hywel Dda and Swansea Bay University Health Boards. Each of the health boards have between one and three EDs within their localities, with a total of 12 across Wales.

Powys Teaching Health Board does not provide an emergency care service, although does provide minor injury care within its four Minor Injury Units (MIUs) across its localities.

5 Non-Emergency Patient Transport Services are provided to get patients, who are unable to transport themselves due to medical reasons, to and from hospital and clinic appointments.

6 The 111 service is an online or free telephone number available 24 hours a day, providing health information, advice and access to urgent out-of-hours primary care.

7 NHS Direct Wales is a health advice and information service available 24 hours a day. It has operated across Wales for many years and forms the backbone of the 111 service which is currently operating in four of the seven health board areas in Wales and will, over time, be replaced by 111 entirely.

8 The GP out of hours service is for people who need urgent medical treatment but cannot wait until their doctor's practice is open.

9 Amber Review Report 2018 www.wales.nhs.uk/sitesplus/documents/1134/NHS-Amber-Report-ENG-LR.PDF

The map below details the location of each ED and MIU across Wales:

What we did

Focus of review

We reviewed how patient safety, privacy, dignity and their overall experience was managed by WAST ambulance crews and health board ED staff, whilst they waited on-board ambulances during delayed handover to ED staff. To achieve this, we explored the following five areas:

- **Patient handover** – to consider the procedures in place between the WAST and each acute hospital ED for accepting patients from ambulances into the care of health board staff
- **Patient experience** – to assess the overall experience of patients whilst waiting in an ambulance to include their safety, care and any impact on their wellbeing. We also considered how patient dignity is maintained and needs are met, to include nutritional, hydration and toilet needs
- **Workforce** – to consider the impact of handover delays on ambulance crew to include their welfare and support
- **Escalation processes** – to consider the risk management and escalation arrangements of WAST during periods of high pressure as a result of delayed handovers
- **Governance arrangements** – to consider incident reporting, investigation of incidents of patient harm due to delayed handovers and learning from incidents.

Scope and methodology

The pandemic introduced unique and unprecedented pressures on the healthcare system; in view of this, we considered patient experiences between 1 April 2020 and 31 March 2021 in order to understand what impact the pandemic had on this issue.

To review the areas detailed above, we requested relevant documentation and issued a self-assessment document to WAST and each health board. We also considered local and national performance data and statistics.

We held interviews with a variety of WAST staff, and conducted a survey for both WAST and health board staff.

In addition, we conducted a survey of people who used the emergency ambulance service in the 12 month period highlighted above.

Self-assessment

We asked six of the seven health boards across Wales to complete and return a self-assessment document. This helped us to understand the degree of insight each health board has of its strengths and areas for improvement with the process in place for ambulance patient handover, and the management of patients awaiting handover.

We wanted to understand the views of the public and staff on ambulance handover delays, and developed and launched two national surveys to help capture this information.

Staff survey

We developed and launched a staff survey to obtain the views of WAST and health board staff on the patient handover processes in place between ambulance crew and ED staff. This was to help us understand the impact of delays in the process on staff well-being, and to identify any areas for improvement.

We asked WAST and health boards to distribute our online smart survey details to relevant staff, and we also promoted the survey through our social media channels.

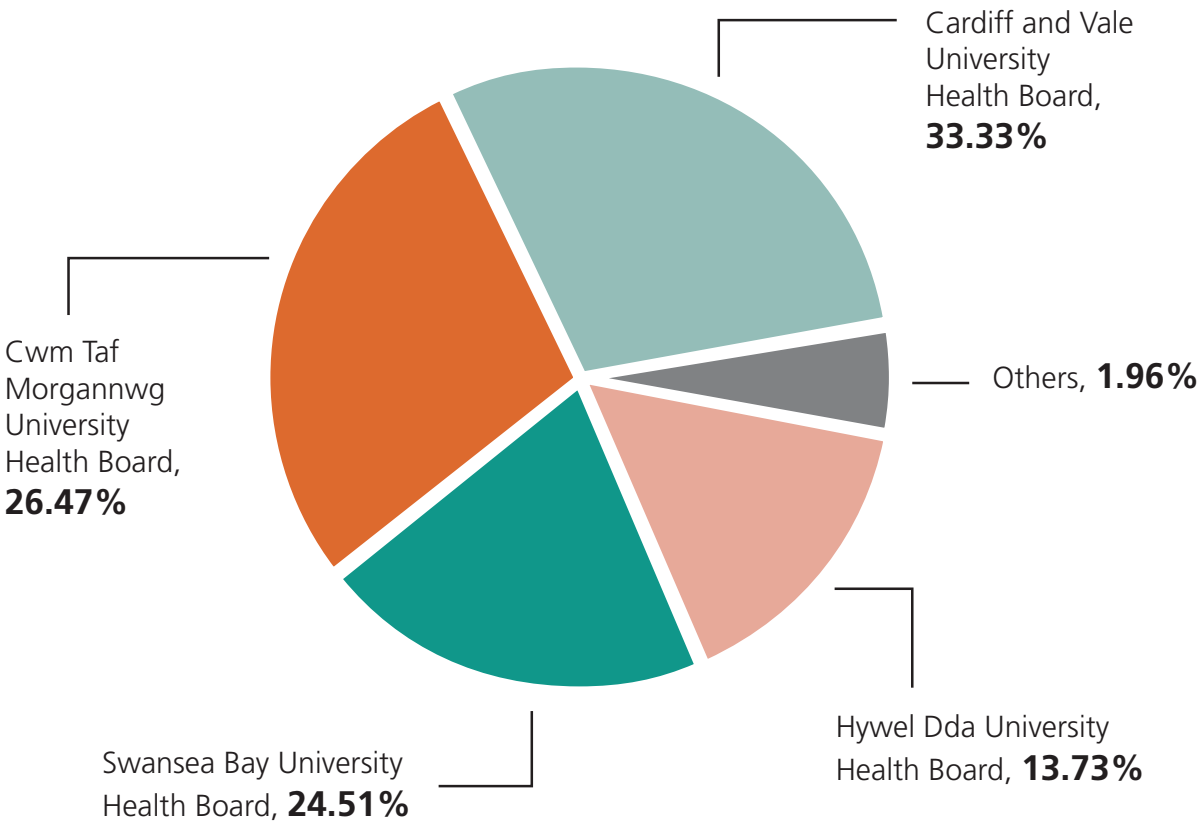
We received a total of 438 responses, which covered a range of staff across Wales, which included:

- 271 WAST Paramedics and Ambulance Technicians
- 64 'other' WAST staff, which included First Responders, Duty Operational Managers and Urgent Care Assistants
- 98 health board ED staff and ED managers
- 5 'other' ED staff which included Patient Flow Managers.

Despite engagement with the six health boards providing emergency services, only staff within four health boards provided a response. We therefore did not receive the opinions from ED staff working within Aneurin Bevan University Health Board and only one response was received from Betsi Cadwaladr University Health Board. These two health boards cover four of the 12 EDs across Wales. Therefore, where reference is made to ED staff survey comments, this may not be reflective of staff within Betsi Cadwaladr or Aneurin Bevan University Health Boards.

Breakdown of staff responses per health board

Which Health Board / Trust are you employed by?



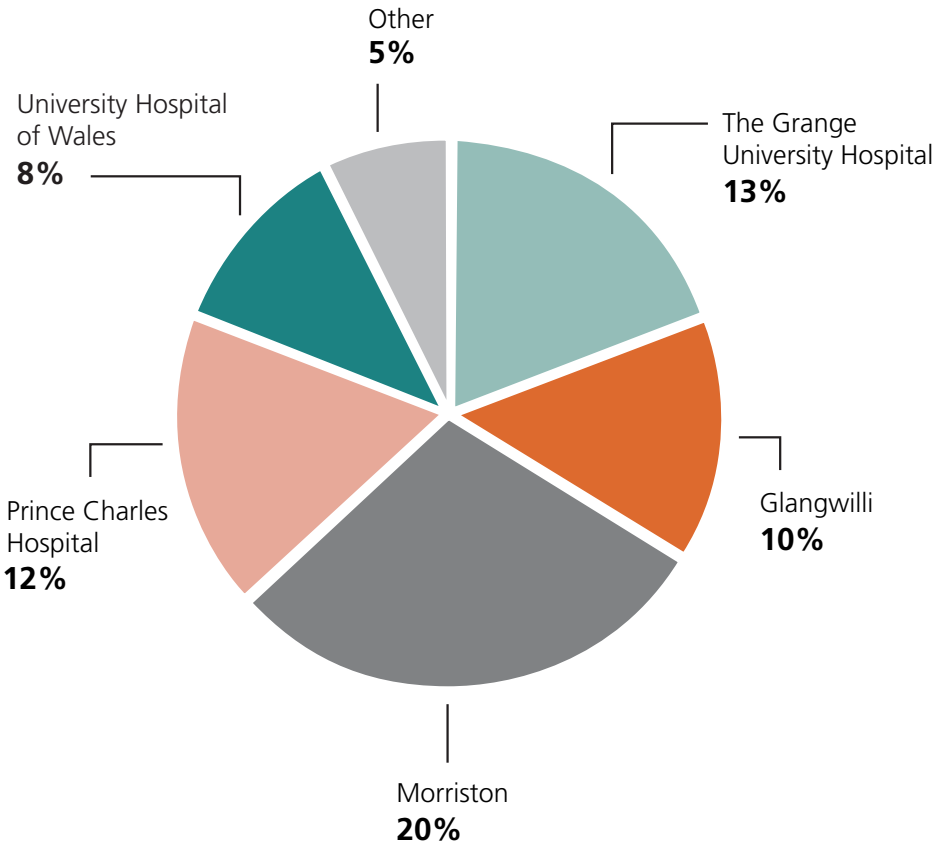
Public survey

In parallel with the staff survey, we also launched a national public survey, to capture the views of patients who had used an emergency ambulance. This was to gain an understanding of their experiences whilst waiting on board an ambulance outside an ED.

The survey was distributed via smart survey and was open to all people in Wales to capture the views of those who used WAST emergency services between March 2020 and April 2021. We engaged with WAST, health boards, and also the Community Health Councils in Wales, who provided their support with obtaining patient views.

We received a total of 137 responses, with 85% having used WAST emergency services within the last 12 months. Representation was from patients who had attended EDs across health boards in Wales.

Public Survey response per hospital



Staff Interviews

Due to restrictions in place relating to the COVID-19 pandemic, the majority of our fieldwork was completed remotely, including most of our staff interviews. Where we completed site visits, each was individually risk assessed to minimise the risks to our staff and healthcare providers.

We held a number of interviews with ambulance crews from across Wales. This included Paramedics, Ambulance Technicians, Duty Operational Managers and Urgent Care Assistants. Staff we interviewed shared their views and experiences of working within the service, which included the main challenges they faced with handover delays.

As part of our fieldwork, we also interviewed senior staff from within the Trust, including members of the Executive Team. We completed a total of 31 interviews and our findings will be highlighted throughout the report.

What we found

The handover process

It is a regular occurrence across Wales for multiple ambulances to be stationary outside hospitals for prolonged periods, waiting to hand over their patients to the health board.

Wales Hospital Handover Guidance 2016[10]

The hospital handover guidance issued by Welsh Government in 2016 stipulates the need for timely handover of patients from ambulance crew to hospital staff, to optimise performance and patient care. The guidance highlights that health boards are responsible for arranging the safe emergency transfer and timely treatment of citizens in their local area.

The statement of intent within the guidance indicates that the safety, effectiveness and patient dignity must be at the forefront of systems of emergency care. In addition, that the best care is provided to patients in the correct care environment. Therefore, when an ambulance crew takes a patient to hospital, it is essential that they are released promptly so they can continue to provide a safe and efficient service to the local community.

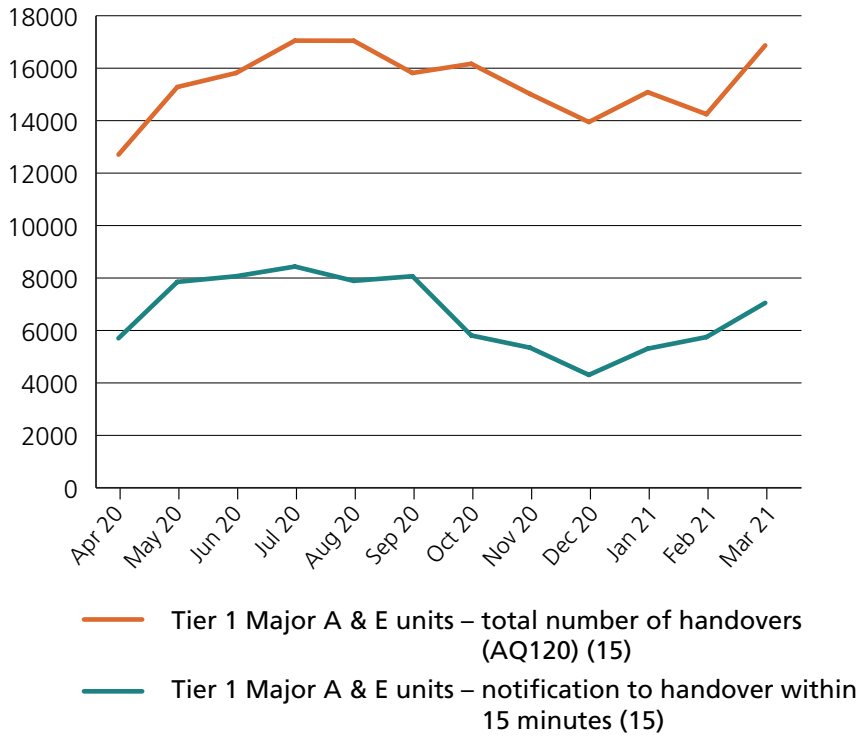
According to the above guidance, when a patient is conveyed to a hospital by ambulance, care must be handed over to the hospital team within 15 minutes. Health boards are responsible for ensuring this happens reliably. Hospital clinical staff must ensure that any patient waiting more than 30 minutes has been assessed and moved immediately into hospital if there is a risk to patient safety. Management of delays of over 60 minutes are unacceptable, and Welsh Government states that they should be the exception.

Data published by Welsh Government on the StatsWales[11] website, highlights that between April 2020 and March 2021 there were approximately 185,000 handovers at acute EDs throughout Wales. Of which, just over 79,500 occurred within the target of 15 minutes.

10 Wales Hospital Handover Guidance 2016

11 Ambulance Quality Indicators – Number of notification to handover within 15 minutes of arrival at hospital Tier 1 Major A&E units (AQI20ii)

This is highlighted in the chart below and relates to over 105,000 handovers falling outside of the Welsh Government target.



The impact of handover delays is that there are occasions where multiple ambulances are waiting together outside EDs for long periods of time. This can often affect the service to the extent that there are no ambulance resources available to respond to new emergencies within the community, thus increasing the risk to patient safety or life.

WAST data demonstrates that between April 2020 and March 2021, there were 32,699 incidents recorded across Wales, where handover delays were in excess of 60 minutes, of which, 16,405 involved patients over the age of 65. This is a concern since many older adults can be considered more vulnerable and at risk of unnecessary harm due to frailty and pre-existing health conditions which are more common with older age.

Data published by Welsh Government of the recorded number of lost hours as a result of hospital handover delays, highlight that in December 2020, a total of 11,542 hours were lost due to handover delays. This is a further monthly increase in the data published in the 2018 Amber Review Report, as highlighted earlier. These delays have serious implications on the ability of the service to provide timely responses to patients requiring urgent and life threatening care.

Patient flow issues, such as system bottlenecks and discharge problems can negatively impact on the availability of beds within EDs, since the departments cannot transfer patients to wards due to insufficient ward bed availability. These concerns were echoed by numerous WAST and ED staff within our survey. Patient handover delays are not directly a WAST problem, but are a consequence of wider systemic patient flow issues through NHS healthcare systems and social care services. Concerns were also highlighted to us of severe overcrowding within EDs, which leads to the inability to offload patients from ambulances. This is consistent within a number of our findings during previous HIW inspections of EDs across Wales.

We found handover delays impact on the ability of ambulance crew to provide a positive experience for patients. It may also increase the risk to patient safety, through delays in diagnosis and receiving treatment, as well as to the risk to people awaiting an ambulance in the community, with fewer ambulances available to respond to their needs.

During our review of WAST in 2019-20, we made a recommendation to WAST to consider a holistic review with stakeholder engagement, of the handover arrangements in place across Wales, to help address the patient flow issues through NHS healthcare systems.

The Trust has been working on actions to make improvements in this area and with its stakeholders since 2020. However, our review has found ongoing issues in relation to patient flow within each health board across Wales. We have therefore recommended that Welsh Government considers how this broader issue can be tackled, and to coordinate a collaborative approach to ensure consistency across Wales.

Recommendation

Health boards and Welsh Government should consider what further actions are required to make improvements regarding the patient flow issues impacting on delayed patient handover. This may include consideration of whether a different approach is required by WAST, health boards, and social care services within Wales, to that taken to date in tackling this system-wide problem.

Ambulance arrival at ED

Six health boards were asked to complete a self-assessment regarding ambulance patient arrival and handover procedures within their EDs. The assessment responses helped us to understand the degree of insight each health board has into its own strengths and areas for development with ambulance patient handover.

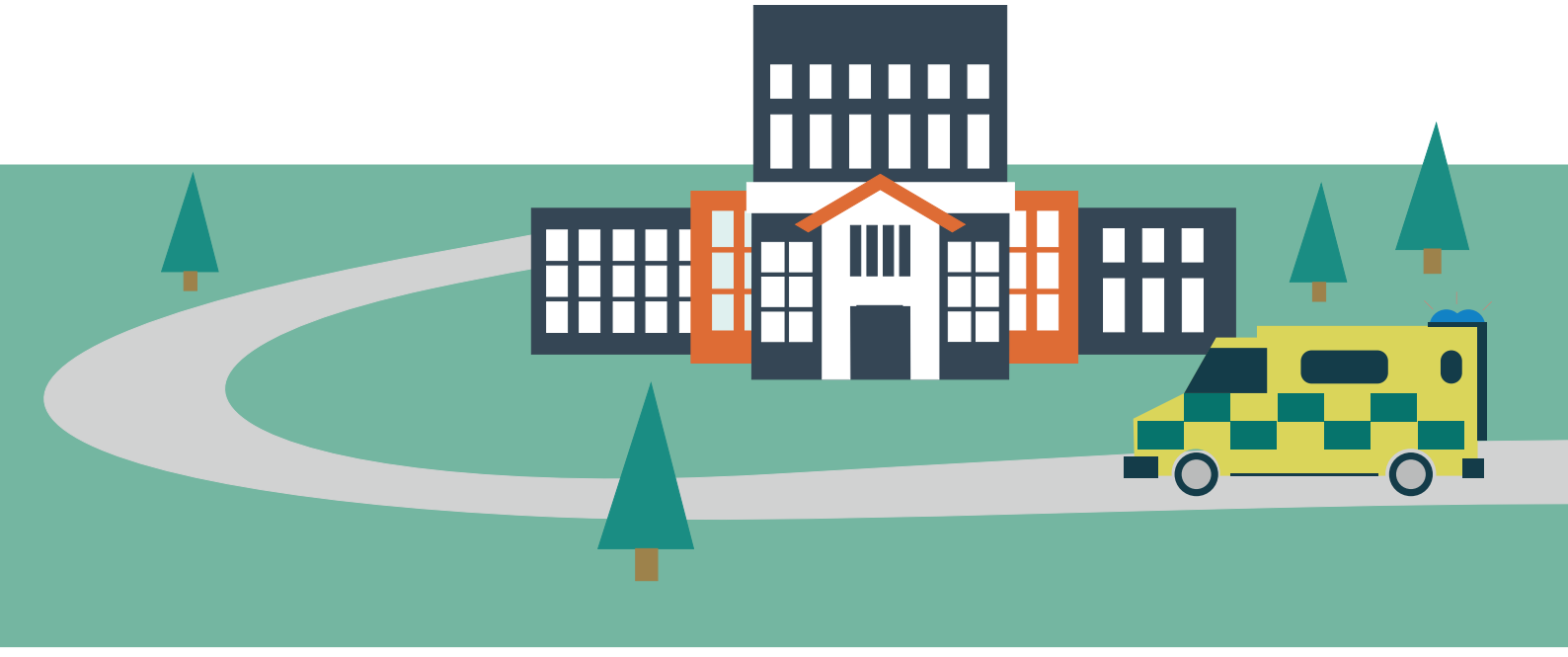
Overall, we found that handover processes across Wales were broadly similar. There were, however, some variations in processes between each individual EDs within health board areas, and some disparities with the processes in place across health boards in Wales. This was due to local joint SOPs being in place within WAST and EDs, due to geographical layouts of ED environments, staff roles and levels of staffing available. We will elaborate further on these inconsistencies and the risks associated later within the report.

Since the start of the pandemic, we found that handover processes were consistently reviewed to meet the evolving national COVID-19 guidance. This included social distancing guidance and admission routes into EDs to support Red and Green pathways, and processes were changed to align with this to maintain patient and staff safety.

Pre-alert calls

In emergency and life threating situations, there are consistent arrangements in place across Wales for ambulance crew to provide pre-alert calls to a dedicated phone in ED, to notify staff of inbound patients who require immediate attention. For example, with patients experiencing cardiac arrest, difficulty breathing or heavy bleeding.

Pre-alert calls allow time for ED staff to prepare and prioritise for the arrival of the patient. Upon arrival to ED, ambulance crew immediately transfer the patient to an allocated space for assessment and treatment by the ED team. Once the patient transfer from ambulance stretcher to an ED trolley is complete, a formal dual pin handover[12] is completed between ED staff and ambulance crew, and is documented on the Hospital Arrival Screen (HAS).



12 Dual Pin Handover refers to an element of the handover process where both a paramedic and ED staff nurse communicate the formal handover of care, with each entering their pin number into the hospital arrival screen. Welsh Government statistics relating to handover times are generated as a result of the timings of the dual pin handover process.

We were informed that ED staff regularly monitor the HAS for inbound ambulances. When patients arrive by ambulance (not requiring a pre-alert), an ambulance crew member registers the patient either at the ED reception, or with a dedicated ambulance receptionist, which in some EDs is a dedicated role. Patients are triaged[13] (assessed) either on board the ambulance or within a designated triage area of the ED, dependent upon capacity.

Dual pin handover process

The handover process involves both a paramedic and ED staff nurse communicating the formal handover with each entering their pin number into the hospital arrival screen. Welsh Government statistics relating to handover times are generated as a result of the timings of the dual pin handover process.

We received negative comments from ambulance crew in our survey regarding the timing of the formal handover to ED staff. They stated that at times, ED staff may complete the dual handover process and patients would be classified as handover complete whilst the formal handover was still taking place.

In addition, we received 15 comments from ED staff who provided an insight from their perspective, around the difficulties that hospital staff are facing with the dual pin process. One comment included:

> *"As ED staff - once the ambulance verbal handover is complete and a patient is in the care of the ED in an appropriate area, I find it very frustrating to have to spend extra time chasing the ambulance crew, often back outside for their PIN number to clear the crew from the HAS handover screen. Ambulance crew are also sometimes reluctant to provide their PIN number to ensure a timely handover. This takes extra time which removes nurses from providing care to patients."*

In response to our self-assessment evidence from WAST, we were told that the dual pin handover process has led to improved data quality when examining the lost hours due to hospital handover delays. However, during our fieldwork interviews with ambulance crew, the issue of inaccurate handover recordings was repeatedly highlighted, which supported our findings from the staff survey. Correct application of the dual pin process will ensure that accurate timings of handovers are recorded and reported on by Welsh Government.

13 Triage is the process of determining the priority of patients' treatments by the severity of their condition or likelihood of recovery with and without treatment.

We also received a number of concerns around the process for dual pin handover from health board self-assessments, where the process is not consistent between hospitals or across health boards. Some said that the processes in place does not always provide an accurate picture of handover timings.

Recommendation

WAST should engage with health board representatives to ensure there is improvement in practice between ambulance crew and ED staff to ensure the dual pin process is consistently followed, and ensure Welsh Government reporting data is accurate.

Patient triage

We found variation across Wales in the staff roles that undertake triage assessments. This ranged between dedicated ED Triage Nurses, dedicated Ambulance Triage Nurses, the Nurse in Charge, or a Rapid Assessment Team (which may include a registered nurse, ED doctor and Healthcare Support Worker).

Across Wales, it is the aim is to commence triage within 30 minutes of patient arrival at ED, in line with the Welsh Government target. Patients are triaged using the Manchester Triage System[14], which enables the triage clinician to assign a clinical priority, according to the patient's presenting signs and symptoms. Data published on the NHS Wales National Collaborative Commissioning Unit (NCCU) website[15] for its Urgent and Emergency Care Programme highlights that on average, between October 2020 and July 2021, patients are being triaged within 30 minutes.

If, following triage, patients are deemed as 'Fit to Sit', meaning people are well enough to sit within the ED waiting area, they are transferred from the ambulance and escorted to the ED waiting area, and a dual pin handover between ambulance crew and ED staff takes place.

When patients are not considered to be suitable to stay in the waiting room, the patients are usually offloaded from an ambulance and transferred to an appropriate area according to clinical priority. If there is no capacity within the ED to accept patients from the ambulance crew, they will remain on board the ambulance until a space becomes available.

Following triage, we found a commonality across Wales where patient investigations commence, such as blood tests, X-rays or Computerised Tomography (CT) scans. Where appropriate, other time critical procedures and/or treatments are also commenced, such as Sepsis and Stroke pathways. This will commence regardless of ED space, and will include patients located on board ambulances.

Mitigating risks for patients arriving by ambulance

We asked health boards how they identify, manage, and mitigate any risks associated with patients arriving on ambulances. Each response highlighted the aim to achieve a 15 minute handover time for patients arriving at ED. When this is achieved, and an ambulance is released, it is beneficial to the patients' condition, positively impacts on their experience, and further benefits those awaiting an ambulance resource within the wider community. However, our review has found that this target is not often met across Wales.

14 The Manchester triage system is an algorithm based on flowcharts and consists of 52 flowchart diagrams (49 suitable for children), that are specific for the patient's presenting problem. The flowcharts show six key discriminators (life threat, pain, haemorrhage, acuteness of onset, level of consciousness, and temperature), as well as specific discriminators relevant to the presenting problem. Selection of a discriminator indicates one of the five urgency categories, with a maximum waiting time ("immediate" 0 minutes, "very urgent" 10 minutes, "urgent" 60 minutes, "standard" 120 minutes, and "non-urgent" 240 minutes)

15 NCCU – Urgent and Emergency Care Programme https://nccu.nhs.wales/urgent-and-emergency-care/experimental-kpis/

During times of increased pressure and numerous ambulances waiting to hand over the care of their patients to ED staff, a WAST Duty Operational Manager (DOM), may attend the hospital site, to provide welfare support to ambulance crews who are unable to offload and handover their patients. This is a new role that has been introduced by WAST. The DOM will provide cover for ambulance crew to take their breaks, and/or help enable crews to finish their shift on time, by taking over the care of the patient. The DOM will also liaise closely with ED staff and the hospital site managers, to plan what action is required to progress and facilitate the handover of patients to the care of the ED staff.

Health boards also highlighted to us the benefits of the role of Ambulance Patient Flow Co-ordinators or HALO within the EDs. Their role is to assist in achieving a timely handover, and to maintain effective communication between ambulance crew, ED staff and patients. In addition, they aim to reduce delays by helping to mitigate risks to patient safety on board an ambulance, by minimising long waits outside ED, which in turn will benefit those waiting in the community for emergency care. Furthermore, the role also aims to improve the overall experience for patients, by working with ambulance crew in providing care. Our review has found that where these roles have been introduced, they have helped to ease some of problems associated with the handover process and have been beneficial to patient experience as a consequence.

During times of delayed handover, we identified that ambulance crews monitor the patient's condition and escalate any concerns to the ED nurse in charge. In the event of a patient's condition deteriorating further, ambulance crew will enact a formal process for escalating a clinical concern with a deteriorating patient outside the ED. We will elaborate further on the effectiveness of this process later within the report.

We also found consistently across Wales, that during periods of high demands on the service, such as multiple delays with handover, each hospital has an internal escalation plan which is actioned, and plans are implemented with the to aim to reduce ambulance offload delays.

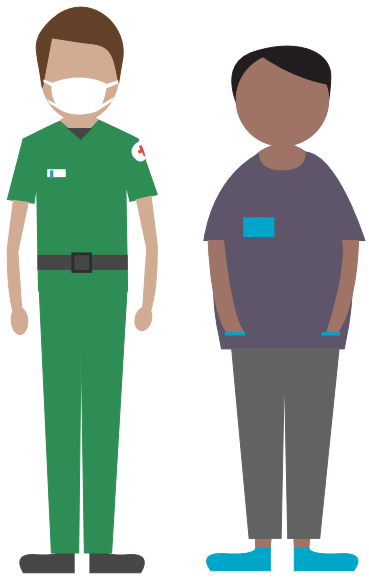
Other consistent measures in place across Wales are regular hospital patient flow meetings and hospital bed management meetings. The meetings allow staff to assess the availability of hospital beds, and to monitor the capacity within ED and the number of ambulances waiting to handover. However, despite these measures, the problem of prolonged handover remains an issue.

Strengths with handover processes

Health boards were asked to tell us about the strengths they have identified as part of their handover processes. Across Wales, there was unanimous agreement that EDs have introduced an effective COVID-19 point of contact testing, where patients are tested for the virus at their point of entry, and are allocated a waiting area based on their expected or predicted status for the virus. Some health boards highlighted an improvement with patient flow, as a result of point of contact testing particularly during the height of the pandemic, which resulted in reduced delays with transferring patients to wards.

During our interviews with ambulance crew, they spoke of the positive impact on handover, as a consequence of the roles of the dedicated Ambulance Triage Nurses or Ambulance First Point of Contact. As mentioned, staff in these roles determine the level of acuity of patients arriving by ambulance, and assist in helping to achieve 15 minute handover targets and to commence triage within 30 minutes of arrival.

Ambulance crew also highlighted that dedicated ambulance receptionists help make the handover process more efficient in enabling them to register patients upon their arrival. The role of the HALO or Ambulance Flow Co-ordinator was also reported to help assist with handover and relieve pressure from the Ambulance Triage Nurse. We found that the introduction of these roles assists in improving the patient experience and welfare by providing positive links for effective communication between ambulance crew and ED staff. However, the presence of these receptionist, liaison, and patient flow roles is not consistent across each ED in Wales.



We were told that patients are re-triaged once clinical interventions have been initiated on board ambulances. As a consequence, any improvements in a patient's clinical condition could expedite their admission to the department, for example if they are assessed as 'Fit to Sit' in the ED waiting area. In addition, in some instances, patients may be well enough for discharge, to recover at home.

Areas that require improvement

Health boards highlighted some areas that require strengthening with handover. There was unanimous agreement across Wales that improvement is required with patient flow through hospitals, in order to improve bed availability and trolley space capacity within EDs. This included improvement in the timely discharge of patients from hospitals, to assist with patient flow. This would lead to improved patient handover times from ambulance crew to ED staff, an improvement in the overall patient experience, and benefits to timely care with emergency responses in the community.

We found that improvements need to be made in relation to collaborative working between WAST and health boards, particularly in regards to communication and the management of serious incidents arising from delayed handover. There is a need to ensure health board representatives regularly attend WAST SCIF meetings, to enable timely management of concerns and to develop action plans and feedback throughout the organisations. This is referred to in more detail later within this report. Whilst there appear to be robust processes in place for triage, initiating treatment and handover process, issues remain with delayed handover due to the lack of bed space within ED and the wider hospitals, which significantly affects patient flow.

Recommendation

Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process the handover of patients from ambulances.

Health boards must ensure that appropriate representation is present at WAST Serious Clinical Incident Forum meetings, to aid with the timely management of concerns and service improvement.

Staff perceptions of the handover process

We considered the perspective of ambulance crew and ED staff of the handover process. This was achieved through our staff survey and our interviews with ambulance crew.

Through our staff survey, we found that 90% of ED staff were familiar with the handover policy for their hospital. This was slightly less for ambulance crews, with just over three quarters of them aware, although with a slight increase in number for their most frequented hospital. These numbers give rise to concern, as it is suggestive that some ED staff and ambulance crews are unfamiliar with handover policies.

The majority of ambulance crew respondents also expressed frustrations of their experience of waiting outside hospitals and their dissatisfaction with the handover process in place both at a local level and nationally. We had a strong response on the comment section for this area with almost half of WAST respondents providing additional detail when sharing their experiences.

The comments enabled us to identify some key themes such as, some ambulance crews told us that handover processes frequently change and they are not familiar with current practices. Ambulance crew who regularly attend more than one ED also face the challenge in different local practices. Some said that processes differ day to day, and that each clinician and member of ED staff implements them in different ways therefore, making it difficult for staff to remain up to date with current processes. There are variations in processes due to local SOPs, geographical layout of each environment, job roles and levels of staffing. It was also highlighted to us that the impact of the pandemic on practices has been that it is challenging for staff to stay up to date with current processes.

Recommendation

If and where local standard operating procedures are absolutely necessary, WAST and health boards must work together to ensure that ambulance crew are familiar with the handover policy for that ED.

Ambulance crews also provided their comments in our survey on their view of the effectiveness of the hospital guidance issued by Welsh Government in 2016 process. These included:

"The process seems to be centred around ambulance turnover rather than a focus on patient care. This in turn creates more delays for ambulances as the processes put in place differ day by day, nurse by nurse as there is no full understanding of what the procedure should be. My experience has been waiting upwards of 30 mins just to notify the hospital of our patient. That's before they are booked into the department and triaged."

"ED staff are excellent and do as much as they can to assist/handover patients however they cannot do this when there are not beds available. It is not appropriate to manage patients on the back of an ambulance for several hours and should be avoided where possible."

"There is a reluctance to follow the 'Fit to Sit' agreements that the Welsh ambulance service have in place."

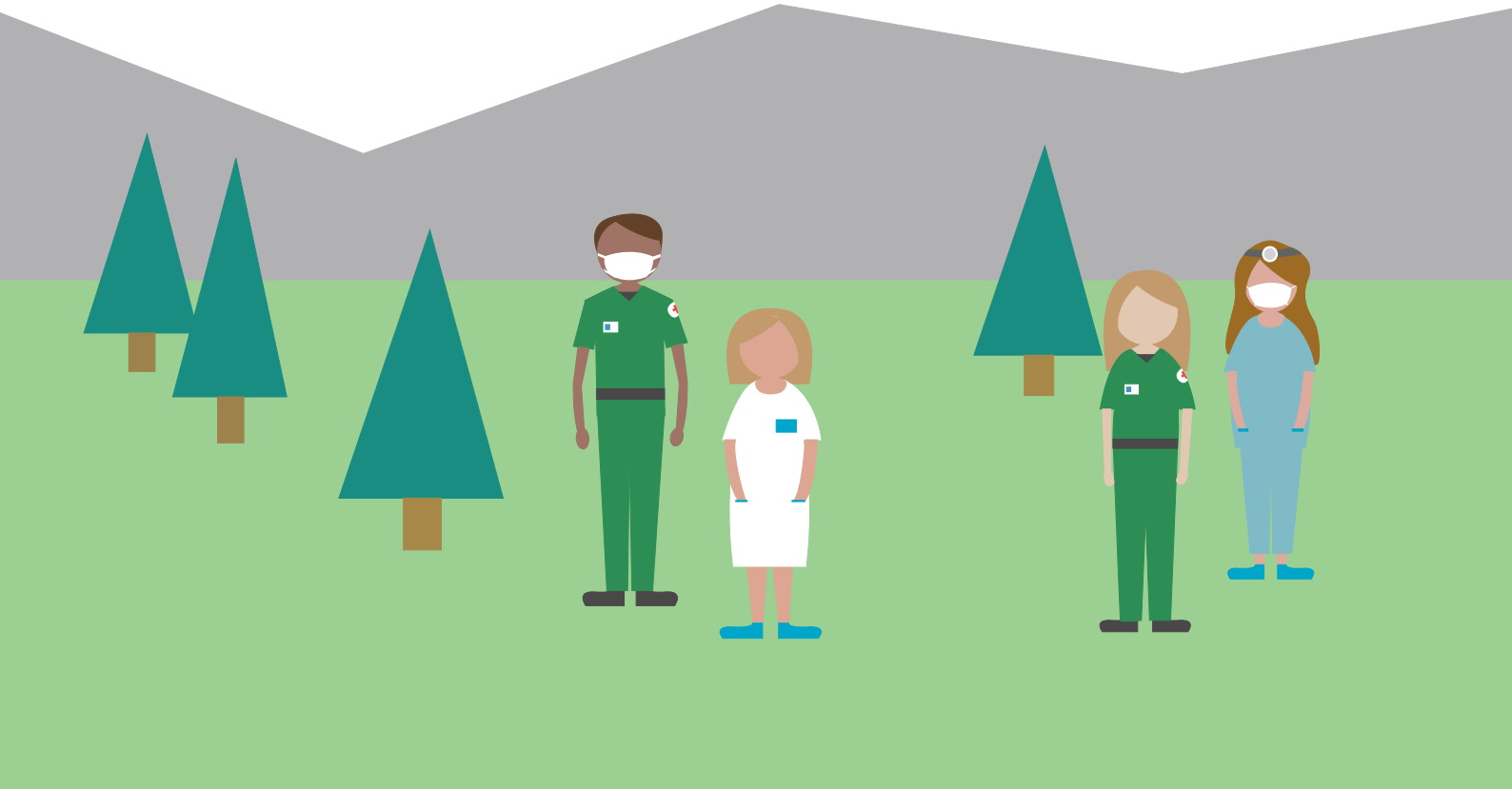
Our staff survey responses noted ambulance crew sometimes attend EDs within England. Concerns were highlighted that handover delays have become routine in Welsh hospitals, and are less frequent in England. A number of ambulance crew provided their opinions to us during interview, that handover processes within EDs in England are more efficient than the processes in place in Wales, which compound the frustrations with handover delays across Wales. Comments from ambulance crew included:

"Patients waiting in the community are coming to a wide range of harm due to no ambulances to send to them due to the ambulances being queued outside hospitals. I've recently transferred to Wales from England and this problem very rarely happens in England but is a daily problem in Wales. Very poor."

"When I visit other ED outside of Wales, we take the PT straight in to EDs, even large City EDs. But for some reason Welsh EDs struggle with this."

Relationship between ambulance crew and ED staff

Throughout our interviews, ambulance crew told us that in general, positive relationships had been formed with ED staff across Wales. We were told that both parties were working towards the same goal of achieving early handovers to release ambulance crews to respond to emergencies. However, this was not consistent with our survey results, with 71% of ambulance crew stating that they did not feel ED staff and the service provided by ambulance crew worked together to provide seamless patient treatment and care. However, 69% of ED staff felt they work together with ambulance crew to provide seamless patient care.



One comment received from a member of ED staff highlighted:

"There is no single issue which would resolve the problem, neither is it solely a problem of a specific group. Again, I would like to reiterate that ED is locked between a rock and a hard place; trying our best but with many obstacles in our way. We used to have a really positive working relationship with our WAST colleagues which has deteriorated over time."

The findings from our survey and interviews suggests a mixed relationship, and issues can occur on a case by case basis. We recognise the pressure and intensity that handover delays must have on both ambulance crew and ED staff to minimise risks to patients, and that working relationships may be strained as a consequence. However, this can have a negative impact on the overall patient experience.

We also found through our interviews and staff survey that ambulance crew feel their vehicles are used inappropriately, and as an extension of the ED. The term 'warding' was commonly used to refer to this. Ambulance crew told us that ambulances are used as waiting rooms or additional beds, with many staff elaborating that a bed shortage within ED is the reason for this.

We also learned that patients are often taken off an ambulance for scans or other investigations, and returned to the ambulance due to no capacity in the EDs. We were also told about occasions when following investigations and treatment, patients who did not require hospital admission, were transported home by the same ambulance crew who had responded to the initial emergency call. Some ambulance crew also said that hospitals manage their own risks by keeping patients on the ambulance. Comments from ambulance crew included:

"The feeling that the patient isn't the problem of the hospital until they get in through the front doors is widespread. We are extended waiting rooms for the hospitals and this shouldn't be the situation."

"The current system is not working, emergency departments are using ambulances to treat patients in and this is not what they are intended to do. While this is happening and we are waiting to handover our patients there is patients within the community not getting the medical help needed for many hours."

"The problems with handover are not due to WAST. The issue is severe overcrowding of the EDs which then leads to lack of ability to offload. The systems in the hospitals prioritise patients who have been seen and treated (inpatients) over patients who have not been seen or treated by the ED which is wrong and unsafe. As well as this, having ambulances stacked outside causes there to be increased response times by WAST. So in turn, we are prioritising seen and treated patients (inpatients) over those waiting for an ambulance…..The subsequent problems of even more overcrowding that will cause, will lead to innovation within the hospital. Unless we bring the problem into the hospital, the hospital will not solve it."

As highlighted earlier, the role of ambulance crew is to provide an emergency response and transportation for patients to EDs. Welsh Government guidance is clear that patient care should be handed over to hospital staff within 15 minutes of their arrival, but most certainly before 60 minutes.

Ambulances are designed as a pre-hospital environment and are equipped to transport ambulance crew and other first responders to the waiting patient. The vehicles carry equipment for administering emergency care to treat patients at the scene, and transport patients when necessary to EDs for advanced treatment. They are not designed and equipped for patients to be cared for during periods of extensive waits outside EDs. The impact of patients remaining within the back of an ambulance can negatively impact on the patients' experience and their safety.

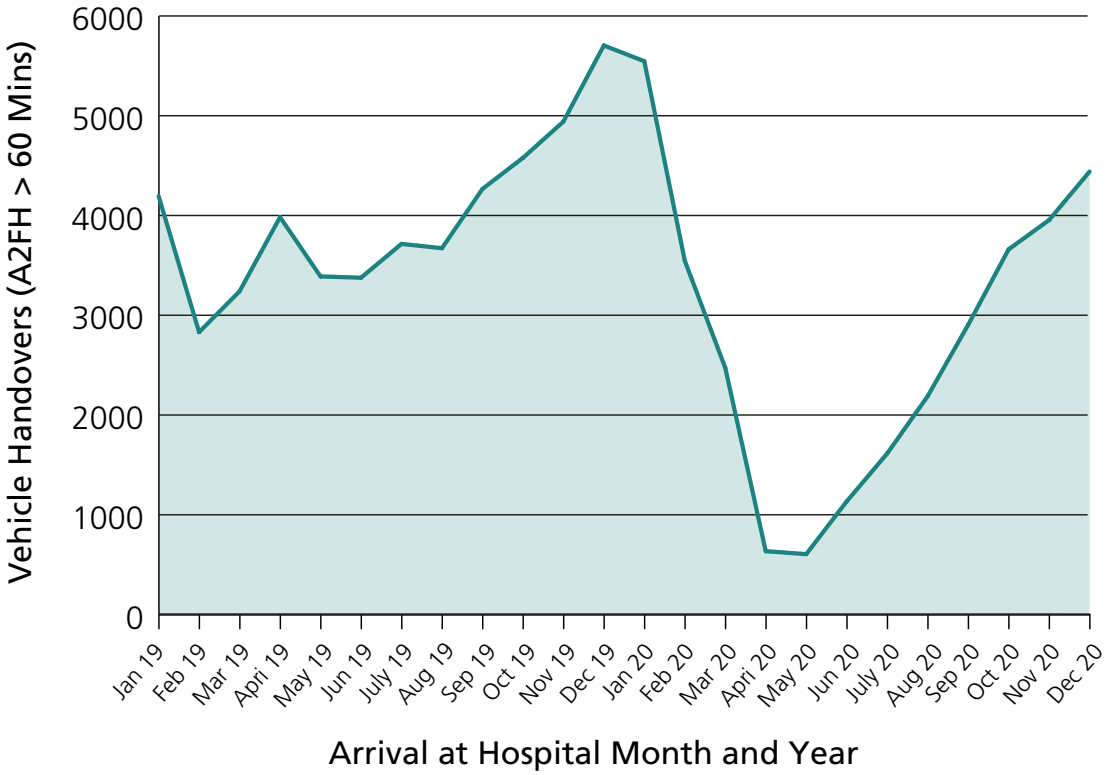
Patient experience

Impact of the pandemic on patient experience

The NHS Wales activity and performance summary highlights fewer attendances to all NHS Wales EDs during the first wave of the pandemic, with April 2020 seeing the lowest number of attendances at ED since current reporting began in 2012.

Handover delays during the first wave of the pandemic were substantially lower. We were informed that this was the result of a significant decrease in demand, and an initial pandemic response to improve hospital capacity. This is highlighted in the chart below, which reflects the number of patients who experienced handover delays over 60 minutes across all health boards in Wales.

Trend of number of Patiens Waiting >60mins



We considered the views of patients on whether the pandemic impacted on their experience of attending the ED. In the public survey responses, the majority said they were not displaying COVID-19 symptoms, and were not attending ED due to suspected COVID-19.

It was positive to learn that the majority of respondents felt that measures to minimise the spread of COVID-19 were being followed by both ambulance crew and ED staff. The majority of respondents said all staff wore PPE on the ambulance and at hospital, their temperatures were taken on arrival at hospital, and they were transferred to a designated green areas away from suspected or positive COVID-19 patients. However, we did find in a small minority, where some concerns were highlighted in the survey, as highlighted below:

"Unfortunately dad was infected with COVID in hospital."

"We were all asked to wear masks in the house whilst the paramedics were there. However, I noticed that although the crew were wearing masks they weren't wearing any other form of PPE."

Overall, our findings reflect that despite the severe impact of the pandemic, it did not negatively affect the experience of patients who used emergency ambulances services across Wales, and on the whole patients were satisfied with the care provided. Our COVID-19 themed national review report[16] highlights further our understanding of how healthcare services across Wales met the needs of people and maintained their safety during the pandemic.

Patients awaiting ambulances in the community and their arrival at the ED

Standard 5.1 within the Health and Care Standards 2015[17] states that all aspects of care should be provided in a timely way, ensuring people are treated and cared for in the right way, at the right time, in the right place and with the right staff.

Of the 137 responses to our public survey, approximately half waited under an hour in the community for an ambulance to arrive, with most waiting less than 30 minutes. However, 26% of respondents waited between one and four hours, and 22% waited over four hours. For those who waited over four hours, each commented that they felt their health condition deteriorated over this time. Around a third of these patients were admitted immediately into the hospital on arrival, however, another third had a further wait of over two hours on-board an ambulance following arrival at the hospital.

We received several concerning comments from people about prolonged ambulance waits, despite the possibility of them experiencing a stroke, heart attack or other serious health concerns. Comments included:

"I waited over 2 hours for an ambulance after having a stroke. Ambulance never showed. First responder arrived at 2 hours and tried to get an ambulance and was told none available."

"Things could have been a lot worse as Dr said by rights my dad should not still be here after having to wait 3hrs whilst having a major heart attack."

Several people in response to our public survey highlighted long waits of between four and 13 hours for an ambulance after sustaining an injury due to falls at home, particularly in relation to older adults. Long waits in the community were also substantiated by ambulance crew in response to our staff survey and during our fieldwork interviews. Staff highlighted that the risk from handover delays is not only to the patients waiting in ambulances but also to patients in the community, who are waiting for an emergency response.

16 HIW COVID-19 National Review Report
17 The Health and Care Standards 2015

Comments included:

"Patients queuing up in ambulances probably have the same outcomes as patients in the ED, as HB clinicians will always see and treat our patients. It's the patients that are waiting for ambulances that are most at risk."

"Handover delays impact me and my patients negatively as I am often on scene with an unwell patient waiting for an ambulance to become available. It is common to have to wait 2-4 hours for 'emergency' backup. This can be very detrimental to patients and is hugely stressful for me. I have been on my own with patients having multiples seizures, heart attacks or severe breathing difficulties for 1-2 hours. As well as patients likely to come to harm, this is very stressful for me and affects my mental health."

Throughout our fieldwork, the majority of ambulance crew interviewed expressed their frustrations of waiting outside EDs to handover patients, in the knowledge that patients are waiting in the community in need of an emergency response. This is consistent with the findings highlighted in the Amber Review report in 2018. These patients have not been physically assessed by a clinician and therefore, their clinical condition is unknown. This is particularly concerning for conditions such as strokes or heart attacks, where time critical treatment is essential due to specific therapeutic window timescales, and any delays to treatment may negatively impact on their clinical outcome, future rehabilitation or even their life.

People indicated in the survey comments, that due to long ambulance waits they sometimes had to arrange alternative transport, such as driving their loved one to the hospital or arrange a taxi. Comments included:

"Ambulance wait time over 2 hours. This was not made clear at 999 call only that an ambulance has been requested. After 2nd call to 999 after half an hour I was told it could be 2 hours. Took him in the car and hospital was excellent. Could and should have gone sooner if wait time had been honest in the first place."

The risk to patients in the community was a key finding from our previous review of WAST in 2019/2020, and has been repeatedly highlighted by staff throughout this review.

As referred to earlier in this report, a recommendation was made in our previous report that WAST should consider a holistic review with stakeholder engagement, of the current handover arrangements in place, which should include current escalation arrangements during periods of high demand. Whilst we are satisfied that progress has been made, this re-iterates the need for Welsh Government to ensure a prompt collaborative approach between WAST, health boards, and social care services within Wales, to make improvements with the ongoing patient flow issues.

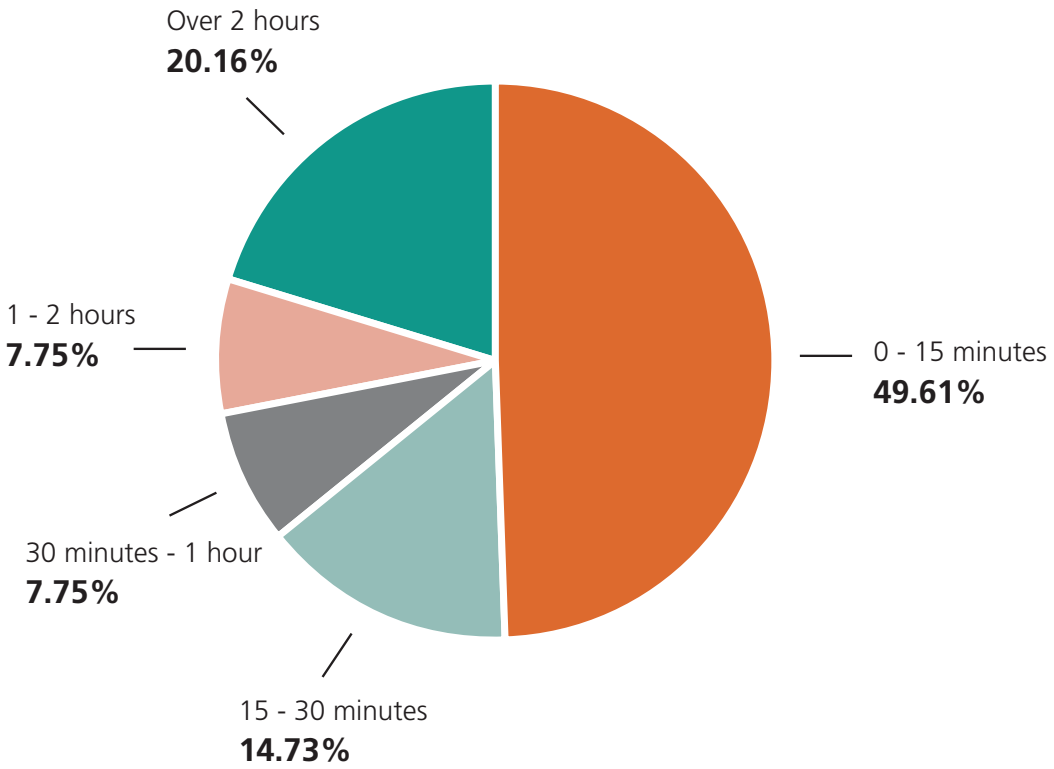
Patient experience with handover and triage

We asked patients in our public survey to tell us about their experience during handover between ambulance crew and ED staff. As highlighted earlier, the Welsh Government target for patient handover to the ED team, is within 15 minutes of arrival at the hospital.

Our public survey identified that only half the respondents said they were admitted to ED within 15 minutes. A further 15% waited between 15 to 30 minutes, and a minority waited between 30 minutes to 2 hours. However, 1 in 5 patients told us they waited over two hours in the ambulance, before being handed over to the care of ED staff.

"I had a four and a half hour wait for the ambulance which had been requested (highest priority) by my GP in the surgery. On arrival at the hospital there were 17 ambulances waiting to hand over the patients. I was waiting for a further three and a quarter hours."

How long did you wait in the ambulance, one it arrived at the hospital, before being admitted into the emergency department?



As highlighted earlier in the report, any delay over 60 minutes should be the exception. Prolonged patient waits on board an ambulance are not acceptable, in particular for those who may have already waited for long periods for an ambulance in the community.

Our public survey highlighted that the majority of people who engaged with us were triaged within 30 minutes of arrival at the hospital. This is in line with Welsh Government targets and data available on the NCCU website for its Urgent and Emergency Care Programme. However, around a quarter reported that it took longer than 30 minutes. Whilst most patients were assessed in hospital, 30% reported that assessment took place on board the ambulance. Only a few patients told us they had been assessed in hospital and then taken back to the ambulance.

We received one comment from a patient who reported 17 ambulances were outside the ED at the time that they attended, waiting to handover patients to hospital staff. This is concerning and reflective of the difficulties ambulance crews and ED staff are frequently facing.

A quarter of patients told us they received treatment from ED staff whilst on board the ambulance, but most remained under the care of the ambulance crew. One patient told us that no ED staff assessed them for the duration of their time on board the ambulance, whilst another said:

> *"I was in the ambulance from 8.30am to sometime around 4pm. A doctor paid a number of visits and also nursing staff to take blood and to give me painkillers."*

We asked patients to provide their views on the triage/assessment process upon their arrival at the hospital. Comments we received were mixed, with some stating that it worked efficiently and they were seen immediately, however, there were a number of comments about how long it took to be seen upon their arrival at hospital. One commented included:

> *"After assessment and excellent care and treatment by ambulance personnel I was treated almost immediately after arriving at hospital by a superb team."*

Whilst it is positive that most patients were triaged within 30 minutes, it is concerning that not all patients were assessed by a health board clinician in the appropriate timeframe. This can negatively impact on the patient experience and clinical condition, when they are not reviewed in a timely manner.

As part of our review, we also considered communication with patients' relatives/carers. We found a clear divide, with half stating that relatives were kept updated, and half stating they were not. Comments indicated that ambulance crew communicated well with relatives, to update them on what was happening. However, only half of the survey respondents said they were kept informed about how long the wait on board the ambulance would be. Our survey highlighted that communication once the person was admitted to hospital was experienced as variable.

Our interviews with ambulance crew indicate that they always endeavour to engage with and build a positive rapport with patients. However, they said that during periods of long delays, there are limitations to the number of times they can apologise to patients and their loved ones, either for the delays they experience whilst waiting for an ambulance in the community, delays outside the hospital, or at both locations.

The hospital handover guidance issued by Welsh Government in 2016 is clear, that when delays occur patients and their relatives or carers should be kept fully informed of the reasons and the progress being made in resolving them. We recognise that it may not always be possible to provide accurate timescales to people, since the clinical priority of patients for handover to ED is continuously assessed and changing. However, the importance of clear communication with patients to ensure they are informed of the reasons for delay, is key in alleviating their anxieties or frustration with waiting.

Recommendation

WAST and health boards need to ensure that when delays occur, patients and their relatives or carers should be kept fully informed of the reasons and the progress being made in resolving them.

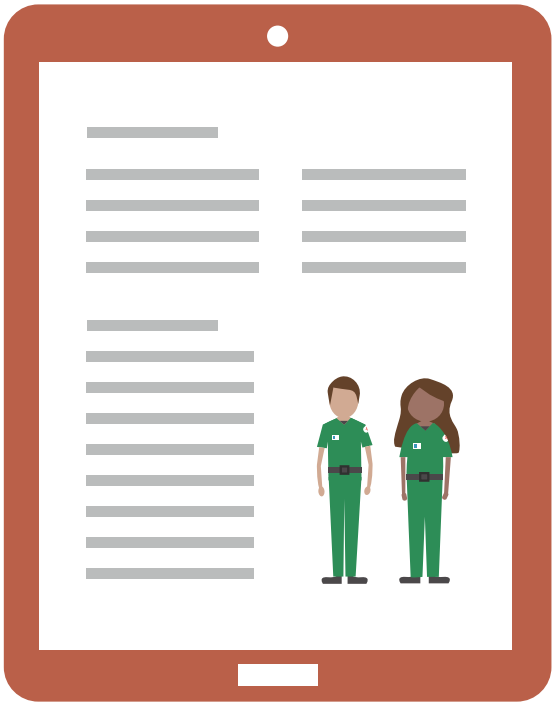
WAST and health boards across Wales should ensure patient feedback is obtained regularly to understand their experiences of long waits on board an ambulance, in order to inform improvement.

Delayed diagnosis and treatment

Although a minority, several views were communicated to us from people in our public survey regarding ineffective diagnoses made by both ambulance and ED staff. It also included a few dissatisfied comments about ineffective diagnosis and treatment of conditions once admitted.

> *"If there's a documented history of sepsis. Surely the sepsis protocols could be followed."*

We also received comments from ambulance crew relating to the delays in treatment and diagnosis for patients by ED staff. The comments included concerns where a patient's health could deteriorate whilst on board the ambulance, such as a patient experiencing chest pain.



Other comments from WAST staff suggested that they believe diagnosis should commence whilst the patient is waiting on board the ambulance, such as blood tests and x-rays. This somewhat contradicts the self-assessments completed by health boards which suggest that ED staff do commence investigations, diagnosis and treatment while the patient is on board the ambulance. This suggests that the commencement of investigations whilst the patient is on the back of the ambulance does not consistently happen across all EDs. The comments included:

"Our patients are left stuck on ambulances without having bloods etc. done which could speed up the process for them to discharge patients. There should be a system for WAST staff to take bloods and take patients for x-rays or appropriate investigations whilst waiting outside hospitals as it benefits the patient and the staff at the hospital."

We believe that commencing investigations whilst the patient is on board an ambulance has a benefit of earlier diagnosis, admission or even discharge of some patients, which could enable ambulance crews to be released, to undertake their primary role as providing on scene urgent or emergency care, and urgent or emergency transport of patients to hospitals.

Recommendation

WAST and all health boards across Wales must work together to identify a consistent approach in providing timely investigations and treatment for patients on board ambulances, to enable ambulance crews to be released quickly.

Patient privacy and dignity

Standard 4.1 within the Health and Care Standards 2015, states that people's experience of care is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical, psychological, social, cultural, language and spiritual needs.

In its handover guidance, Welsh Government states that the safety, effectiveness and dignity of care of patients must be at the forefront of systems of emergency care.

As highlighted earlier, our review considered how delayed handovers impacted on the privacy and dignity of patients on board the ambulance. This included the toilet needs of the patient either within the ED, or on board the ambulance.

Overall, our patient survey highlighted that patients were very positive about their experience waiting on board an ambulance due to delayed handovers. We received very positive feedback about ambulance crew, particularly in relation to their kindness, overall communication and managing of distressing situations. Patient comments included:

"The ambulance service went above and beyond."

"They were excellent, really helped with my mother-in-law's anxiety and kept us fully informed throughout."

Nearly all who engaged in our public survey said they were treated with dignity and respect by ambulance crew, and felt safe and cared for, and that staff were knowledgeable. Most also said they felt ambulance crew treated their condition effectively. Patients also indicated that they were satisfied by the care and treatment from ED staff.

The results of our staff survey, however, were not as positive in relation to their ability to maintain patients' dignity during delayed handovers. For ED staff, whilst 78% felt that patients were well cared for on board ambulances, only 68% said that the patient's privacy and dignity is maintained. In addition, only 62% of ambulance crew were felt that patient privacy and dignity is maintained.

This was also highlighted in our interviews with ambulance crew, with some specifically raising concerns with their ability to maintain the privacy and dignity of patients. The comments included:

"Patients never provided with reason as to why they are waiting on an ambulance or have to endure the indignity of using a commode on an ambulance."

"The biggest issue I have come across resulting from patients waiting for many hours on the back of an ambulance is that comfort and dignity is compromised. The ambulance stretcher is not designed for patients, especially elderly patients with thin skin to be laying on them for hours. Also, during long waits patients often need to go to toilet and as a result of very poor mobility end up soiling themselves. So to preserve their dignity we clean them up as best we can with very limited items as it's an ambulance and not a hospital ward."

One area of concern consistently highlighted by ambulance crew, was the difficulty in facilitating patients to access a toilet during their wait. Whilst most patients told us they were able to access a toilet, it is concerning that some patients reported they did not have access to facilities. In addition, during our staff interviews, concerns were highlighted by numerous ambulance crew with the difficulties encountered in assisting patients to use a commode or a bedpan on board an ambulance, due to the limited space available. Some also expressed concern over appropriateness, when two male ambulance crew were required to assist female patients with their toileting needs.

Wherever possible, ambulance crew told us they take patients inside the ED to use the department's toilet facilities, and request nursing staff assistance as appropriate. Overall, staff highlighted the issues with accessing toilet facilities as having a negative impact on patient privacy and dignity. Whilst ambulance crew told us that every effort is made to help maintain patient dignity, they described this as not always possible.

It was positive to note in one ED, that the ED sister attends the ambulance bays to enquire whether patients require the use of a toilet, and ensures staff are available to assist them. Patients are taken inside the ED whenever possible, or assistance is provided on board the ambulance.

Good practice in toilet management can help patients to maintain their dignity. Whilst we acknowledge the efforts made by ambulance crew to protect patient dignity, further efforts are required by both ED staff and ambulance crew to ensure all patients can access appropriate toilet facilities to maintain their privacy and dignity at all times.

Recommendation

Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.

Preventing pressure and tissue damage

It is highlighted within Standard 2.2 of the Health and Care Standards 2015 that people should be helped to look after their skin, and every effort should be made to prevent people from developing pressure and tissue damage.

In response to our staff survey, ambulance crew raised concerns around the suitability of ambulance stretchers for patients who experience long handover waits. In particular, for patients who are immobile and lying on a trolley on board an ambulance are at an increased risk of sustaining skin tissue pressure damage. We received numerous comments from ambulance crew which included:

"Patients are regularly suffering due to excessive handover delays. Ambulance stretchers are not designed for prolonged use and vulnerable patients are being put at risk of pressure sores and other tissue viability issues despite the efforts of ambulance staff to turn and adjust their positions."

"Often waiting outside with a patient for extended hours anywhere from 2 to 12 hours with a patient on an ambulance stretcher that is not designed for. Hard to give pressure relief to patients especially the heavier ones."

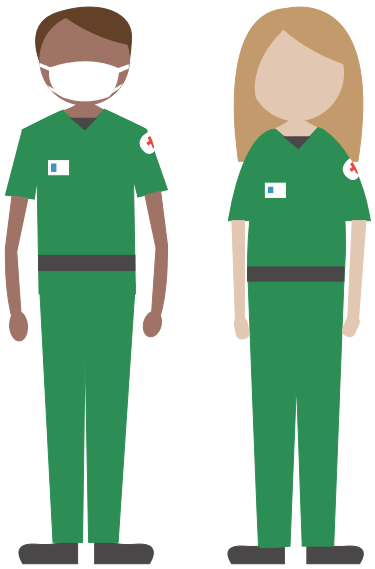
We were told during our interviews with ambulance crew that they are required to undertake an on-line clinical training module on the risk of pressure damage and pressure relief. However, despite their knowledge and understanding of the risks, and crew efforts to mobilise patients where appropriate, staff told us it can be very difficult to prevent skin tissue pressure damage for all patients. This in particular is an issue for patients, such as those with a suspected fractured neck of femur or spinal injury, who cannot be appropriately moved.

In addition, there is an increased risk of skin tissue damage with patients over 70 years of age, as a result of frailty and/or decreased mobility and/or poor nutrition and hydration on board an ambulance. Given the patient demographics provided to us by WAST, the majority of patients taken to EDs by ambulance are aged 65 and above, which highlights additional concerns associated with long patient waits outside ED.

We acknowledge the efforts made by both ambulance crew, and ED staff who support them, to help provide pressure relief and assess patients' skin for signs of pressure damage on arrival to ED. However, we are concerned that the risk of skin tissue damage remains for all patients experiencing long handover delays, in particular older adults, and will continue until prolonged handover delays are resolved.

Recommendation

During prolonged handover delays, WAST and health boards must work collaboratively and consistently, to minimise the risk of skin tissue damage for patients.



Nutrition and Hydration

Standard 2.5 of the Health and Care Standards highlights that that people should be supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury.

During our review, we considered how patients' nutritional and hydration needs are met whilst they wait on board an ambulance.

As highlighted earlier in the report, the purpose of ambulance crew is to provide urgent or emergency care to patients in the community and where necessary, to transport them to hospital on board an ambulance. Ambulances are therefore not equipped to provide food and drinks to patients. One member of ambulance crew commented:

> *"Hospital delays have been allowed to happen without any care or thought to keeping patients hydrated, fed and toileted appropriately whilst in the Ambulance. Ambulance Staff are not provided for, and often left hours without access to food and drink."*

In our public survey, it was concerning to find that half of the respondents said they did not receive sufficient food and drink during their wait for handover to the ED. However, we are mindful that there are occasions when patients are designated as 'Nil by Mouth' due to their clinical condition, and therefore cannot consume food or drink, unless assessed as safe to do so. This may include examples with patients with gastric complaints, such as diarrhoea and vomiting, or severe abdominal pain, or for those who are suspected as required urgent surgery.

We found positive examples during our interviews with staff, where the majority told us that patients were supported by British Red Cross workers, who were contracted to work within EDs, who provided assistance to patients with food and drinks, and offered emotional support through engagement with patients.

It is concerning that patients who are waiting on board an ambulance are reliant on others for the provision of food and drink, to ensure their nutritional and hydration needs are met. We also acknowledge the difficulties that ambulance crew and ED staff face in providing food and drink for patients. The uncertainty of when patients may be able to eat and drink will negatively impact on them physically, especially given the uncertainty around timescales of when they may be handed over to hospital staff.

Recommendation

WAST should work with health boards to ensure that patients' nutritional and hydration needs are consistently met whilst waiting in the back of an ambulance due to delayed handovers.

Pain Management

During the review, we considered how patients' pain was managed on board the ambulance during triage and thereafter. Our public survey provided mixed comments, though overall, patients reported that ambulance crew managed their pain well. This is consistent with the findings within the 2018 Amber Review report. There was also a good response from ambulance crew in relation to the management of the patient's pain, with 81% stating they had access to pain relief should the patient require it. However, this was not consistent with their hospital experience, where patient comments indicated that their pain was at times not managed well once admitted to the ED. The comments included:

"The paramedics ensured I received additional pain relief in the ambulance on arrival."

"Unfortunately the hospital left me in a great deal of pain for quite some time."

It is reassuring that ambulance crew are acting positively in managing patients' pain. This is imperative, given the uncertainty of the length of handover delays. This may be reflective of the one to one care patients receive from the ambulance crew in comparison to staff-patient ratio in the ED. Health boards should reflect on these findings, and consider how pain management can be appropriately maintained, for patients experiencing pain once admitted in to the ED.

Infection Prevention and Control (IPC)

Standard 2.4 of the Health and Care Standards 2015, highlights that effective IPC is everybody's business, and must be part of everyday healthcare practice and based on best available evidence, so that people are protected from preventable healthcare associated infections.

Our staff survey highlighted a generally positive response to IPC from ED staff. Whilst 83% said that IPC procedures are followed, almost all said there is a sufficient supply of PPE, and 89% highlighting decontamination arrangements are in place for used equipment and relevant areas.

However, the survey response from ambulance crew was less assuring with 79% saying that IPC procedures were followed, and only 70% highlighting they felt there are adequate decontamination arrangements in place on the vehicle.

During our interviews with ambulance crew, concerns were highlighted by a number of staff regarding their ability to appropriately maintain safe IPC measures on board the ambulance. They provided examples with patients requiring a commode on board the ambulance, and with patients needing to eat and drink within the vehicle during long delays. In addition, crew members who may assist patients with enabling a patient to use a commode or bed pan are unable to change their uniform (if required), and may attend further emergency calls during their shift.

These examples highlight the difficulty in maintaining a safe and infection free clinical environment. The vehicles are a confined environment, and are not appropriate to provide adequate care for patients during periods of long delays with handover. This not only increases the risks with maintaining IPC, but can be considered detrimental to the patient experience.

Recommendation

WAST should consider how ambulance crew and patients can be supported to achieve and maintain high standards of hygiene and IPC, in particular during periods of delayed handovers for patients on board an ambulance.

Safe Care

People's health, safety and welfare actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented.

Within our staff survey, we asked whether staff were satisfied with the quality of care, treatment and diagnosis they give to patients during periods of handover delays. It was positive to find that 89% of ambulance crew said they were satisfied with the care they give to patients, although only 74% of ED staff were satisfied with this.

We asked ambulance crew in our survey if patients were monitored and assessed for acute illness; 87% confirmed they were, and this was also reflected in our findings from the ED staff. In addition, more than three quarters of ambulance crew said there was access to higher clinical support should it be required.

We also asked staff whether patients were involved in decisions about their care. Three quarters of ambulance crew and ED staff confirmed they were, however, we identified some negative comments from ED staff in relation to this question. Once comment included:

> *"There are issues with regards to ongoing care of patients who remain on vehicles for long periods of time; as a department we are trying to look after patient's both physically in and out of the ED, sometimes with little support from the crew."*

Despite receiving positive responses regarding the quality of care provided to patients from ambulance crew, it was very concerning that only 41% of ambulance crew said it was clearly understood who has responsibility for the patient at all times. However, three quarters of ED staff said it is clearly understood who has responsibility for the patient at all times. The hospital handover guidance highlights that ambulance crew should not routinely be responsible for monitoring patients for prolonged periods outside ED.

During our interviews with ambulance crew we identified that the lines of responsibility for patients on board an ambulance are blurred, due to ED staff going on board ambulances to assess and treat patients, and ambulance crews moving patients around hospitals for X-rays, CT scans and other investigations.

Overall, we identified from our interviews and staff survey that ambulance crew are not clear at all times as to who has responsibility for the patient prior to the formal handover taking place to ensure the safety of patients.

Recommendation

WAST and health boards must ensure there is absolute clarity, consistency and understanding between both ambulance crew and ED staff, as to where the responsibility and accountability lies for patient care on board an ambulance following triage, until transferred into the ED.

Discharge planning

During our interviews, a theme emerged from both ambulance crew and senior WAST managers that discharge planning could be improved. We were told that the anticipated date and time of patient discharge often appeared to be a 'last minute' decision in some EDs. The implication of this on the system is that a decision to discharge a patient may not take place until later during the day, which results in less time to obtain patient medication from pharmacy to take home, to arrange take home transport, thus impacting on delayed bed availability for patients in ED.

As referred to earlier within the report, the role of patient flow coordinators at some hospitals is seen as having a positive impact on this issue. On a day to day basis, their role includes co-ordinating a discharge time for a patient to understand the time their bed will become available for patients in ED. Some hospitals also provide the service of a discharge lounge, where patients can wait for their take home medication, and transport home. This means that their hospital bed is made available sooner and helps improve patient flow within the hospital.

Earlier patient discharge planning could result in more timely bed availability within the hospital. This could result in improved patient flow and improved ambulance patient handover times. Consequently this could release more ambulances to respond to emergency calls to patients waiting within the community.

Whilst overall we found that patient privacy and dignity may be compromised when patients are confined to excessive waits on ambulances, people who engaged with our survey were generally positive about their overall experiences. The outcome from our public survey is a positive reflection on the professionalism and caring attitude of the ambulance crews towards their patients.

Workforce

Within the Health and Care Standards, standard 7.1 highlights that healthcare services should ensure there are enough staff with the right knowledge and skills available at the right time to meet needs of patients.

Staff numbers and staff pressures

We received a number of comments from ambulance crew relating to perceptions that EDs are under staffed and under pressure, comments included:

> *"Due to low staffing, there can be long delays waiting to hand over. During busy times it feels like the staff aren't listening to us when handing over."*
>
> *"Slow ... ED staff under too much pressure often short staffed or lack of bed spaces."*

This was supported in our findings from ED staff, with only a fifth (23 of 103) of respondents saying there are enough staff for them to carry out their role safely and effectively. This is also consistent with our findings of previous ED inspections across Wales.

These findings are a concern, since insufficient staff numbers within EDs will have an impact on the quality and safety of patient care, and the ability to facilitate a timely ambulance patient handover, thus affecting people waiting for an ambulance in the community. Whilst the scope of our review did not include consideration staffing levels within EDs across Wales, health boards should review, and continue to monitor their staff establishments in EDs, and take action to improve the ongoing issues identified with staffing during our review and in our previous ED inspections.

We identified that during 2020-21, WAST recruited over one hundred additional frontline staff to gain a more timely response to the public's demand on its services. However, it was concerning to find that in response to our survey, only 31% of ambulance crew said there were adequate staff for them to do their job properly. Only 65% said they were able to meet the demands on their time at work. We were informed that there are further plans for WAST to recruit similar additional numbers of staff during 2021-22, however, this may not necessarily result in improved handover times to ED staff. Although, it may help improve the patient experience and staff well-being. It is at present too early to make a judgement on the increase to WAST staff establishments.

Recommendation

WAST and health boards must review and continuously monitor their staff establishments, in order to ensure appropriate levels of staff are maintained at all times.

Impact of hospital handover delays on staff

We asked ambulance crew in our survey whether there was sufficient support available when they wait for long periods on board an ambulance due to delayed handovers. It was disappointing to find that 93% of respondents said there was insufficient support available to them.

Only 36% of ambulance crew said their working pattern allows for appropriate breaks throughout their shift, and that their working pattern allows for a good work life balance. Ambulance crew we interviewed reported that shifts overrunning have become a normal part of their work. The term overruns refers to crews who have no option other than to work beyond their shift end time.

We identified that staff welfare in urban areas is easier to manage than rural areas, since crews are stationed closer to the ED they most often attend with patients, and are therefore able to return to their base station during their breaks and sooner at end of shift times.

In rural areas, we were told that it is not uncommon for shifts to overrun by two to three hours. The impact of delayed handovers is also increased in areas where a high number of tourists arrive during peak holiday times. If ambulance crews are late leaving the ED at the end of their shift whilst awaiting the arrival of a relief crew, at times, crews may be delayed by up to a further two hours before they arrive back at their base station.

These delays mean they have to start their shift the following day at a later time, to ensure they have sufficient down time between shifts. This can have a knock on effect to staff availability in the earlier part of their next shift.

It was positive to find that that 'pool cars' have been implemented at some ambulance stations, to help alleviate the impact of overruns on crew. They are used to transport ambulance crews to return to base for their breaks, and at the end of their shift, once the new crew arrive to take over the patient care on board the ambulance, waiting outside the ED to handover.

As referred to earlier within the report, the role of a Duty Operational Manager (DOM) has been implemented across Wales. The DOM is responsible for the operational leadership and supervision of a defined group of Paramedics, Emergency Medical Technicians and Urgent Care Assistants.

Additionally, they provide proactive and reactive operational leadership as a role model and operational commander at operational incidents, in line with the Civil Contingencies Act 2004[18] and as required to support the wider unscheduled care system. In addition, part of their role is to facilitate crews to take their allocated breaks, and to finish their shift on time wherever possible, by taking over the care of patients, therefore providing relief to crew members. We learned that the role is a relatively new initiative within WAST, and a number of DOMs had only recently been appointed at the time of our fieldwork interviews. The positive impact of this role in supporting ambulance crews is welcomed by those who have experienced this support.

Staff access to food and drink

Our review considered whether ambulance crews have reasonable access to food and drink during their shifts and prolonged waits outside of EDs. Only two in five said they had reasonable access to food and drink.

We established that ambulance crew who attend EDs in rural areas, or those whose ambulance base station is a great distance from their most frequented EDs, have more issues in accessing food and drink, especially during night shifts. This is because they cannot store their food at their base station and return to get it during their breaks, and there are no facilities for them to purchase food, either within the hospital or nearby vicinity. Ambulance crew working within urban areas said access to food was easier, since their base station was near the hospital, which allowed them to return either to their base station, or access food within the vicinity of the hospital, when relieved by Duty Operational Managers. Staff comments included:

"Food or a hot beverage is not available on nights and when working with a less experienced individual you cannot leave the patient when stuck outside hospital for hours on end. Only some hospitals offer the concession of £5. The patient does not get a warm drink or food whilst waiting."

"During night shifts access to food and drink becomes much more difficult and wish this should be addressed."

18 The Civil Contingencies Act 2004 is an Act of Parliament which provides the framework for emergency and disaster planning and response on local and national levels in the UK.

Staff well-being

Our review has highlighted a number of key issues discussed above, which impact on the health and well-being of ambulance crews, as a direct result of delayed handovers and their knock on effect on crews' working conditions, this was also highlighted within the Amber Review report. During interviews, a number of ambulance crew told us that handover delays have a direct impact on their own health and well-being, comments included:

> *"Hospital handover delays are having significant impact not only on patients but on WAST as an organisation, and also on morale, since they [staff] feel they are unable to provide the best service possible to the community that they serve."*

In addition to these issues, staff highlighted further concerns regarding the poor ventilation on board an ambulance. We were told this has had a significant impact during the pandemic, where crews have spent prolonged periods on board ambulances waiting to handover to ED, and were required to wear full PPE whilst caring for suspected COVID positive patients. Furthermore, other concerns were highlighted regarding exposure to exhaust emissions from older ambulance vehicles when waiting outside EDs, where engines must run to maintain power to the vehicle.

During interview, some senior WAST staff highlighted their concerns with the impact handover delays have on ambulance crews. Consequently, actions have been implemented to support patients and staff. These include the initiatives highlighted earlier, such as Red Cross teams supporting patients, DOMs and pool vehicles supporting crews and the provision of concessions at hospital canteens for staff meals, when delayed with handover.

The crews we interviewed expressed their support and gratitude for the initiatives, however not all the measures are available consistently across Wales.

In response to our staff survey, 84% of ambulance crew said they were aware of the occupational health support available to them to support their health and well-being, and around 65% said their work place provides support for their mental health. However, it was disappointing to find that only 39% of ambulance crew said their organisation takes positive action on staff health and well-being, and just over 25% said that their employer provides support for their physical health.

Our survey findings also highlighted that just 73% of ambulance crew feel safe at work, and only 47% were content with the efforts of the organisation to keep them and patients safe. Staff repeatedly expressed their frustrations with the impact of handover delays on the experience of patients, and on their own well-being. Further comments in our staff survey included:

> *"The effects of waits and frustrations are impacting on staff wellbeing."*
>
> *"We are expected to have a good level of fitness to perform our roles yet no access to gyms/PTs/ equipment is made."*
>
> *"WAST have improved in helping with mental well-being but they are very poor at ensuring staff are able to meet the physical requirements of the role. We should have access to gym facilities, discounted gym memberships, a sports club and easy access to physiotherapy. There should be a regular assessment of staff fitness."*
>
> *"I feel all efforts to improve wellbeing are paper exercises only and there is no real support."*

Our staff interviews identified positive comments from ambulance crew regarding access to mental health support at work. The support included referral to TRiM[19], access to the 'Headspace' mindfulness app, and mental health awareness weeks, which promote the services available to staff. Crews also highlighted that following attendance at a serious incident, staff are automatically referred to the TRiM process.

Whilst, in general ambulance crew said that the Trust provides support for their mental health, the majority of DOMs we interviewed said that the support offered to them is limited. They also highlighted that as peers, they provide support to each other, but are not always considered for referral if they have attended the scene of a serious incident, which may have been stressful and upsetting.

Recommendation

WAST should consider how initiatives already introduced can be made consistently available to all ambulance crew across Wales. In addition, consideration should be given to how the welfare and support available to ambulance crews can be further improved.

WAST must ensure that the support for staff mental well-being is consistent across Wales, and that staff are routinely referred when appropriate and aware of how to access support if required.

19 TRiM is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic event.

Training and development

We considered the training and development of WAST staff. 85% of our survey respondents said they had received relevant training to allow them to undertake their role with confidence. Some ambulance crew comments suggested that despite caring for patients for prolonged periods on board an ambulance awaiting handover, training is not provided to support staff with this. This training issue was also highlighted by the ambulance crew we interviewed. Comments included:

> *"We are not nursing staff, but are expected to look after patients as though they are in the department, this includes having to try and toilet patients."*

Recommendation

WAST should ensure that appropriate training is provided to ambulance crew in providing care to patients on board an ambulance, during prolonged periods of handover delays.

Escalation arrangements

Escalating a clinical concern with a deteriorating patient

Our review considered the escalation process in place should a patient's condition deteriorate whilst they are on board an ambulance awaiting handover to the care of ED staff.

In 2018, following the sad death of a patient who had endured a delay with handover from WAST to an ED, the Coroner, issued the Trust with a Regulation 28[20] letter in December 2019 to implement an escalation process for delayed handover. The process was implemented in February 2021 and stipulates circumstances when escalation is required, and what actions must be taken by ambulance crew and ED staff. As part of the escalation process, a Datix incident (electronic incident reporting system) will be completed. This will flag the incident with senior health board and WAST staff to investigate jointly the delay, to help prevent reoccurrence.

In response to our staff survey, only 49% of ambulance crew said that there was a robust system to alert ED staff should a patient's health deteriorate. This was concerning given that a clear process has already been implemented. In addition, not all the staff that we spoke with during our interviews were aware of the process. One comment received by a member of ambulance crew said:

> *"We have patients who regularly take the turn for the worse and are waiting outside, we raise with hospital staff and management and it's a slow process to get the patient into the department."*

20 The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a 'report under regulation 28' or a Preventing Future Deaths report because the power comes from regulation 28 of the Coroners (Inquests) Regulations 2013.

Ambulance crew who had an awareness of the new escalation process told us that it is available on the Trust's intranet which is accessible to all ambulance crew via their iPads.

During our interviews, we spoke with a senior manager within the Trust who said that since its implementation, the impact of the escalation process was being monitored. The process had been presented to the Trust's scrutiny panel and an all Wales audit had commenced with Datix incidents being dip-sampled. The effectiveness of the process is to be gauged within the first six months since its implementation. At the time of our interviews, we were told that it was too early to gauge the effectiveness of the escalation process. As part of HIW's review action plan follow up processes, we will seek an update on the Trust's assessment of the effectiveness of the escalation process.

Recommendation

WAST must ensure all relevant staff are fully aware of the escalation process in place should a patient's health deteriorate, in order to minimise risks to patient safety.

WAST must provide HIW with evidence of its assessment of the effectiveness of the escalation process.

Escalation arrangements at a strategic level

Our review also considered how WAST manages escalation arrangements at a strategic level during periods of high pressure and demand during delayed handovers, and the subsequent lack of vehicle resource. In addition, how risks are identified, managed, and mitigated to ensure patient safety is maintained on board the ambulance during delayed handover.

To explore this, we attended the Trust's Operational Delivery Unit (ODU) in Cwmbran. This is the central hub and support network which provides leadership and co-ordination for the unscheduled care system in Wales. The ODU provides a single point of access for the identification and mitigation of risks in relation to hospital handover delays. Where ambulance crews are delayed, early escalation will occur via the ODU to the site manager and senior manager on call when necessary.

National Delivery Managers located within the ODU work collaboratively with health boards, WAST, Welsh Government and wider organisations and networks. Their role is to monitor WAST's status across all health boards in Wales, which includes the number of ambulances delayed outside each hospital, the hours they have been delayed, and the number of calls from patients who are waiting for an ambulance within the community.

We observed a live intelligence led integrated unscheduled care dashboard, which displays the data highlighted above, and provides a clear visual representation of the situation across Wales. The ODU currently operates seven days a week from 08.00am to 08.00pm or 02.00am during peak periods, and planning is in progress for the ODU to be operational 24 hours a day, 7 days a week.

We observed the daily WAST Risk and Safety Huddle, which is a video call chaired by the National Delivery Manager, with operational management representatives from across each region of Wales and specific service areas. This includes but is not limited to Emergency Medical Service Clinical Contact Centre's, 111 and Non-Emergency Patient Transport Services. Individuals provide an update in relation to identified risks to provide mitigation where required to assess and plan for the day ahead.

We also observed the daily National Risk and Safety Huddle, which is a video call with senior hospital managers within each health board and Welsh Government leads. This is chaired by the WAST Strategic Lead or the Head of the ODU. During the huddle, we observed how intelligence is gathered, performance and risk information is shared nationally, and the regional health system plans for the day are set to maintain the public and patient safety and identify risks, and plan for mitigation of these.

Information is submitted by health boards prior to the meeting which includes hospital escalation status and risk level, hospital bed capacity, and speciality bed numbers, such as those available in critical care. During the call, WAST provides an update on the levels of activity, demand, performance, escalation status and pressures within the unscheduled care system. Areas with significant handover delays, and areas within the community experiencing lengthy patient ambulance response times are prioritised, and health boards report the risks and their plans for mitigation of handover delays. Risks and action plans are agreed and a regional escalation stage is agreed based on demand.

The development of regional escalation protocols has ensured risk is balanced across the healthcare systems. When hospital handover delays are causing issues with vehicle resource and the demand for beds at a hospital has reached maximum capacity, decisions can be made dynamically to divert ambulance resources across geographical borders, to help maintain patient safety. Each health board will take responsibility for ensuring that all appropriate actions have been taken to manage demand within their own boundaries before cross border or regional actions are implemented in line with those defined within their own escalation plans, supported by regional escalation stages.

During periods of high demand on WAST emergency services, ambulance waiting times will inevitably increase. During these periods, WAST utilises the Demand Management Plan (DMP) framework. The DMP is used to deal with real time acute operational issues, which are not likely to have any long term service impact. There are eight DMP levels (DMP-1 to DMP-8) which are reflective of the scale of demand experienced by the service. The DMP aims to reduce demand and increase capacity of the service, which requires decisions at operational, tactical and strategic command level, in-line with the DMP level.

During any handover delay of more than six hours, alerts are automatically generated to the WAST Director of Operations and Chief Executive, to ensure key organisational leads can act on the issues identified and plan to mitigate the risks to patient safety.

During late 2020, WAST commissioned a Quality Governance Report associated with hospital handover delays. The report detailed the background, complexity, and significance of handover delays with the aim to embed robust governance processes, to monitor and manage the issues. The report also provided an account of activities undertaken to promote improvement, an assessment of the likely outcome of improvement actions being undertaken and significance of negative patient experience or patient harm.

WAST also has a Notification and Escalation Procedure, which provides guidance on the incident notification procedures followed within WAST. It also articulates the escalation process for hospital delays and/or patients awaiting an ambulance response within the community. To provide a consistent process, as to when, and to who, hospital handover delays need to be escalated.

In order to ensure the safe handover of patients to secondary care, WAST has developed systems, which identify risks, provide mitigation and escalate concerns, through timely, efficient and safe processes. The development of the ODU has had a significant impact in providing system oversight, and enabling effective management and practice across the healthcare system. The ODU is able to focus on immediate 'red release requests of ambulances from hospitals, hospital diversions to less busy sites, and enabling ambulance crews to handover patients in a timely manner.

Governance Arrangements

The Health and Care Standards stipulate that governance, leadership and accountability should be in keeping with the size and complexity of the healthcare service, are essential for the sustainable delivery of safe, effective person-centred care.

Reporting handover incidents

We found a robust process in place for managing handover incidents which may result in patient harm or death. Daily reviews of the Trust's electronic clinical incident system 'Datix' is undertaken by patient safety officers and managers. The Trust's SCIF, also meets twice weekly to review any serious incident reports, for investigation, and to identify any actions, lessons learnt and themes or trends.

WAST local management teams meet regularly with health board clinical leads to escalate any concerns, present data and discuss local mitigation. A Joint Investigation Framework process is also in place, and guides the Trust and health boards across Wales to review and investigate serious patient safety incidents identified within SCIF.

The process involves a collaborative investigation between WAST and the relevant health board. WAST staff highlighted issues with inconsistency in engagement in the joint process from all health boards, where identifying and sharing of learning from incidents is inconsistent across Wales. However, they did acknowledge that positive steps have been made, to improve engagement from all health boards.

Within our staff survey, only 63% of WAST respondents said they felt secure in raising concerns about unsafe clinical practice, although almost all staff knew how to report it. In relation to patient safety incidents, 64% of WAST respondents said they had seen a patient safety incident, near miss or an error, and of these almost all said they or a colleague had reported it.

It was disappointing to find that only 41% of WAST respondents said they believed their organisation would address their concerns. Our staff interviews supported this finding, with some staff highlighting that any response or feedback they receive as a result of reporting an incident, is a generic response. This therefore does not provide the reporting person with any action plan or learning as the result of a reported incident.

Comments included:

> *"Items are reported, there is no feedback and the issue is recurrent."*
>
> *"Handover delays and long response times are not seen as near misses anymore. They are normal."*
>
> *"Not confident in reporting any concerns due to backlash."*

Despite an overall negative response to incident reporting management, good practice was reported from staff from one ambulance base, which reported a process in place for a designated member of staff to provide feedback to the teams regarding Datix incidents and reports. This has a positive impact on staff, with the feedback encouraging teams to report any incident that occurs.

Our findings highlight the need for WAST to identify more effective processes for sharing feedback from incidents. This was discussed with senior staff who acknowledge improvements can be made to ensure incident investigation outcomes are effectively shared with staff, to help improve the quality and safety of care.

Recommendation

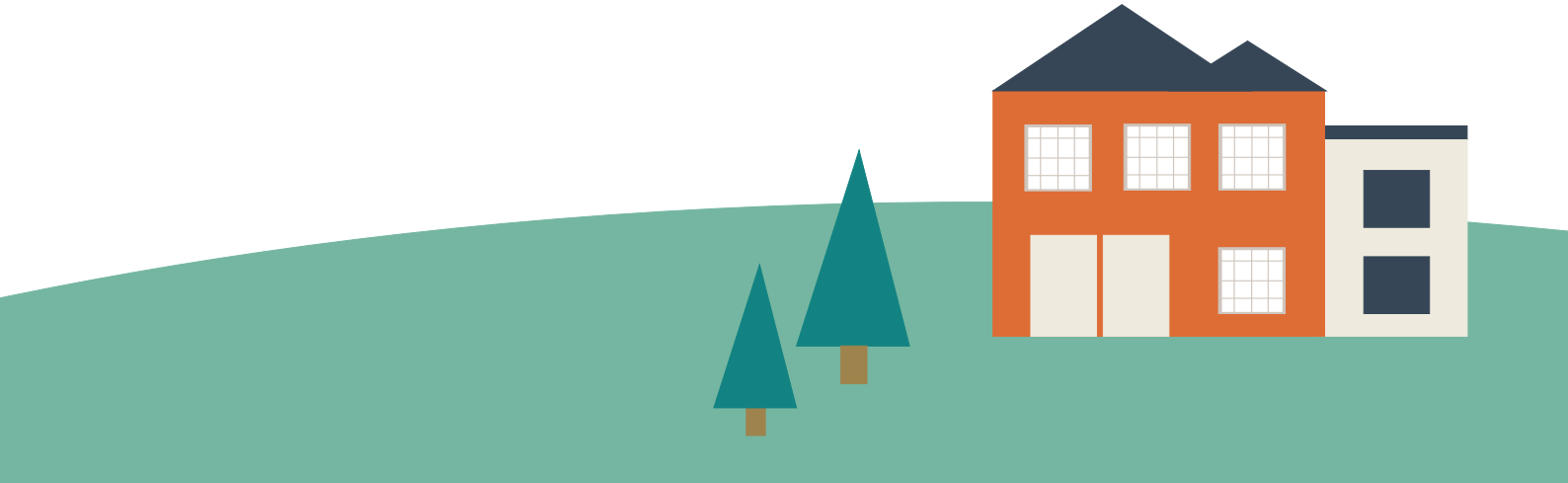
WAST must do more to ensure that its staff feel able to, and are confident in raising concerns. It must also ensure that robust processes are in place to share the learning with staff following incident investigations, in order to improve quality and safety of patient care.

Risk Registers

Hospital handover delays are identified by WAST as a significant corporate risk, which has been assessed at the highest score on its risk register. The risk relates to patients not being able to access secondary care assessment and treatment due to prolonged handover delays. In addition, the consequence of emergency response vehicles unable to attend patients requiring and ambulance in the community.

Such situations place WAST in a position where it is managing the consequence of handover delays. These delays are generally caused by a wider set of factors within the hospital setting including patient flow issues.

It is clear that WAST cannot, alone, improve patient flow through hospitals, to support the prompt transfer of patient care in to EDs. The significant level of risk to patient safety associated with delays handovers including the risk to patients in the community, cannot be one that is accepted any longer. It is essential that WAST, each health board across Wales, including Powys Teaching Health Board, consider whether actions taken to date have gone far enough to resolve this issue.



Conclusion

The aim of our review was to consider the experience of patients, including their safety, care, privacy and dignity whilst waiting on board an ambulance outside EDs during delayed handovers.

Despite finding that patients were, on the whole, positive about their experience, we have identified a wide range of evidence that handover delays have a significant impact on the ability of ambulance crew to provide a positive experience for patients. This included negative impact on the dignity of patients, and potential increased risks to patient safety.

It is clear that the issue of delayed handover has a hugely negative impact on the unscheduled care system as a whole. Each ambulance that encounters a prolonged stay at an ED potentially means fewer ambulances available to respond to emergency situations elsewhere.

National guidance is clear on the targets and expectations regarding handover and there is an apparent clear will to meet and achieve these expectations. However, it is clear that the issues around handover have not been resolved to date, with inconsistency in approaches apparent across Wales introducing risks to patient safety.

Whilst WAST has a role to play in addressing the issues described within this report, it does not have the ability to unilaterally resolve these problems. The whole healthcare system has a role and part to play in addressing the issues that we have highlighted in our report, and it is imperative that a reinvigorated, strengthened and concerted approach is taken to ensure that these problems are overcome.

HIW plans to undertake a National Review during 2021-22 which will focus in more detail on the issue of patient flow, examining in greater depth the cause and impact of patient flow issues.

What next?

We expect the Welsh Ambulance Services NHS Trust, health boards, and Welsh Government to carefully consider the findings from this review and the recommendations set out in Appendix A. We hope that this information will be used to further improve the service being provided by the Trust, and to inform further work and investigation across Wales, as highlighted within the report.

The Trust, health boards and Welsh Government will be required to submit a joint action plan in response to the recommendations highlighted within our report. HIW will undertake follow-up activity on recommendations made. This is to ensure that the Trust, health boards and Welsh Government are being vigilant in addressing the matters raised and taking all necessary action to improve the issues highlighted in our review.

Appendix A – Recommendations

As a result of the findings from this review, we have made the following recommendations in the table below.

Recommendations	Action
Health boards, and Welsh Government should consider what further actions are required to make improvements regarding the patient flow issues impacting on delayed patient handover. This may include consideration of whether a different approach is required by WAST, health boards, and social care services within Wales, to that taken to date in tackling this system-wide problem .	
WAST should engage with health board representatives to ensure there is improvement in practice between ambulance crew and ED staff to ensure the dual pin process is consistently followed, and ensure Welsh Government reporting data is accurate.	
Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.	
Health boards must ensure that appropriate representation is present at WAST Serious Clinical Incident Forum meetings, to aid with the timely management of concerns and service improvement.	
If and where local standard operating procedures are absolutely necessary, WAST and health boards must together ensure that ambulance crew are familiar with the handover policy for that ED.	
WAST and health boards need to ensure that when delays occur, patients and their relatives or carers should be kept fully informed of the reasons and the progress being made in resolving them.	
WAST and health boards across Wales should ensure patient feedback is obtained regularly to understand their experiences of long waits on board an ambulance, in order to inform improvement.	
WAST and all health boards across Wales must work together to identify a consistent approach in providing timely investigations and treatment for patients on board ambulances, to enable ambulance crews to be released quickly.	
Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.	
During prolonged handover delays, WAST and health boards must work collaboratively and consistently, to minimise the risk of skin tissue damage for patients.	
WAST should work with health boards to ensure that patients nutritional and hydration needs are consistently met whilst waiting in the back of an ambulance due to delayed handovers.	

Recommendations	Action
WAST should consider how ambulance crew and patients can be supported to achieve and maintain high standards of hygiene and IPC, in particular during periods of delayed handovers for patients on board an ambulance.	
WAST and health boards must ensure there is absolute clarity, consistency and understanding between both ambulance crew and ED staff, as to where the responsibility and accountability lies for patient care on board an ambulance following triage, until transferred into the ED.	
WAST and health boards must review and continuously monitor their staff establishments, in order to ensure appropriate levels of staff are maintained at all times.	
WAST should consider how initiatives already introduced can be made consistently available to all ambulance crew across Wales. In addition, consideration should be given to how the welfare and support available to ambulance crews can be further improved.	
WAST must ensure that the support for staff mental well-being is consistent across Wales, and that staff are routinely referred when appropriate and aware of how to access support if required.	
WAST should ensure that appropriate training is provided to ambulance crew in providing care to patients on board an ambulance, during prolonged periods of handover delays.	
WAST must ensure all relevant staff are fully aware of the escalation process in place should a patient's health deteriorate, in order to minimise risks to patient safety.	
WAST must provide HIW with evidence of its assessment of the effectiveness of the escalation process.	
WAST must do more to ensure that its staff feel able to, and are confident in raising concerns. It must also ensure that robust processes are in place to share the learning with staff following incident investigations, in order to improve quality and safety of patient care.	

Appendix 2

Management response action plan for Welsh Ambulance Service Trust local review: Review of Patient Experience whilst Waiting in Ambulances during Delayed Handover

Review Recommendations				
Recommendation 1				
Health Boards, and Welsh Government should consider what further actions are required to make improvements regarding the patient flow issues impacting on delayed patient handover. This may include consideration of whether a different approach is required by WAST, health boards, and social care services within Wales, to that taken to date in tackling this system-wide problem.				
Action		**Site**	**Responsible Officer**	**Timescale**
Escalation process to support demand	1.1 Review of escalation process across the HB to support demand analysis, agree warning and trigger responses	YG/YGC/WMH	Hospital Management Teams	Oct-21
	1.2 Review of Operational Delivery Unit structure to encompass HB staffing for global overview.		Sites Programme Teams	
	1.3 Development of rapid communication process to support demand.		Hospital Management Teams	
Redirection process	1.4 Review of directory of services. Explore system lead role for Directory Of Service work.		WEST-WAST Group/ Sites Programme Teams	Nov-21
	1.5 Survey review of WAST/ED staff on service awareness		Emergency Department Matrons	Oct-21
	1.6 Explore with WAST the development of a Community Falls Service		Sites Programme Teams	
	1.7 Development of direct referral process for Paramedics to Same Day Emergency Care and assessment units		WAST Health Board clinical lead/ / Sites Programme Teams	Dec-21
	1.8 Audit for the 3 Emergency Departments on those conveyed that could have been managed via alternative pathways		Directorate General Manager	Nov-21

Fit 2 Sit review	1.9 HB/WAST review of Fit 2 Sit criteria.		WEST/WAST Group/ Sites Programme Teams	Oct-21
Patient Flow- Restart Programme	1.10 Focus on earlier discharges including to improve utilisation of the discharge lounge pre 11am to facilitate the early release of inpatient bed capacity.	YGC/WMH/YG	Programme Team	Nov-21
	1.11 To improve Board Rounds, which are outcome focused by adhering to the agreed Standard Operating Procedure to maximise communication and decision making.			Oct-21
	1.12 Internal Professional Standards are being reviewed and updated to reflect expectations of all internal services in line with Emergency Department Quality Framework expectations. Internal Professional Standards are a clear, unambiguous description of behaviours expected in an organisation in line with its values. This is a process that has been successfully used across Emergency Departments and acute services to ensure smooth flow through A&E and all ward areas, leading to timely inpatient stay and timely discharge, improved patient experience and staff engagement. It describes 'the way we do things here'			
	1.13 Bed modelling work underway to determine appropriate bed base for all specialties		Hospital Management Team	
GP referrals to Same Day Emergency Care and assessment units	1.14 Scoping exercise with WAST & Primary Care to determine the feasibility of patients being transported earlier in the day to ensure senior clinical staff are available for patient assessment & review		Programme Team	Oct-21

Recommendation 2				
WAST should engage with health board representatives to ensure there is improvement in practice between ambulance crew and emergency department staff to ensure the dual pin process is consistently followed, and ensure Welsh Government reporting data is accurate.				
Action		**Site**	**Responsible Officer**	**Timescale**
Screen availability	2.1 All PC's will have access to the dual pin link to improve availability.	YG/YGC/WMH	Directorate General Manager	Oct-21
Re cascading of dual pin process	2.2 Progress chaser to share dual pin process with all staff and support education.			
Monthly audit of dual pin compliance	2.3 WAST to provide the Health Board with monthly audit reports to support ongoing improvements.		WAST	Nov-21
Recommendation 3				
Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.				
Action		**Site**	**Responsible Officer**	**Timescale**
System review	3.1 Review of clinical staff availability to take timely handover	YG/YGC/WMH	Emergency Deputy Head of Nursing/Matron/Lead Manager	Oct-21
	3.2 Review of non-clinical staff to support departmental processes including handover to release clinical staff, which will improve the handover process.		Emergency Department Deputy Directorate General Manager/Matron/Lead Manager	
	3.3 Audit of lost hours due to delays in handing over due to staffing issues.		Project Manager/Emergency Deputy Head of	Nov-21

			Nursing/Matron/Lead Manager	
Recommendation 4				
Health boards must ensure that appropriate representation is present at WAST Serious Clinical Incident Forum meetings, to aid with the timely management of concerns and service improvement.				
Action		**Site**	**Responsible Officer**	**Timescale**
Governance	4.1 Joint working to align both the Health Board and WAST when supporting serious incident reviews though the allocation of a dedicated Governance Lead.	YG/YGC/WMH	Directorate General Manager WEST	Oct-21
	4.2 Creating a forum for lessons learnt to be created, and shared with local governance leads and areas involved. CPD improvement and monitoring		Emergency Department Clinical Lead	Nov-21
	4.3 Serious Incident Reviews to be uploaded to BCU Datix to prevent duplication			Oct-21
Recommendation 5				
If and where local standard operating procedures are absolutely necessary, WAST and health boards must together ensure that ambulance crew are familiar with the handover policy for that ED.				
Action		**Site**	**Responsible Officer**	**Timescale**
Handover process	5.1 Ambulance handovers are treated in line with Handover to Clear within 15 minutes National Policy	YG/YGC/ WMH	Emergency Department Directorate General Manager - WAST/YGC Programme Team/ Matron/Lead Manager	Nov-21
	5. 2 Explore principles of Every Minute Matters work			Nov-21
	5. 3 Reviewing and educating staff on the handover and escalation pan BCU process at the monthly BCU WAST Interface meetings		BCU USC Programme Director/WAST	Nov-21
Recommendation 6				
WAST and health boards need to ensure that when delays occur, patients and their relatives or carers should be kept fully informed of the reasons and the progress being made in resolving them.				
Action		**Site**	**Responsible Officer**	**Timescale**

Escalation process Communication	6. 1 As part of the patient clinical assessment in the ambulance, the patient will be kept updated as to the progress of the care and this information will be documented in patient records and in the nurse in charge log.	YG/YGC/ WMH	Emergency Department Matron	Nov-21
Recommendation 7				
WAST and health boards across Wales should ensure patient feedback is obtained regularly to understand their experiences of long waits on board an ambulance, in order to inform improvement.				
Action		**Site**	**Responsible Officer**	**Timescale**
Patients survey	7.1 CIVICA – the Health Boards patient, carer and service user feedback system, will be used to learn, act on feedback received and improve services. Utilisation of Happy or Not survey to support patient feedback in line with Emergency Department Quality Development Framework.	YG/YGC/ WMH	Project Manager	Oct-21
	7.2 Patient Experience Group, lessons learnt to be shared at the forum and the result of survey discussed in the Emergency Care Directorate meeting and cascaded appropriately.			
Recommendation 8				
WAST and all health boards across Wales must work together to identify a consistent approach in providing timely investigations and treatment for patients on board ambulances, to enable ambulance crews to be released quickly.				
Action		**Site**	**Responsible Officer**	**Timescale**
Ambulance escalation process	8.1 Departmental escalation process to support timely investigations and care when delays are occurring following the National Institute for Health and Care Excellence	YG/YGC/ WMH	Emergency Department Directorate General Manager Clinical Lead	Nov-21

Shine Audit	8.2 Shine Audit review to ensure timely investigations and treatment of patients who are delayed in the back of Ambulances		Emergency Department Matron	

Recommendation 9				
Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.				
Action		**Site**	**Responsible Officer**	**Timescale**
Facilities	9.1 Facilities available for Green and suspected patients following IPC guidance	YG/YGC/WMH	Lead Managers for Emergency Care/Matrons	Sep-21
Portable facilities	9.2 Available at both entrances	YG		Sep-21
Chaperone support	9.3 Emergency Department Nursing staff will provide support should a chaperone be required for a patient to use facilities.	YG/YGC/WMH		Sep-21

Recommendation 10				
During prolonged handover delays, WAST and health boards must work collaboratively and consistently, to minimise the risk of skin tissue damage for patients.				
Action		**Site**	**Responsible Officer**	**Timescale**
Triage Shine Audit	10.1 Patient triage due to delays includes a skin assessment and recorded on patient records	YG/YGC/WMH	Lead Managers for Emergency Care/Matrons	Oct-21
	10.2 Shine Audit review to ensure timely investigations and treatment of patients with pressure sores who are delayed in the back of Ambulances			

Recommendation 11				
WAST should work with health boards to ensure that patients nutritional and hydration needs are consistently met whilst waiting in the back of an ambulance due to delayed handovers.				
Action		**Site**	**Responsible Officer**	**Timescale**
Triage	11.1 At point of triage nutritional review to be undertaken, recorded on patient records and escalated when physically assessing	YG/YGC/WMH	Emergency Department Matrons	Oct-21

	patients.			
	11.2 Any WAST concerns to be captured on Patient Report Form and on patient records			
Recommendation 12				
WAST should consider how ambulance crew and patients can be supported to achieve and maintain high standards of hygiene and IPC, in particular during periods of delayed handovers for patients on board an ambulance.				
Action		**Site**	**Responsible Officer**	**Timescale**
WAST				
Recommendation 13				
WAST and health boards must ensure there is absolute clarity, consistency and understanding between both ambulance crew and ED staff, as to where the responsibility and accountability lies for patient care on board an ambulance following triage, until transferred into the ED.				
Action		**Site**	**Responsible Officer**	**Timescale**
Handover policy	13.1 Handover policy to be reviewed and confirmed joint care for managing the patient in the ambulance	YG/YGC/WMH	Emergency Department Directorate General Manager / Site Programme Teams	Oct-21
	13.2 Reminding staff from the point of triage until transferred to the emergency department of the Handover policy to ensure a clear understanding should a patient deteriorate while awaiting a handover.		Emergency Department Clinical Leads-WAST	
Recommendation 14				
WAST and health boards must review and continuously monitor their staff establishments, in order to ensure appropriate levels of staff are maintained at all times.				
Action		**Site**	**Responsible Officer**	**Timescale**

Emergency Department Business case	14.1 Executive sign off for business case to provide safe staffing levels across the HB approved	YG/YGC/WMH	Programme Lead	Sep-21
Rota Review	14.2 Continuously review rotas to support the demand analysis			
Recommendation 15				
WAST should consider how initiatives already introduced can be made consistently available to all ambulance crew across Wales. In addition, consideration should be given to how the welfare and support available to ambulance crews can be further improved.				
Action		**Site**	**Responsible Officer**	**Timescale**
WAST				
Recommendation 16				
WAST must ensure that the support for staff mental well-being is consistent across Wales, and that staff are routinely referred when appropriate and aware of how to access support if required.				
Action		**Site**	**Responsible Officer**	**Timescale**
WAST				
Recommendation 17				
WAST should ensure that appropriate training is provided to ambulance crew in providing care to patients on board an ambulance, during prolonged periods of handover delays.				
Action		**Site**	**Responsible Officer**	**Timescale**
WAST				
Recommendation 18				
WAST must ensure all relevant staff are fully aware of the escalation process in place should a patient's health deteriorate, in order to minimise risks to patient safety.				
Action		**Site**	**Responsible Officer**	**Timescale**
WAST				
Recommendation 19				
WAST must provide HIW with evidence of its assessment of the effectiveness of the escalation process.				
Action		**Site**	**Responsible Officer**	**Timescale**
WAST				
Recommendation				

WAST must do more to ensure that its staff feel able to, and are confident in raising concerns. It must also ensure that robust processes are in place to share the learning with staff following incident investigations, in order to improve quality and safety of patient care.			
Action	**Site**	**Responsible Officer**	**Timescale**
WAST			

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 2nd November 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Public Service Ombudsman for Wales - Public Interest Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris (Executive Director, Nursing and Midwifery/Deputy CEO)
Awdur yr Adroddiad Report Author:	Denise Williams (Senior Complaints Manager – Ombudsman) Carolyn Owen (Acting Assistant Director, Patient Safety & Experience)
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes (Acting Associate Director, Quality Assurance) Gill Harris (Executive Director, Nursing and Midwifery/Deputy CEO)
Atodiadau Appendices:	1. Public Service Ombudsman for Wales' Public Interest Report 2. Action Plan 3. DRAFT Terms of reference for Royal College review

Argymhelliad / Recommendation:

The Committee is asked to note the Public Service Ombudsman for Wales' Public Interest Report for information which was published on 09 September 2021.

Please tick as appropriate

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

Sefyllfa / Situation:

The Health Board received the attached Public Service Ombudsman for Wales' Public Interest Report issued under S23 of the Public Service Ombudsman (Wales) Act 2019 on 26 August 2021. Given Committee meeting dates, it was provided at the last meeting in private as the report was embargoed until publication by the Ombudsman. This report therefore provides the report formally in public.

Cefndir / Background:

During another investigation into concerns raised by Mr Y, the Ombudsman received evidence from the Health Board which indicated that, at the time Mr Y was placed on the urgent list for prostate cancer treatment in August 2019, there were a total of 16 other patients with the same urgent clinical priority awaiting the same procedure (prostatectomy - surgery to remove the prostate). As the Ombudsman had reasonable suspicion there were other possible incidents of service failure and maladministration in relation to the other patients on the waiting list, he commenced an

investigation using his own initiative power of investigation to consider whether the Health Board exceeded the Referral to Treatment Time ("RTT" – the waiting time management rules) target for cancer waiting times for treatment of prostate cancer in respect of the 16 patients who were awaiting prostatectomies.

The attached report sets out the analysis, findings and recommendations.

Asesiad / Assessment & Analysis

The Health Board accepted the findings and conclusions of the public interest report and agreed to implement the recommendations listed.

An action plan has been developed (Appendix 2)

The Health Board's Quality Assurance Department will monitor the action plan to ensure all recommendations are implemented and lessons have been learned.

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.

Ombwdsmon Ombudsman
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU
PUBLIC SERVICES OMBUDSMAN FOR WALES

An Own Initiative Investigation issued under s23 of the Public Services Ombudsman (Wales) Act 2019 against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202002273

Contents	Page

Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019 ("the Act").

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted.

Summary

During another investigation into concerns raised by Mr Y, the Ombudsman received evidence from the Health Board which indicated that, at the time Mr Y was placed on the urgent list for prostate cancer treatment in August 2019, there were a total of 16 other patients with the same urgent clinical priority awaiting the same procedure (prostatectomy - surgery to remove the prostate). As I had reasonable suspicion there were other possible incidents of service failure and maladministration in relation to the other patients on the waiting list, I commenced an investigation using my own initiative power of investigation to consider whether the Health Board exceeded the Referral to Treatment Time ("RTT" – the waiting time management rules) target for cancer waiting times for treatment of prostate cancer in respect of the 16 patients who were awaiting prostatectomies.

My investigation found that, in August 2019, the Welsh policy position in accordance with Welsh Government guidance was that, only patients treated in Wales were reported against the Welsh cancer waiting time targets. The Health Board therefore only produced "breach reports" and undertook harm reviews for the patients it treated. This did not apply to patients referred by the Health Board for treatment in England. Of the 16 patients on the waiting list in August 2019, 8 were referred to England for treatment. If they had been treated in Wales, the breaches of the target timescales would have been reported for all 8 patients because the amount of time they waited for treatment exceeded the 62 and 31-day target for cancer RTT (the target times relate to whether a patient had been designated as urgent suspected cancer or non-urgent suspected cancer). Four of the patients on the waiting list who were treated by the Health Board had exceeded the cancer waiting time target and these breaches of the target timescales were reported and harm reviews were completed.

While the Welsh policy position at the time meant there was no requirement to produce breach reports to the Welsh Government or to carry out harm reviews for Health Board patients treated in England, the geographical location of treatment should not have left these 8 patients in the position where they were denied the harm review process because

they were treated outside Wales. Regardless of the Welsh policy position at the time, the Health Board was obliged to undertake appropriate monitoring of the care and treatment of its patients under its commissioning and contracting arrangements. It should also have considered the impact of the delay in treatment. These failures amounted to maladministration.

The new Single Cancer Pathway ("SCP") which has replaced all previous cancer targets, has addressed the anomaly of the previous approach and all patients now referred from secondary care for treatment outside Wales for their cancer treatment must be included in cancer waiting times monitoring arrangements and all patients not treated within the target should have an internal breach report completed. However, to remedy the injustice to the 8 patients, in line with my approach to remedy, I recommended that the Health Board should return these patients to the position they would have been in had they been treated in Wales and carry out a harm review for each patient. I also recommended that the Health Board reviewed its harm review process to ensure it was in line with the requirements of the SCP.

I have reported on the Health Board's urology service several times and I am concerned that issues relating to capacity and succession planning within the urology department seems to be longstanding. I therefore recommended that the Health Board refers the report to its Board to consider capacity and succession planning for the urology department. The Health Board accepted my recommendations.

My jurisdiction

1. Under Section 4 of the Public Services Ombudsman (Wales) Act 2019 ("the Act"), I may carry out an investigation using my own initiative power of investigation. I am required, under section 5 of the Act, to publish criteria for own initiative investigations. The criteria allow me, where I have already commenced an investigation, to embark on an own initiative investigation into matters that have a "substantial connection" with the matter already being investigated. I can therefore begin an extended investigation using my own initiative power. Such investigation may be carried out where a complaint about 1 element of a service and / or 1 service provider is closely linked to another possible incidence of service failure.

The background

2. In December **2019** I received a complaint from an individual ("Mr Y") about the prostate cancer care and treatment he received from Betsi Cadwaladr University Health Board ("the Health Board"). Mr Y was concerned that the Health Board failed to meet the guidelines for cancer diagnosis which led to him seeking private treatment due to concerns about the impact of the wait for treatment. I commenced an investigation into Mr Y's complaint in January **2020**.[1] The investigation considered the following:

- "that the Health Board exceeded the referral-to-treatment target for cancer waiting times for treatment of prostate cancer. Mr Y was concerned that following a biopsy which confirmed this diagnosis, there was a delay in providing him with an appointment for treatment. As Mr Y was concerned about the impact of the delay, he sought private treatment".

3. During the course of the investigation into Mr Y's concerns, I received evidence from the Health Board which indicated that, at the time Mr Y was placed on the urgent list for cancer treatment in August 2019, there were a total of 16 other patients with the same urgent clinical priority awaiting the same procedure (prostatectomy - surgery to remove the prostate).

[1] Case reference: 201905373

4. As I had a reasonable suspicion that there were other possible incidents of service failure and maladministration in relation to the other patients on the waiting list, I commenced an investigation on my own initiative on 22 September 2020. The investigation considered whether the Health Board exceeded the Referral to Treatment target ("RTT") for cancer waiting times (this sets out the waiting time management rules, including cancer waiting time targets) for treatment of prostate cancer in respect of the other 16 patients with urgent clinical priority awaiting prostatectomies in August 2019. I was satisfied that the own initiative criteria had been met as there was a "substantial connection" with Mr Y's investigation, namely, a possible incidence of service failure linked to the Health Board's urology service in terms of RTT breaches in relation to provision of urology cancer care. I was concerned that there was a possibility that these 16 patients may have waited beyond the 62-day wait for treatment with potential consequences for their prognosis / treatment. Additionally, previous investigations by my office also highlighted concerns about the Health Board's prostate cancer care management.

5. On 3 December 2020 I published a public interest report against the Health Board in relation to the investigation of Mr Y's complaint.[2] The Health Board had breached the RTT in Mr Y's case; it acknowledged that it had done so and apologised for this. Based on the evidence, I found that Mr Y would not realistically have received his treatment until at least 168 days after receipt of the urgent suspected cancer ("USC") referral. [3] The Health Board would therefore, at a minimum, have missed the 62-day target by 106 days. Given that advice from my professional adviser, indicated that early radical treatment was essential in high-risk disease (and Mr Y was deemed high-risk), the wait for treatment was unacceptable and a service failure. As Mr Y had opted to receive private treatment, the actual impact of the delay was mitigated in Mr Y's case and the delay was not as significant as it would have been, had he waited for treatment by the Health Board. However, when Mr Y sought private treatment, he was concerned that the cancer would spread if he waited for NHS treatment. The delay caused Mr Y distress and anxiety, and the decision to seek private treatment, rather than wait for the Health Board to

[2] https://www.ombudsman.wales/wp-content/uploads/2020/12/CASE_201905373_231.pdf
[3] USC referral – a referral where a suspicion of cancer is stated by the GP and confirmed by the specialist.

provide treatment, did not lessen the impact of the Health Board's service failure on him at a very worrying time. I found that Mr Y suffered an injustice as a consequence.

Relevant guidance

My guidance

6. The "Principles of Remedy" outlines my approach to remedying injustice. My aim is to secure suitable and proportionate remedies. I am satisfied that these principles are relevant to my investigations using my own initiative power. A key driver in my approach to remedy is to return a complainant, and where appropriate, others who have suffered injustice and been treated unfairly, to the position they would have been in or, if not possible, to take remedial action. I advocate that people should be treated consistently.

7. The "Principles of Good Administration and Good Records Management" elaborates on the above points, and relevant to this investigation is the principle of acting fairly and proportionately. In seeking to achieve this, public service providers should ensure that people are treated fairly and consistently so that those in similar circumstances are dealt with in a similar way. Additionally, public service providers should seek to address the unfairness if applying the law, regulations or procedures strictly would lead to an unfair result for an individual.

Welsh Government and Health Board guidance

8. The Welsh Government's "Rules for Managing Referral to Treatment Waiting Times" ("the RTT Rules"), which was in place at the time of the events under investigation, set out the waiting time management rules, including cancer waiting time targets. The guiding principles included the values that, "all patients should wait the shortest possible time for treatment"

and that “RTT targets are maximum acceptable waits and urgent patients should be treated as their clinical need dictates”. In relation to cancer target times, there were 2 targets – the 62 day and 31-day targets:

- Newly diagnosed cancer patients that have been referred as USC, and confirmed as urgent by the specialist, to start definitive treatment within 62 days from receipt of referral at the Local Health Board (“LHB”).

- Newly diagnosed cancer patients not included as USC referrals (“NUSC” – non urgent suspected cancer)[4] to start definitive treatment within 31 days of a decision to treat.[5]

In relation to accountability for monitoring, performance and reporting of the RTT target, the RTT Rules stated:

- “When a referral is made to an English provider, the LHB commissioning the pathway is accountable for monitoring of that patient’s pathway. LHBs must ensure that communication protocols are utilised so that appropriate information is shared, and RTT periods are measured accurately”.

- “Where NHS activity is commissioned from an English provider, the accountability for performance against the targets lies with the LHB commissioning the activity”.

- “When a referral is made to an English provider, that provider is responsible for reporting performance against the target. LHBs must ensure that requirements for reporting are contractually included in commissioning agreements”.

- “The LHB with clinical responsibility for the patient…is responsible for reporting performance against the open pathway waiting time target”.

[4] Any patient diagnosed as having cancer who was not referred by their GP as a USC or upgraded by the specialist on analysis of the GP referral.
[5] Decision to treat - the date upon which the decision to treat was confirmed between a designated member of the multi-disciplinary team and the patient.

9. Cancer specific additional guidance to support revised RTT Guidance (issued April 2017) – the guidance provided by the Health Board and which it said it followed at the time of the events being investigated - repeated the 62 and 31-day targets.

10. Welsh Health Circular (2019) 028 ("the WHC") The Consolidated Rules for Managing Cancer Waiting Times (September 2019) was circulated to the Chief Executives of all Welsh health boards in September 2019; this was noted as the final version of the updated rules for managing cancer waiting times ("CWT") which would replace all previous guidance with effect from 1 December 2019. The document provided guidelines relating to the management of CWT and the reporting of performance against the cancer targets.

11. The guiding principles stated that the guidance, "is to ensure that the patients' wait for suspected cancer diagnosis and treatment are measured and reported in a consistent and fair manner. The guiding principles of CWT clearly reflect the prudent health principles. Patients should be managed with the aim of starting treatment at the earliest clinically appropriate time rather than against any performance measures".

12. The WHC, when published, indicated in relation to Welsh patients treated in England that:

- "At a later date, our intention is to report on Welsh patients treated in England. At present (August 2019) this is not possible. Discussions are taking place with NHS Digital to explore how this might be achieved. Until a solution is agreed, patients treated in England will be treated in line with the English cancer standards".

- "When a referral is made to an English NHS provider, the English NHS provider is accountable for the monitoring of that patient's pathway. English NHS providers must ensure that communication protocols are utilised so that appropriate information is shared, and CWTs are measured accurately. The Welsh targets need to be communicated as part of any contracts with other NHS providers (England and Wales). It is the responsibility of the commissioning Welsh health board to ensure they have processes in place to monitor and performance

manage their contracts for cancer provision, ensuring targets are met. It is our intention to capture patients treated in England on the SCP,[6] however systems and process do not allow this at present. Discussions are underway with NHS Digital and this guidance will be updated when the systems to allow this are in place".

- "Where NHS activity is commissioned from an English provider, the accountability for manging the patient wait lies with the health board commissioning the activity. The commissioning health board will need to ensure data is shared with the reporting health board, if different, as the reporting of the patients' pathway remains with the health board who received the original patient referral".

13. In terms of reporting, the WHC stated that:

- "All patients who are not treated within the NUSC and USC targets should have a breach report completed detailing their pathway journey and outlining the lessons learnt and remedial actions taken within the health board".

14. The 'Consolidated Guidelines for Managing Patients on the Suspected Cancer Pathway' (December 2020, Version 2.0) ("the Guidelines for SCP") provides guidelines relating to the management of patients on a suspected cancer pathway and the reporting of performance against the cancer target. The updated guidance introduces new rules around the management of patients on a suspected cancer pathway and includes the reporting of patients treated outside of NHS Wales when referred from secondary care in NHS Wales. In terms of CWT targets, a new single cancer pathway replaces the previous 2 standards - the USC and the NUSC. In relation to patients treated outside Wales, it states:

- "Those patients who are referred from NHS Wales secondary care to have their further investigation, and/or first definitive treatment undertaken outside of NHS Wales must be included in cancer waiting times reporting but those referred directly from primary care will not".

[6] Single Suspected Cancer Pathway – measures CWTs from the point of suspicion of cancer until start of first definitive treatment for all newly diagnosed patients.

- "When a referral is made to an English NHS provider, the English NHS provider is accountable for the monitoring of that patient's pathway. English NHS providers must ensure that communication protocols are utilised so that appropriate information is shared, and CWTs are measured accurately. The Welsh targets need to be communicated as part of any contracts with other NHS providers. It is the responsibility of the commissioning Welsh health board to ensure they have processes in place to monitor and performance manage their contracts for cancer provision, ensuring targets are met. All patients referred for treatment outside NHS Wales from secondary care will be included in CWT reporting".

- "Where NHS activity is commissioned from outside NHS Wales, the accountability for managing the patient's wait lies with the health board commissioning the activity. The commissioning health board will need to ensure data is shared with the reporting health board, if different, as the reporting of the patient's pathway remains with the health board who received the original patient referral".

15. In relation to patients not treated within target, it states:

- "All patients who are not treated within the target should have an internal breach report completed detailing their pathway journey and outlining the lessons learnt and remedial actions taken within the health board. All patients who have waited too long from POS[7] for their treatment and are suspected of coming to harm should have a clinical review undertaken and submitted to Welsh Government".

16. The Health Board's "Cancer 104 Day Harm Review Group" Terms of Reference (April 2020 – "the Harm Review Group") aim to review the care of cancer patients with a waiting time of over 104 days to identify any avoidable clinical and non-clinical factors. The Harm Review Group will consider whether harm has been caused by the wait, and the process will be used for patients presenting to and treated by the Health Board. If a

[7] Point of suspicion – the waiting time for patients on the suspected cancer pathway starts at the point which cancer is suspected (i.e. the point of suspicion).

patient's pathway starts and remains outside of the Health Board, the Health Board's commissioning team "will request harm reviews be completed by treating organisations".

The Health Board's evidence

17. I obtained comments and copies of relevant documents from the Health Board. In summary, the Health Board confirmed:

- That it was working to the Welsh Government Policy in terms of the 62/31-day cancer target times.

- In line with Welsh Government policy at the time of the events under investigation, only patients treated in Wales were reported against Welsh cancer waiting time targets which is why breach reports and harm reviews were only completed for patients treated by the Health Board. The Welsh Government changed this position with effect from January 2021 to include patients treated in England. This was following requests to include reporting of these patients treated in England from the Health Board and others (the Health Board referred to the relevant sections in the WHC and the Guidelines for SCP outlining these guideline changes – see paragraphs 10 - 15).

- Of the 17 patients (including Mr Y), there were 2 NUSC breaches reported, harm reviews were completed for both patients and no harm was identified; 2 USC breaches were reported, harm reviews were completed for both patients and no harm was identified; 8 patients were treated in England (a mixture of USC/NUSC patients); 2 NUSC where there were no breaches; 2 USC patients where there were no breaches and 1 patient who was not reportable against the Welsh cancer waiting times target.

- That harm reviews are completed for all cancer patients treated by the Health Board over day 104 on their cancer pathway (see paragraph 16) and that this was not mandated by Welsh Government in 2019 but completed by the Health Board as good practice.

- It would only complete harm reviews for patients treated by the Health Board. It will review this decision in line with the Guidelines for SCP and when it reviews the harm review process at the next harm review panel.

- The 4 harm reviews completed identified action points for learning including placing prostatectomy capacity on the Health Board risk register (added 24 July 2018 - current risk is scored as high) and to review how patients are counselled over treatment options for prostate cancer (an agreement was made to develop a protocol at the urology clinical advisory group in October 2020).

- A risk register entry (updated on 16 September 2020) identified risk relating to urology surgical capacity impacting on the ability to deliver RTT targets for urology. To address this risk, the Health Board identified the need to move forward with service remodelling and that there were short term contracts in place with 2 English Trusts to support with the delivery of prostate surgery and other urological cancers.

- It wrote to the Welsh Government Health and Social Services Group in September 2020 in response to the WHC, and amongst other things, noted that there was no mention in the document of reporting waiting times for patients treated in England. It said that it did not, at that time, report waits for those patients which it said "appears to be an anomaly".

- It had contracts with 2 English Hospital Trusts ("the First Trust" and the "Second Trust" respectively): with the exception of the contract with the Second Trust for 2018/2019, they were unsigned. The contracts were implied by performance given the contracts were issued to both providers. The contracts' operational standards in terms of cancer waiting times indicated that any breach of the 62-day USC wait target would lead to formal escalation of performance reporting to the Health Board; a breach of the 31-day target NUSC resulted in a financial penalty.

- The arrangement for the First Trust to treat prostatectomy patients is an ongoing historical one. A contract with another English Hospital Trust ("the Third Trust") started in February 2020 for prostatectomies.

- It holds regular weekly access meetings to discuss the performance of English providers in relation to RTT Rules.

18. A urology service update report in September 2020 identified recruitment and contractual capacity concerns.

Welsh Government comments

19. I obtained comments from the Welsh Government relating to cancer treatment time targets. In summary:

- It clarified that, since the introduction of RTT Rules, Welsh policy has been to report on the performance of Welsh health boards as providers only; it does not formally report, or performance manage their commissioning arrangements.

- It said there was a very clear expectation that the Health Board through its own commissioning policy ensures that patients are treated in a timely manner in line with Welsh standards; the performance with English providers is discussed at the regular quality and delivery meetings between each health board and the Welsh Government and any issues or concerns are raised in that forum. Health boards report to their board on the effectiveness of their commissioning strategies and performance of Welsh patients treated in England.

- It would expect, as a minimum, that the Health Board had a policy regarding delayed treatment with their providers to mirror Welsh standards that included formal reviews, breach reports, harm reviews and serious incidents on all patients who breach cancer waiting times.

- From January 2021 all patients will be managed on the new single cancer pathway and the other cancer pathways will no longer be managed and reported on. In introducing the pathway, it has decided

that all patients referred from secondary care for treatment outside Wales for their cancer treatment must be included in cancer waiting times.

- Guidelines (i.e. before the single cancer pathway) required all health boards to produce a breach report for any patient who did not start treatment within 62 or 31 days, depending on the pathway they were on, but it did not appear that breach reports were always used in a systemic manner to drive improvements and highlight service issues. It is currently reviewing whether health boards need to formally submit breach reports to the Welsh Government in future, but its expectation is clear that these need to continue within each health board and be used for service improvement and peer review.

- In response to the Health Board stating that only patients treated in Wales are reported against Welsh cancer waiting times targets, which is why breach reports and harm reviews have only been completed for patients treated by the Health Board (which it said was in line with Welsh Government policy), it said that it expected this to be embedded in health boards' commissioning contracts and that the health boards would have requested this from their English providers who currently operate a harm review process.

Analysis and conclusions

20. I commenced this investigation on my own initiative to consider whether the Health Board had exceeded the RTT target for cancer waiting times for treatment of prostate cancer in respect of 16 patients who, in August 2019, were awaiting prostatectomies. The Health Board told me during my investigation into Mr Y's complaint that all 16 patients had an urgent clinical priority. My own initiative power allowed me, in this case, to extend my investigation of Mr Y's complaint to consider whether there were systemic issues within the Health Board's urology service in terms of delivery of prostate cancer treatment (particularly prostatectomies) within Welsh cancer targets.

21. In August 2019 only patients treated in Wales were reported against Welsh cancer waiting time targets, the Health Board only produced breach reports and harm reviews for patients treated by the Health Board; this did not apply to patients referred by it for treatment in England. My guidance is clear, good administration requires that public service providers need to ensure that people are treated fairly and consistently so that those in similar circumstances are dealt with in a similar way.

22. Of the 16 patients, 8 were referred to England for treatment. If these 8 patients had been treated in Wales, all 8 would have been reported because they breached the 62 and 31-day target for RTT. Additionally, each of these 8 patients would have received a harm review to determine if the breach in waiting time had any clinical impact on their treatment or prognosis; harm reviews were completed for the 4 patients who were treated by the Health Board who breached the RTT target.

23. Whilst I accept that the Welsh policy position at the time meant there was no requirement to produce breach reports to the Welsh Government or to carry out harm reviews for Health Board patients being treated in England, in terms of fairness and consistency of patient treatment, the geographical location of treatment should not have left these 8 patients in the position where they were denied the harm review process because they were treated outside Wales. Regardless of the Welsh policy position at the time, the Health Board was obliged to undertake appropriate monitoring of the care and treatment of its patients under its commissioning and contracting arrangements. It should also have considered the impact of the delay in treatment. These failures amounted to maladministration which caused injustice to those 8 patients who were treated differently to the patients who were treated by the Health Board. My guidance is clear that if applying procedures strictly would lead to an unfair result for an individual, then a public service provider should seek to address this unfairness.

24. The rules in place in August 2019 stipulated that when a referral was made to an English provider, the Health Board commissioning the pathway was accountable for monitoring the patient's pathway and that accountability for performance against the targets lay with the commissioning Health Board. The Health Board had responsibility for

monitoring compliance of its commissioning arrangements and the contracts I have seen indicated that the Health Board had escalation processes in place for breaches of the 62 and 31-day target. The information I received confirms general high-level oversight of commissioned services was undertaken, with concerns being expressed about the need for extra provision of urology services. However, I have seen no evidence that the Health Board proactively monitored these contracts specifically in line with its contractual operational standards or had regard to the impact of delayed services on the individual patients.

25. The Guidelines for SCP has now addressed the inconsistency of the previous approach; all patients referred from secondary care for treatment outside Wales for their cancer treatment must be included in cancer waiting times (with the exception of those referred directly from primary care) and all patients not treated within the target should have an internal breach report completed, including identifying any lessons learnt and remedial action to be taken. In addition, all patients who have waited too long from POS for their treatment and are suspected of coming to harm, should have a clinical review. Whilst I welcome this change which now addresses the anomaly of the previous approach, the inequity of not carrying out harm reviews for the patients treated in England meant there was a loss of opportunity to ensure harm to individuals did not go unremedied, for potential learning and for improvement. Harm reviews provide health boards with the opportunity to identify service issues and to contribute towards service delivery improvements. In line with my approach to remedy, the Health Board should return these patients to the position they would have been had they been treated in Wales in terms of carrying out a harm review.

26. I have reported on the Health Board's urology services several times, and I am concerned that, even in September 2020, it identified recruitment and contractual capacity concerns. This is not a new issue. Healthcare Inspectorate Wales ("HIW") carried out a Urological Cancer Peer Review of the Health Board in February 2014. Whilst good practice was identified, several serious concerns were highlighted, including:

- A lack of clinically or management led consensus for the delivery model of urological cancer services in North Wales.

- The Multi-Disciplinary Teams ("MDT") stated that patients had been lost or delayed to follow-up and have deteriorated while waiting for their appointment.

- A lack of succession planning for the service "compounded by the lack of strategic direction from management on the delivery of urological services for the population of [the Health Board]".

- The Peer Review team were very concerned that they had not been reassured that high quality and safe urological cancer services would be provided in the future.

- Outpatient and Inpatient capacity.

- Lack of key worker support in general across the Health Board.

27. Additionally, the HIW report stated that "All MDTs stated that it is common practice for patients, who are due to breach, to be invited to have their surgery in centres in England, however the Health Board has had difficulty in finding nearby centres with the capacity to undertake this work. The Review team were informed that this practice was not clearly communicated to medical and specialist nursing staff and has led to some anxiety and confusion". This is concerning, and whilst I am unable to reach a finding that the 8 patients treated in England were referred outside the Health Board in order to avoid breaching the cancer waiting times target, the fact it was recognised that this was its approach in 2014, does raise the question whether this was still happening 5 years later.

28. I am also concerned that capacity issues continue to be a problem and the impact of this on patient care. I am currently investigating another complaint against the Health Board's Urology service. The fact that locum consultants were engaged to support the only 2 employed consultants at that time appears to have led to inconsistent follow up of patients. I will be reporting on this case separately, but it appears that capacity and succession planning for the Urology department is still an issue.

Recommendations

29. I **recommend** that the Health Board, within **3 months** of the date of this report:

a) Carries out harm reviews for the 8 patients treated in England. If the reviews identify that harm was caused, the Health Board should write to the patient explaining this and consider the individual cases under the Putting Things Right Process.

b) Asks the Harm Review Group to review the Guidelines for SCP and review the harm review process to ensure that the terms of reference are updated and in line with the requirements of the Guidelines for SCP.

c) Refers the report to the Board to consider capacity and succession planning in the urology department.

30. I am pleased to note that in commenting on the draft of this report the Health Board has agreed to implement these recommendations.

Nick Bennett 26 August 2021
Ombwdsmon/Ombudsman

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REF: 202002273 / COM46261

Summary: Under the provisions of the Public Services Ombudsman (Wales) Act 2019 ("the Act"), pursuant to S4, the Ombudsman can carry out an investigation using own initiative power. In September 2019 Mr Y complained about the prostate cancer care and treatment he received from the Health Board. He complained that:

- The Health Board failed to meet the guidelines for cancer diagnosis, which led to him seeking private treatment due to concerns about the impact of the wait for treatment.

On 22 September 2020, the Ombudsman commenced an investigation under own initiative power to consider whether the Health Board exceeded the Referral to Treatment target for cancer waiting times (this sets out the waiting time management rules, including cancer waiting time targets) for treatment of prostate cancer in respect of the other 16 patients with urgent clinical priority awaiting prostatectomies in August 2019.

Scrutiny	Divisional Clinical Director Divisional Head of Nursing Divisional General Manager Divisional Head of Governance	**Supporting Documents / National Drives**	
Action Plan Lead(s)	Divisional General Manager		
Updated	Created 30.07.2021, updated 12.8.2021, updated 17.8.2021, updated 26.8.2021		

	Ombudsman Recommendations	Leads	By	RAG	Comments/update
a.	Carries out harm reviews for the 8 patients treated in England. If the reviews identify that harm was caused, the Health Board should write to the patient explaining this and consider the individual cases under the Putting Things Right Process.	Caroline Williams, Performance Lead, Cancer Services	26 November 2021		
b.	Asks the Harm Review Group to review the Guidelines for SCP (suspected cancer pathway) and review the harm review process to ensure that the terms of reference are updated and in line with the	Caroline Williams, Performance Lead, Cancer Services	26 November 2021		This action is compete and the process updated.

REF: 202002273 / COM46261

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	requirements of the Guidelines for SCP.				
c)	Refers the report to the Board to consider capacity and succession planning in the Urology department	Clive Walsh Director of Regional Delivery	26 November 2021		A report on urology services was presented to the QSE Committee in September 2021. This included a proposal for a Royal College Invited Review with the terms of reference presented at the November 2021 meeting.

Appendix 3

Invited review of urology services in North Wales

DRAFT Terms of Reference v0.4

In conducting the review, the review team will consider the standard, safety and quality of care provided by the urological surgery service.

Specific reference should be made to:

1. Clinical Pathways

Both established and developing clinical pathways in providing optimal clinical care, including consideration of:

.

(i) The effectiveness of the management of the urology Suspected Cancer Pathways (SCPs) in-line with national standards, particularly prostate
(ii) The effectiveness of referral pathways in enabling timely access for patients to effective interventions
(iii) Clinical decision making.
(iv) Access and waiting times for cancer and non-cancer pathways
(v) Frequency and adequacy of follow-up arrangements for patients on these pathways

2. Multi-disciplinary Teams

The effectiveness of the multidisciplinary teams (MDTs) in ensuring continuous, consistent and optimal patient-care.

3. Clinical Governance

Clinical governance, including the effectiveness of:

(i) Mortality and Morbidity (M&M) in discussing cases as part of learning and taking forward actions.
(ii) The processes in place for concerns and incidents to be reported and addressed.
(iii) The robustness of recommendations made following Serious Incident Reviews.
(iv) The reliability of follow-up of outcomes from Serious Incident Reviews and external reviews
(v) The appropriate communication of outcomes following reported concerns and incidents
(vi)The response to concerns raised in reports of the Public Services Ombudsman for Wales

4. Clinical Outcomes

Clinical outcomes, complications and mortality for both the service and individual surgeons in the context of accepted national and international standards/norms.

Identify areas of good and exceptional practice

Identify areas of practice which have utilised innovative and/or transformational methodologies

Identify areas of practice which could benefit from innovation and or transformation

5. Staffing

The adequacy of the medical and non-medical staffing and clinical facilities for the volume and type of clinical activity undertaken.

6. **Infrastructure Support**

The adequacy of the infrastructure supporting delivery of clinical services, which should include, but not be exclusive to Information Technology and Informatics.

7. **Behaviours**

Behaviours, communication and team working, including specific reference to:

(i) The team of consultant urology surgeons.
(ii) The wider urology service.
(iii) The multi-disciplinary team (MDT).
(iv) Engagement and communication between the urological surgery service and other hospital services, primary care services, and tertiary referral services.

8. **Communications**

Communication with patients and other health professionals, with specific reference to:

(i) The effectiveness of providing information to patients in supporting and enabling shared decision-making.
(ii) The adequacy and timeliness of the provision of patient clinical information to the appropriate primary and community health care teams.
(iii) The interaction between primary and secondary care and the views of the primary care clusters

9. **Leadership**

Leadership within the urology service, in particular:

(i) leading a coordinated urology service across all three sites and primary care
(ii) encouraging the use of data to improve services
(iii) managing waiting times
(iv) strategic workforce and succession planning
(v) governance processes
(vi) promoting appropriate professional behaviours and culture
(vii) robust accountability

Reporting

The review team will report to the SRO, Gill Harris, Deputy Chief Executive / Executive Director of Nursing and Midwifery.
After review for factual accuracy, the report will be placed in the public domain.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 2nd November 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Annual Report of the Radiation Protection Committee (2020/21)
Cyfarwyddwr Cyfrifol: Responsible Director:	Adrian Thomas Executive Director of Therapies and Healthcare Sciences
Awdur yr Adroddiad Report Author:	Peter Hiles Medical Physics Expert/Radiation Protection Advisor
Craffu blaenorol: Prior Scrutiny:	Radiation Protection Committee and Clinical Effectiveness Group
Atodiadau Appendices:	1. Annual Report of the Radiation Protection Committee 2020-21 2. Report of Radiation Incidents 2020

Argymhelliad / Recommendation:

The QSE Committee is asked to approve the Annual Report of the Radiation Protection Committee (2020/21)

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Sefyllfa / Situation:

This paper forms the annual report from the BCU Radiation Protection Committee

Cefndir / Background:

The Radiation Protection Committee oversees the radiation safety of staff, patients and public. This includes ionising (e.g. X-rays and radioactive substances) and non-ionising radiation (e.g. lasers, UV) and ultrasound and Magnetic Resonance Imaging (MRI).

This annual report outlines the coverage of the work of the Committee over the past year to provide assurance to the Board that radiation safety has been monitored and maintained.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The report aligns to regulatory compliance of BCUHB in the safe and appropriate use of ionising and non-ionising radiation in the diagnosis and treatment of patients.

Opsiynau a ystyriwyd / Options considered

N/A

Goblygiadau Ariannol / Financial Implications

The report does not address specific financial implications but these are being addressed through appropriate business cases.

Dadansoddiad Risk / Risk Analysis

The report identifies a small number of new risks and mitigations which have been escalated to the Executive Director for Therapies and Healthcare Sciences.

The risks are being managed through the risk management process and register and necessary actions are either in place or being developed.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

This reports provides assurance of compliance with radiation regulations, in particular the Ionising Radiation Regulations 2017 (IRR2017) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R2017)

Asesiad Effaith / Impact Assessment

This report applies to the radiation safety of all patients, staff and public equally across the Health Board.

From an equality perspective it provides assurance that radiation dose is optimised for all patients. There is no impact on socio economic duty

Appendix 1

Annual Report

Radiation Protection Committee 2020-21

1. **Title of Sub-Group**: Radiation Protection Committee (RPC)

2. **Name and role of person submitting this report**: Adrian Thomas

3. **Dates covered by this report**: April 2020 – March 2021

4. **Number of times Sub-Group met during the year**: 2

5. **Assurance/s this Sub-Group is designed to provide**:

Radiation safety of staff, patients and public. This includes ionising radiation (e.g. X-rays and radioactive substances) and non-ionising radiation (e.g. lasers, ultra violet) and ultrasound and Magnetic Resonance Imaging (MRI).

6. **Overall *RAG status against Sub-Group's annual objectives / plan**: G

7. Main tasks completed / evidence considered by the Sub-Group during this reporting period:

7.1 **COVID-19 Radiation Safety Issues**. Special meeting held in June 2020 to address several issues including:

- Reviewing temporary regulatory relaxation proposals from Health and Safety Executive, Office for Nuclear Regulation, Health Inspectorate Wales and Natural Resources Wales.
- Maintaining essential services
- Approve a series of radiation safety documents (including special Radiation Safety Handbook for Rainbow Hospitals
- Temporary concession for non-medical referrals
- Emergency orthopaedic work relocation
- PET-CT mobile service relocation issues
- Transfer of sentinel node biopsy theatre work
- Additional transport of radioisotopes due to temporary closure of radiopharmacies
- Testing of Radiology equipment as numbers increase to cover COVID-19 requirements and backlog issues post-COVID
- UV Sterilisation for COVID-19
- Development of virtual training modules

7.2 **Review of radiation incidents**, including those reported to bodies external to the Health Board. The summary in Appendix 2 Report of Radiation Incidents 2020 shows that the overall number of incidents and the number of externally reportable incidents was similar to 2019. To put the externally reportable incidents in context: within Radiology, they represent a very small fraction (just 0.02%) of all X-ray examinations performed. Medical Physics have developed a live dashboard for radiation incidents using Microsoft PowerBI.

7.3 **Review of staff annual radiation doses for 2020**. The Health Board monitored approximately 750 members of staff, issuing over 6,500 dosimeters. This included environmental monitoring of mobile radiography work due to COVID-19. All results were satisfactory with no results exceeding an Annual Threshold Investigation level.

- Pharmacy staff finger doses continue to be under review
- The cost the Health Board due to non-returned dosemeters has increased from £3,900 in 2019 to £5,800 in 2020. However, the difficulties of collecting the dosemeters during the pandemic was a contributory factor. This information was forwarded to local Radiation Protection Groups and services for improvement action.
- Three members of staff exceeded the dose Investigation level: Two interventional radiology staff and one cardiologist. Individuals and managers were informed and action was taken to reduce doses.
- The dose investigation levels have been revised downwards to improve radiation safety.

7.4 **Radiation Safety Audits and inspections**.

- Internal X-ray and Laser audits performed and reported to RPC. Also *Doctor radiation awareness* audit highlighted need for additional training; Orthopaedics recording clinical assessment response required (mandate Tier 2 Audit);
- HSE national report on inspections. Review of issues raised.

7.5 **Safety Issues addressed**:

- Handheld UV decontamination devices
- Current decontamination process for ultrasound is causing significant damage to transducer probes and casing. Formal concern raised with company which has been escalated and alternative (Ultra Violet C) method being investigated.

7.6 **New guidance and safety alerts considered**:

- The Carriage of Dangerous Goods (Amendment) Regulations 2019 came into force on 21st April 2019, but the part relating to emergency plans only came into force in April 2020. Amongst other things, this requires regular testing of plans and, additionally, a report of the test to be sent to the Office for Nuclear Regulation
- Guidance Notes for Dental Practitioners on the Safe use of X-ray Equipment. 2nd Edition. FGDP
- Significant accidental and unintended exposures under IR(ME)R. Guidance for employers and duty-holder. Version 2, August 2020. CQC/HIW

- IR(ME)R implications for clinical practice in diagnostic imaging, interventional radiology and diagnostic nuclear medicine. RCR/BIR/SCoR/IPEM June 2020.
- IR(ME)R implications for clinical practice in radiotherapy. Guidance from the Radiotherapy Board.
- CQC IR(ME)R Annual Report. Highlighted shortage of Medical Physics Experts (MPEs) in England

7.7 **Revised policies**:

- COVID-19 arrangements and documentation
- Revision of Local Rules and introduce Radiation Safety Handbook
- R&D02 v5 Policy for research involving ionising and non-ionising radiation

7.8 **Reviewed planned developments of Health Board** involving radiation. These included new Orthopaedic Operating Theatre; CT-in-a-box relocatable CT scanner; replacement radiography equipment, Eryri Community Hospital and Ysbyty Gwynedd Room 8; modifications to Wrexham Maelor Hospital ENT theatre to take new laser work; issues with cracks in tubes of home phototherapy units;

7.9 **Reviewed Radon radioactive gas levels in Health Board premises** and actions including Radon monitoring, re-monitoring and remediation.

8. Main action plan themes / tasks due for completion in forthcoming year:

8.1 **New Regulations review meetings**. An ad-hoc group, under the RPC, was formed to assess the impact of implementing the Ionising Radiations Regulations 2017 (IRR 2017). An IRR 2017 action plan is being worked through.

8.2 **Risk benefit information for patients**. The new legislation governing ionising radiation requires patients to be informed of the benefits and risks of a radiation exposure beforehand. The way in which this may be performed is currently being discussed on an All-Wales basis.

8.3 **Radiopharmacy staff dose working party**. Formed to review staff finger doses due to variations in doses between centres.

8.4 **MR Physics Safety Expert**. Contract with the Radiation Physics and Protection Service (RRPPS), Birmingham signed, covering 2020/21 and 2021/22. Start date 16th November 2020.

8.5 **Nursing homes registration**. The process by which nursing homes could formally appoint a BCUHB member of staff as their RPA is now resolved. A template letter that can be used has been drafted and approved by the Legal Team. But use of the letter has not progressed due to the small number of nuclear medicine patients being done due to COVID-19 situation

9. New risks and issues identified by this Sub-Group in-year:

9.1 **Non-Ionising Radiation Physics Cover**. Twelve months long-term sick absence and then retirement has meant BCUHB has not had staff to cover this work since May 2020. Risk assessment done and discussions with NWMCS Directorate ongoing.

This was put on the risk register and a temporary contract was put in place with an external organisation to provide this support.

9.2 **Handheld Ultrasound equipment**. Concern raised over increase in handheld (point of care) devices being purchased without suitable governance arrangements. Using these machines would not be safe without suitable training.

A national review of ultrasound governance is being undertaken by the Radiation Protection Safety Advisory Group and the All Wales Imaging Quality Forum.

9.3 **Necessity of Classification for operators handling radioactive substances**. Due to reasonably foreseeable accident scenarios, it has been advised that staff in radio pharmacy be classified. However, BCUHB does not currently have an 'appointed doctor' for ionising radiation as required by the regulations to monitor classified workers.

Occupational Health were informed of the necessity to employ/engage a doctor with appropriate competencies to provide the monitoring for classified workers.

9.4 **Controlled areas in nuclear medicine**. Additional radiation monitoring equipment is required to monitor the designated Controlled Areas.

This is on the risk register (4032) and a business case has been submitted for funding the devices.

9.5 **Guidance on home working and Radon monitoring**. Under IRR 2017, the employer is responsible for ensuring that an assessment of radon levels is undertaken in workplaces in 'radon-affected areas'. In theory, this applies equally to staff working from home, which is currently a significant number due to COVID-19.

This was raised by P Bohan at the Health and Safety Leads meeting, there is no guidance from the HSE regarding radon levels for home working.

10. If appropriate, have these new risks been escalated as an issue of significance.

Yes as noted above.

11. Further comments:

11.1 In response to issues of radiation protection and compliance, the following in-house radiation protection training has been carried out:

- New Radiation Protection Supervisor training
- Radiation Safety Update
- New courses developed: New Dental RPS training. Theoretical training to act as a Radiation Protection Supervisor for dental radiography work.

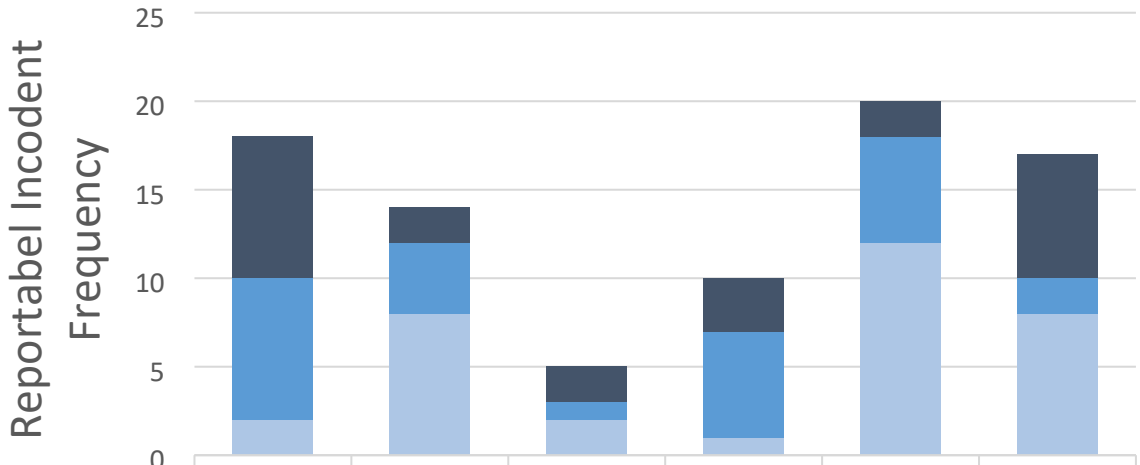
APPENDIX 2

Report of Radiation Incidents 2020

Radiation incidents are analysed and reviewed on a regular basis to ensure we note any trends and highlight learning items.

A1. Trend in externally (outside Health Board) reportable incidents

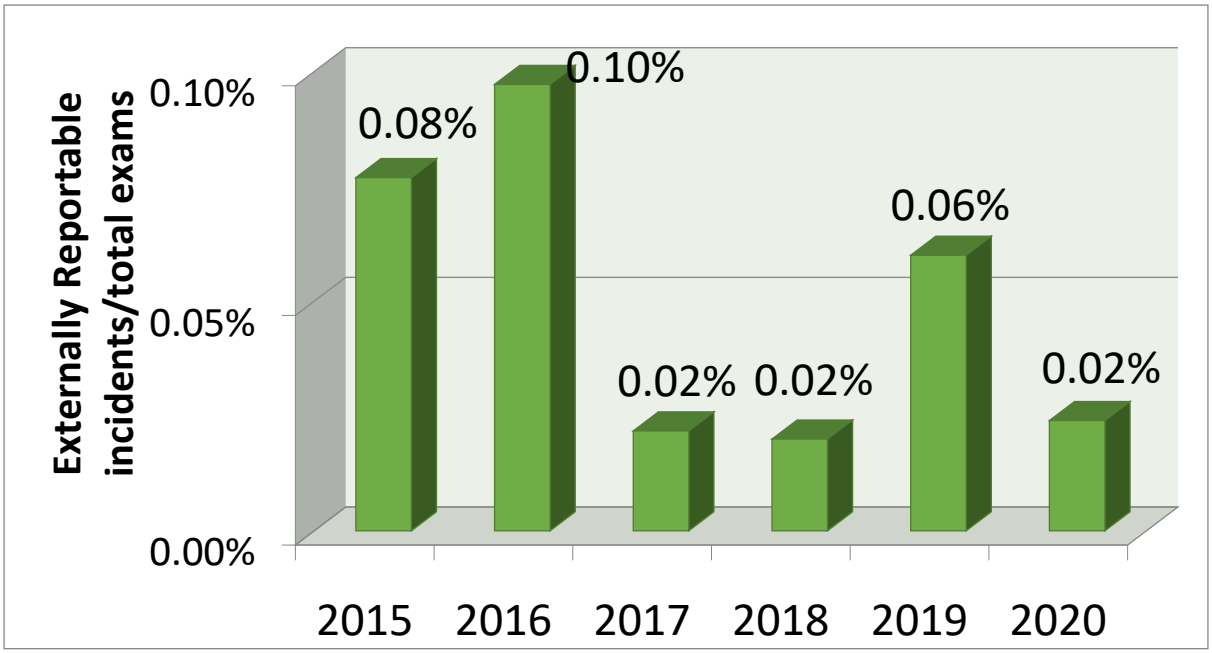
The overall numbers are small and the reporting thresholds defined by the regulatory bodies have changed over the years. This summary shows that the overall number of incidents and the number of externally reportable incidents was similar to 2019.



	2015	2016	2017	2018	2019	2020
West	8	2	2	3	2	7
East	8	4	1	6	6	2
Centre	2	8	2	1	12	8

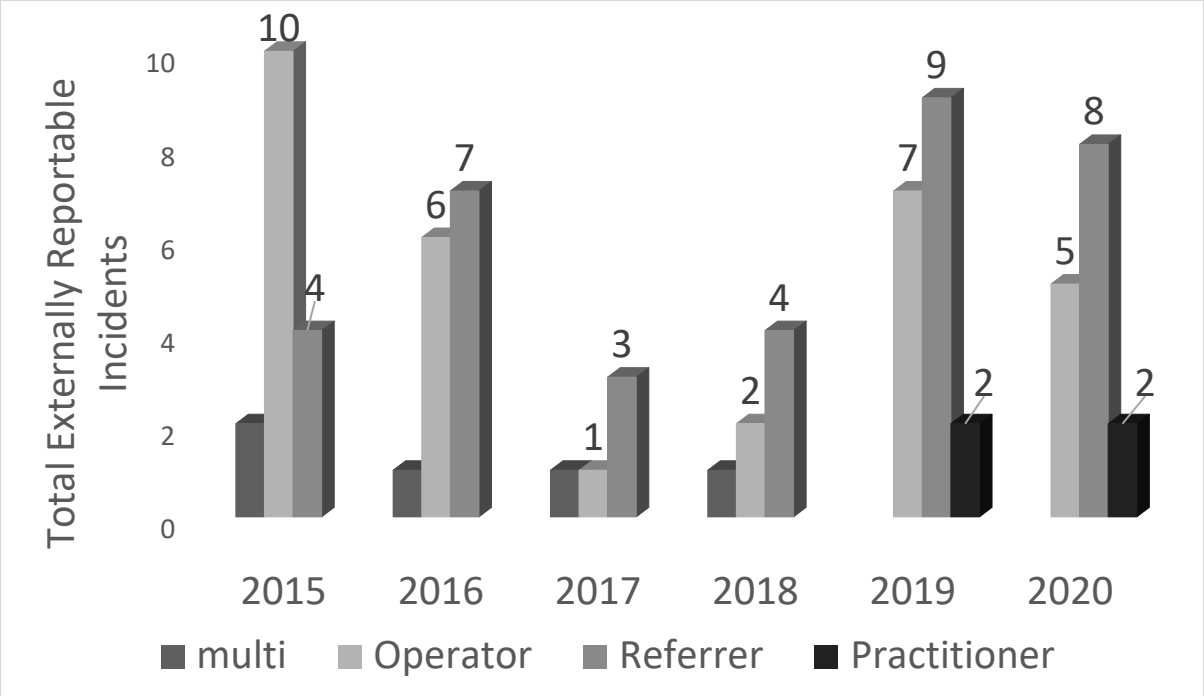
A2. Perspective on externally reportable incidents (Radiology only)

This is an attempt to put the externally reportable incidents in context (within Radiology) by expressing reportable incidents as a fraction of the total workload. This shows they represent a very small fraction (just 0.02%) of all X-ray examinations performed.



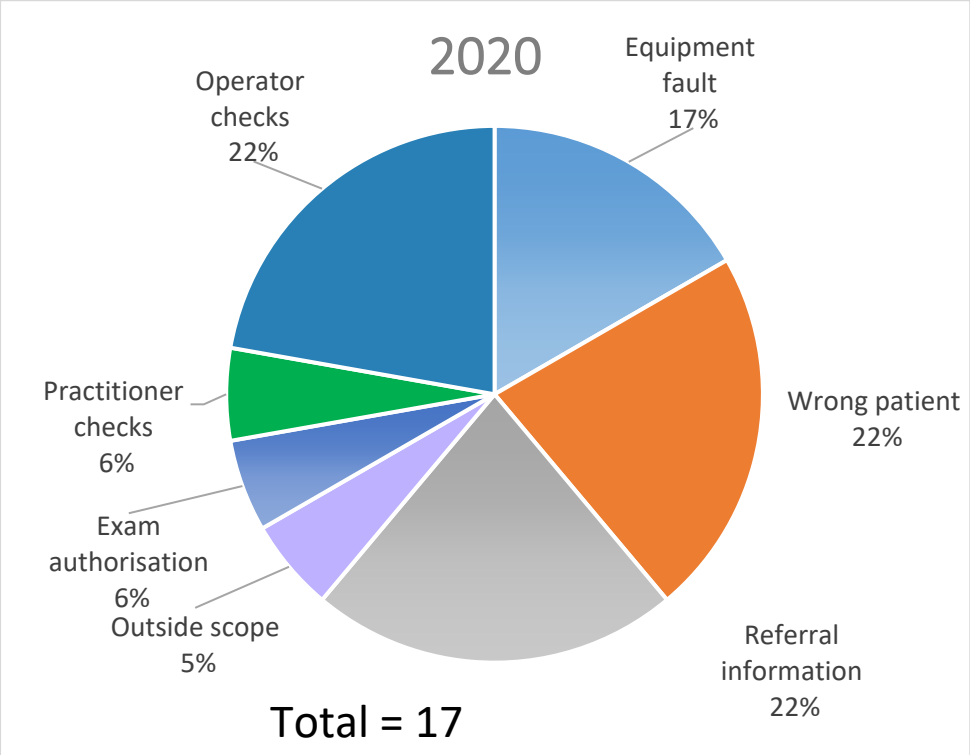
A3. Trend in staff group involved in reportable incident 2015 to 2020

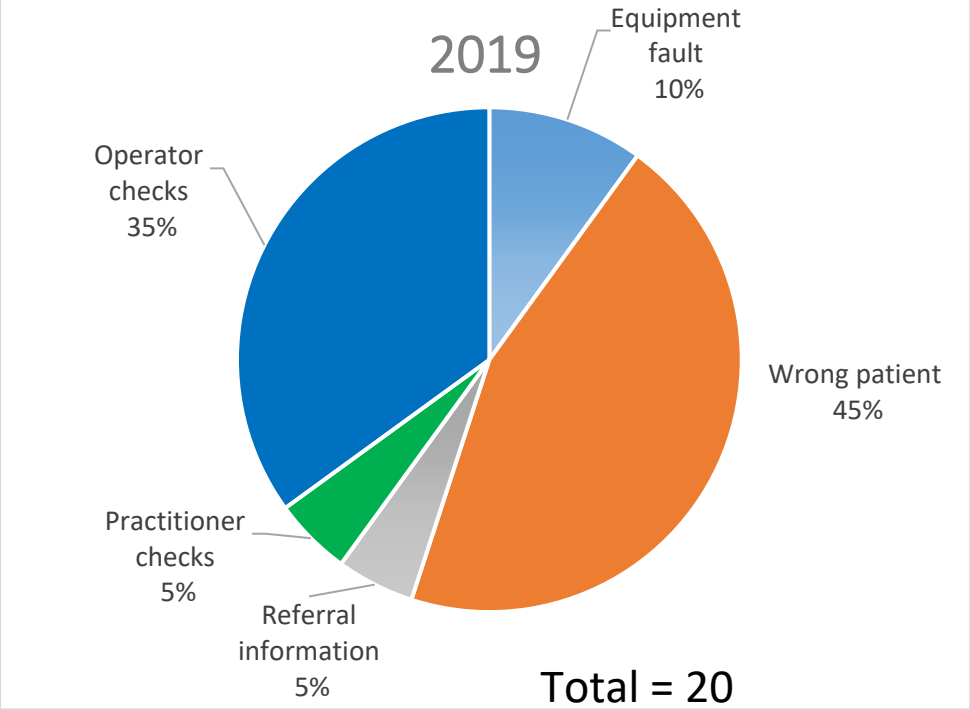
The IR(ME)R Regulations define the duty holders as Referrer (the one referring for the examination); Practitioner (the person justifying and authorising the exposure) and the Operator (the person, or persons, actually performing the exposure). It can be seen that Referrer errors consistently lead to reportable incidents.



A4. Comparison of categories of reportable incidents 2019 and 2020

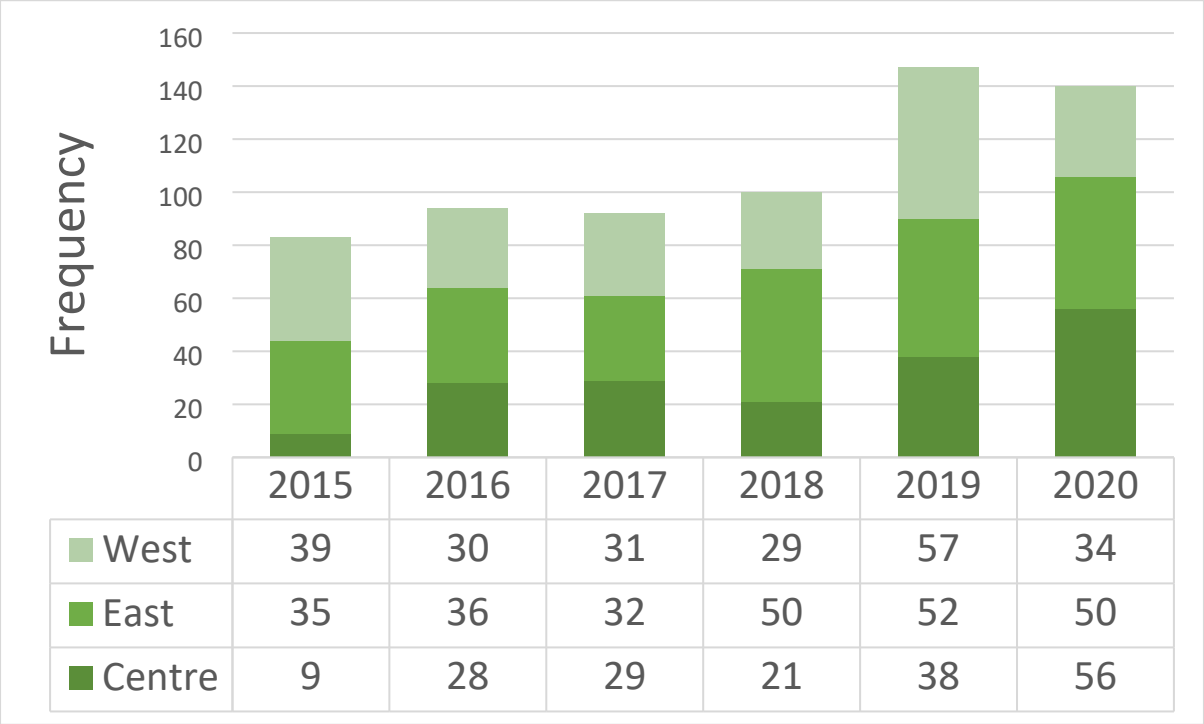
A national taxonomy for radiation incidents has been adopted to enable this categorisation.





A5. Trend in radiation incidents (reportable and non-reportable) 2015 to 2020

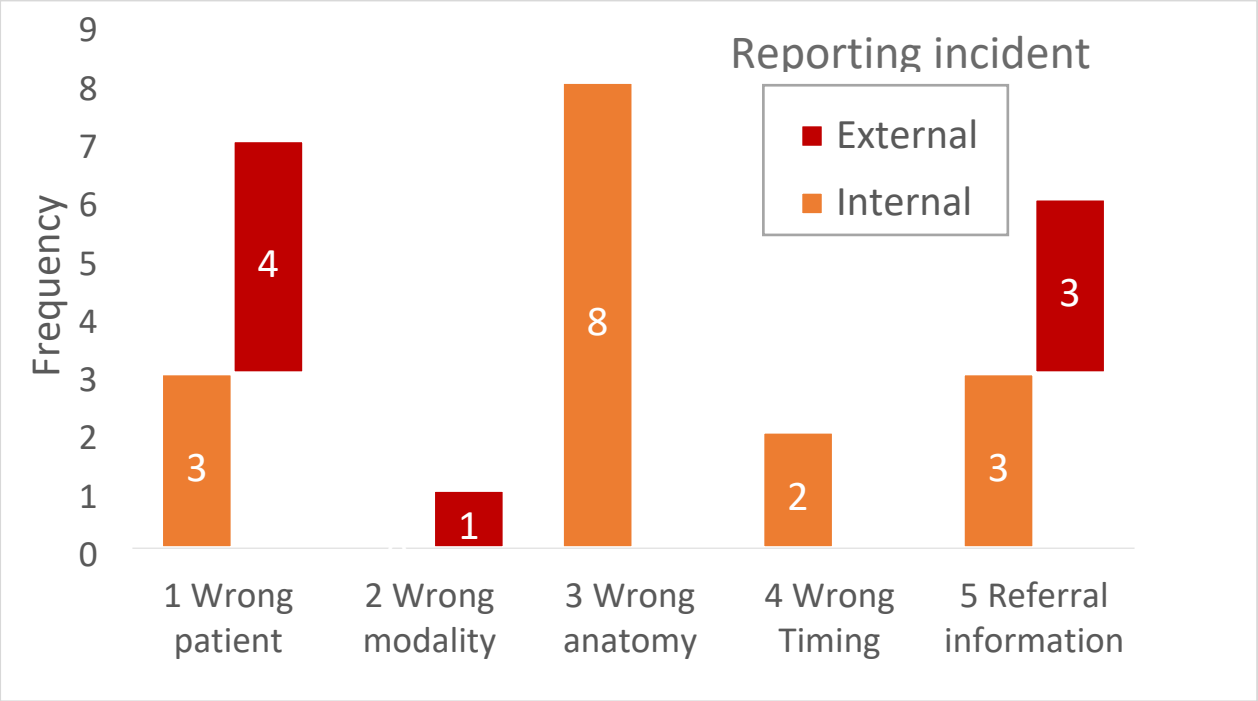
Data separated into areas West, East and Central.



	2015	2016	2017	2018	2019	2020
West	39	30	31	29	57	34
East	35	36	32	50	52	50
Centre	9	28	29	21	38	56

A6. Analysis of Referrer errors for 2020

Incorrect or incomplete referrals waste time and resources, but more importantly can be upsetting for patients, both for those we may miss an appointment and those undergoing the wrong examination.



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 2nd November 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Annual Organ Donation Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Mr Adrian Thomas, Executive Director of Therapies and Health Science.
Awdur yr Adroddiad Report Author:	Dr Andrew Foulkes, Consultant Anaesthetist and Clinical Lead Organ Donation – Ysbyty Glan Clwyd Mr Phil Jones, Specialist Nurse Organ Donation
Craffu blaenorol: Prior Scrutiny:	BCUHB Organ Donation Committee Executive Lead
Atodiadau Appendices:	1. NHSBT Summary Report Actual and Potential Deceased Organ Donation 1 April 2020 – 31 March 2021 2. NHSBT Detailed Report Actual and Potential Deceased Organ Donation 1 April 2020 – 31 March 2021 3. Organ Donation annual plan 2021-22

Argymhelliad / Recommendation:

The Committee is asked to note for information the report contents and future aims and objectives of the Organ Donation Committee.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Sefyllfa / Situation:

This paper aims to inform the Committee of the organ donation activity achieved across the three acute hospital sites in North Wales during 2020-2021. The paper highlights the hugely successful work undertaken by the Organ Donation Committee and describes the priorities set for 2021-2022 to ensure that organ/tissue donation remains an integral part of end of life care planning within critical care and the Emergency Department.

Appendix 1 and Appendix 2 provide a summary and detailed report respectively.

Cefndir / Background:

This annual report highlights the ongoing relationship with NHS Blood and Transplant encompassing organ and tissue donation and transplantation across the UK. In brief, as per the attached data set, BCHUB facilitated 16 proceeding organ donors in the period; along with 3 consented donors that did not proceed (1 Prolonged Time to Asystole (PTA) and 2 stood down post consent on new information). This resulted in BCUHB faclitating 35 transplants UK wide, noteably in pandemic

conditions. Incidentally, of the 49 proceeding organ donors in Wales, 16 were from our 3 District General Hospitals (DGH).

The overall consent rate for families approached in BCUHB for the period is 86%, well above the national and all Wales average. Currently the opt-in rate in Wales is 43% of the population; the majority of our donors are from this pool. This meant we did not require the application of deemed consent in the period which is a success as families are evidently discussing organ donation in life. We had 2 occasions where deemed consent was overridden, 1 approach by our Specialist Nurse Organ Donation (SNOD) requester, and 1 a consultant pre-approach without a SNOD present; we could then not re-approach the family. It is noteworthy that the deemed consent is a complex soft-opt out legislation which requires "gentle and appropriate" probing by a SNOD for its application and we will always respect the wishes of a grieving family.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

Organ donation work is unscheduled, therefore meets the criteria for emergency treatment. To have achieved the successes of this period is a credit to the workforce within BCUHB. The effort has placed an enormous extra workload on under-rescourced units. The units are obviously under-resourced as a consequence of the pandemic, so everyone involved has gone above and beyond.

Going forward, theatre space in particular will become problematic as we recover from the pandemic with the anticipated pressure on lists. Bed pressures within Intensive Therapy Unit (ITU) have represented a challenge at times and will continue to do so, particularly in central as we facilitate cardiac and vascular patient recovery. We have lost 1 potential donor in central recently due to "no bed", this has been escalated to the Welsh Transplant Advisory Group.

Adherence to the Devastating Brain Injury (DBI) pathway and Neurological Death Testing (NDT) protocols within BCUHB are exemplary, despite the prolonged ITU stay that this generates. This gold standard of practice invariably has a positive result on organ donation and good end of life care.

Organ donation remains a critical area of practice UK wide with donor numbers increasing yearly along with transplant lists. Each donor has the potential for 9 life-saving transplants, so the need for emergency care/treatment will continually feature within critical care practice.

Opsiynau a ystyriwyd / Options considered

N/A

Goblygiadau Ariannol / Financial Implications

We continue to have a very efficient and “fit for purpose” Organ Donation Committee who oversee the donor re-imbursement fund (as per best practice UK wide). This is invested appropriately facilitating organ and tissue donation education, staff-wellbeing and reimbursement for donor related equipment/consumables.

Dadansoddiad Risk / Risk Analysis

N/A

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Organ and tissue donation is bound to the Human Tissue Authority (HTA). In Wales, we are required to seek compliance within the boundaries of the Wales Human Tissue Authority Act 2013.

Of significance, is the approach and consent conversation; application of deemed consent has a rigid legal framework that the SNOD’s are trained to apply, thus pre-approaching potential donor families should now be constrained to historic practice.

Asesiad Effaith / Impact Assessment

As a team from NHS Blood and Transplant covering the North West of the country, our workforce is mainly English speaking. However, we have x2 Welsh speakers in the team who are available to facilitate conversations in Welsh if needed. Our promotional work is always bilingual and we have a fantastic working relationship with the BCUHB Communications Team.

Appendix 1

Actual and Potential Deceased Organ Donation 1 April 2020 - 31 March 2021

NHS Blood and Transplant

Betsi Cadwaladr University Health Board

Taking Organ Transplantation to 2020

In 2020/21, from 19 consented donors the Health Board facilitated 16 actual solid organ donors resulting in 35 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

In addition to the 16 proceeding donors there were 3 consented donors that did not proceed.

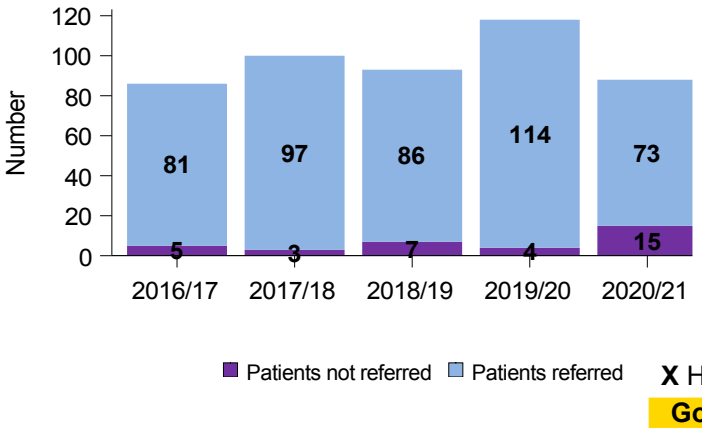
Best quality of care in organ donation

We acknowledge that the data presented in this section includes the period most significantly impacted by COVID-19 and appreciate that the COVID-19 pandemic affected Trusts/Boards differently across the UK.

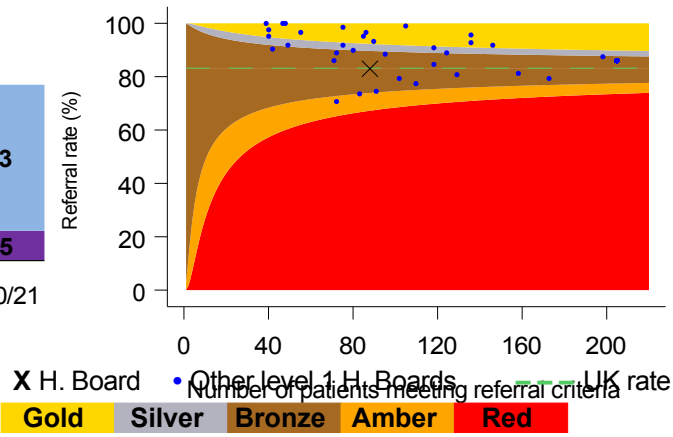
Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart



Aim: The Health Board (marked with a cross) should fall within Bronze, Silver, or Gold

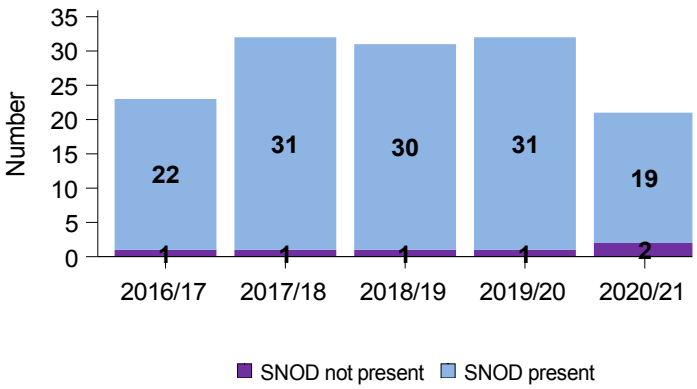


The Health Board referred 73 potential organ donors during 2020/21. There were 15 occasions where potential organ donors were not referred.

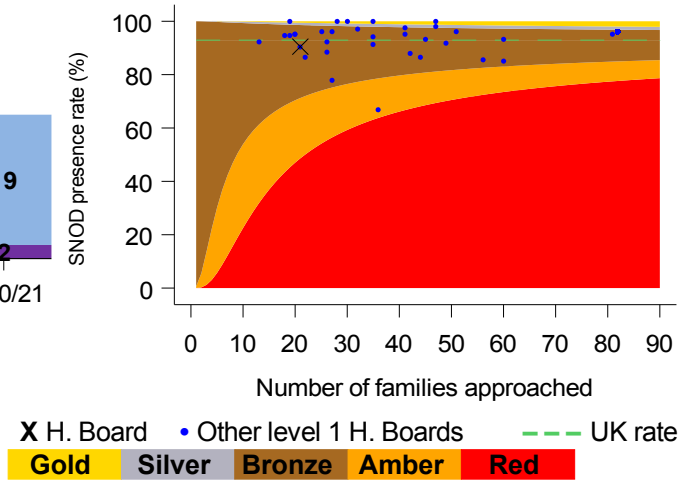
Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart



Aim: The Health Board (marked with a cross) should fall within Bronze, Silver, or Gold



A SNOD was present for 19 organ donation discussions with families during 2020/21. There were 2 occasions where a SNOD was not present.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	Wales*	UK
1 April 2020 - 31 March 2021		
Deceased donors	49	1,180
Transplants from deceased donors	102	2,943
Deaths on the transplant list	17	497
As at 31 March 2021		
Active transplant list	159	4,256
Number of NHS ODR opt-in registrations (% registered)**	1,323,716 (43%)	26,746,406 (41%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 3.1 million, based on ONS 2011 census data

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Health Board are shown below, including a UK comparison. Data obtained from the Potential Donor Audit (PDA).

Key numbers, rates and comparison with UK data, 1 April 2020 - 31 March 2021

	DBD		DCD		Deceased donors	
	H. Board	UK	H. Board	UK	H. Board	UK
Patients meeting organ donation referral criteria[1]	21	1810	71	6027	88	7551
Referred to Organ Donation Service	21	1777	56	4770	73	6282
Referral rate %	G *100%*	*98%*	B *79%*	*79%*	B *83%*	*83%*
Neurological death tested	17	1490				
Testing rate %	B *81%*	*82%*				
Eligible donors[2]	14	1353	36	2860	50	4207
Family approached	14	1210	7	1042	21	2248
Family approached and SNOD present	14	1168	5	925	19	2089
% of approaches where SNOD present	G *100%*	*97%*	B *71%*	*89%*	B *90%*	*93%*
Consent ascertained	14	891	4	665	18	1553
Consent rate %	G *100%*	*74%*	B *57%*	*64%*	S *86%*	*69%*
Actual donors (PDA data)	13	777	3	404	16	1180
% of consented donors that became actual donors	*93%*	*87%*	*75%*	*61%*	*89%*	*76%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

For further information, including definitions, see the latest Potential Donor Audit report at www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/

Appendix 2

NHS Blood and Transplant

Detailed Report

Actual and Potential Deceased Organ Donation

1 April 2020 - 31 March 2021

Betsi Cadwaladr University Health Board

Table of Contents

Further Information

- We acknowledge that the data presented includes the period most significantly impacted by COVID-19 and appreciate that the COVID-19 pandemic affected Trusts/Boards differently across the UK.
- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report is available at http://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2021 based on data meeting PDA criteria reported at 10 May 2021.

1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2020 and 31 March 2021, Betsi Cadwaladr University Health Board had 16 deceased solid organ donors, resulting in 35 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2019/20. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2020 - 31 March 2021 (1 April 2019 - 31 March 2020 for comparison)

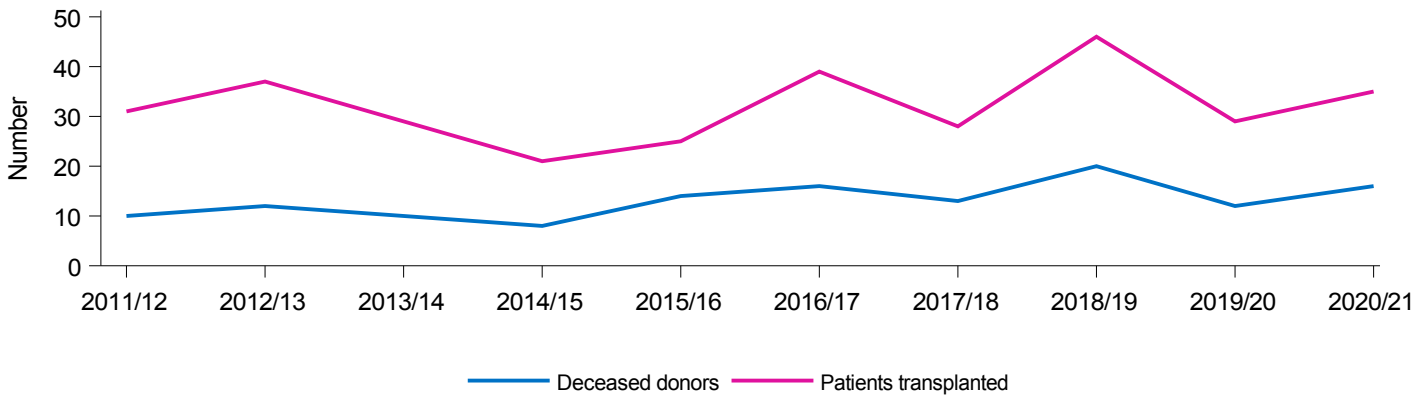
Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor: Health Board		Average number of organs donated per donor: UK	
DBD	13	(7)	31	(20)	3.2	(3.7)	3.3	(3.5)
DCD	3	(5)	4	(9)	2.3	(2.4)	2.7	(2.7)
DBD and DCD	16	(12)	35	(29)	3.0	(3.2)	3.1	(3.2)

In addition to the 16 proceeding donors there were 3 additional consented donors that did not proceed, one where DBD organ donation was being facilitated and 2 where DCD organ donation was being facilitated.

Table 1.2 Organs transplanted by type, 1 April 2020 - 31 March 2021 (1 April 2019 - 31 March 2020 for comparison)

Donor type	Number of organs transplanted by type: Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	21	(10)	1	(2)	8	(7)	3	(1)	2	(4)	0	(0)
DCD	4	(8)	0	(0)	1	(1)	0	(0)	0	(0)	0	(0)
DBD and DCD	25	(18)	1	(2)	9	(8)	3	(1)	2	(4)	0	(0)

Figure 1.1 Number of donors and patients transplanted, 1 April 2011 - 31 March 2021



2. Key Rates in Potential for Organ Donation

A summary of the key rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section presents specific percentage measures of potential donation activity for Betsi Cadwaladr University Health Board.

Performance in your Health Board has been compared with UK performance in both Figure 2.1 and Table 2.1 using funnel plot boundaries and the Gold, Silver, Bronze, Amber, and Red (GoSBAR) colour scheme. When compared with UK performance, gold represents exceptional, silver represents good, bronze represents average, amber represents below average, and red represents poor performance. See Appendix A.3 for funnel plot ranges used.

It is acknowledged that the PDA does not capture all activity. In total there were 0 patients referred in 2020/21 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA. None of these are included in Section 1 because they did not become a solid organ donor.

Note that caution should be applied when interpreting percentages based on small numbers.

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2020 - 31 March 2021

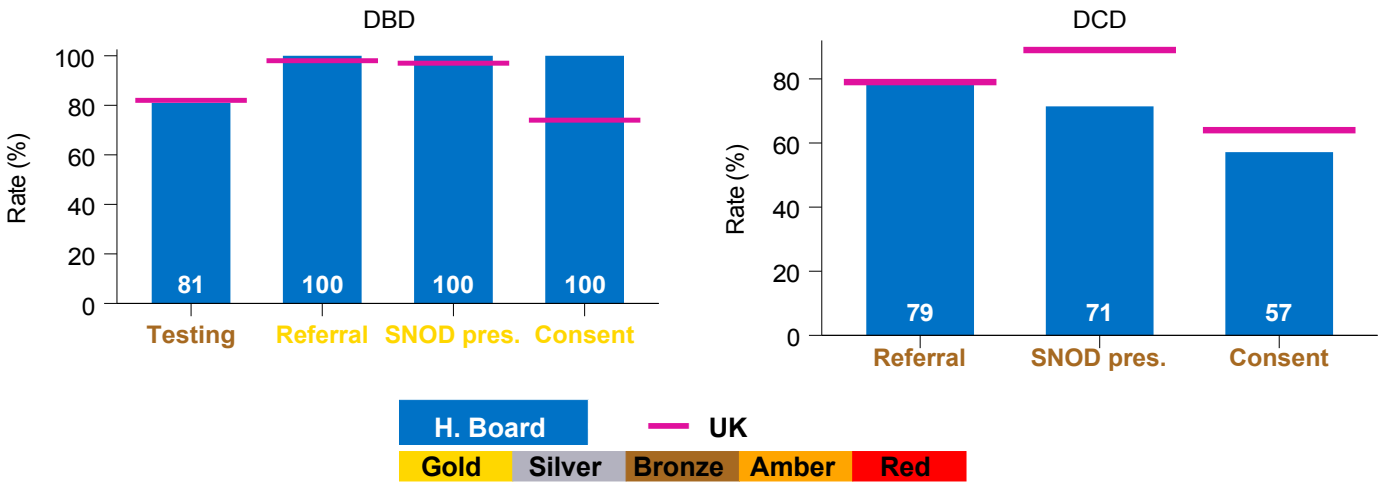


Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2016 - 31 March 2021

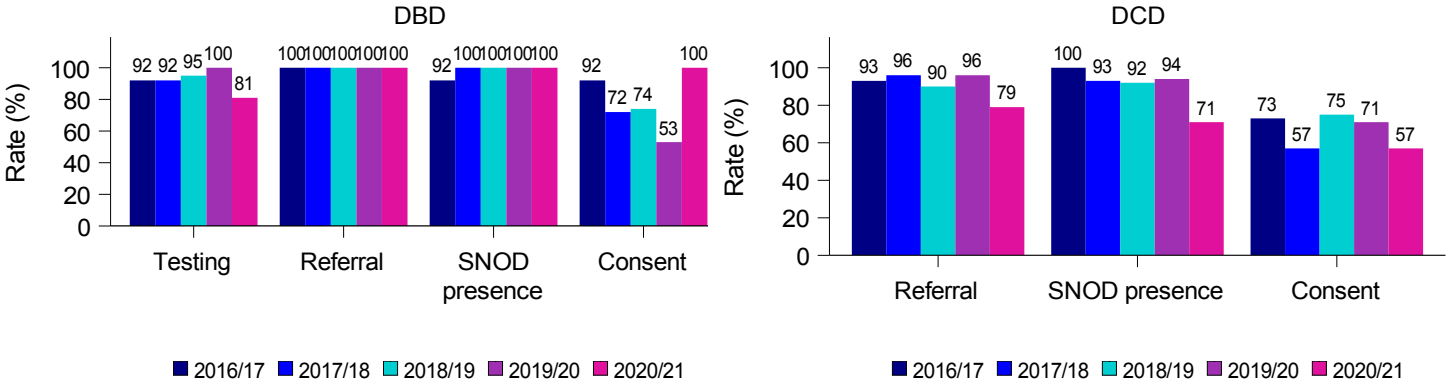


Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2020 - 31 March 2021

	DBD		DCD		Deceased donors	
	H. Board	UK	H. Board	UK	H. Board	UK
Patients meeting organ donation referral criteria[1]	21	1810	71	6027	88	7551
Referred to Organ Donation Service	21	1777	56	4770	73	6282
Referral rate %	G *100%*	*98%*	B *79%*	*79%*	B *83%*	*83%*
Neurological death tested	17	1490				
Testing rate %	B *81%*	*82%*				
Eligible donors[2]	14	1353	36	2860	50	4207
Family approached	14	1210	7	1042	21	2248
Family approached and SNOD present	14	1168	5	925	19	2089
% of approaches where SNOD present	G *100%*	*97%*	B *71%*	*89%*	B *90%*	*93%*
Consent ascertained	14	891	4	665	18	1553
Consent rate %	G *100%*	*74%*	B *57%*	*64%*	S *86%*	*69%*
Actual donors (PDA data)	13	777	3	404	16	1180
% of consented donors that became actual donors	*93%*	*87%*	*75%*	*61%*	*89%*	*76%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Health Board at the key stages of organ donation. The ambition is that your Health Board misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2016 - 31 March 2021

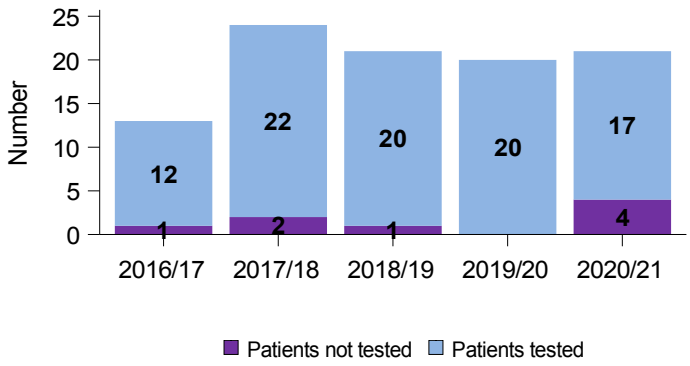


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2020 - 31 March 2021

	Health Board	UK
Biochemical/endocrine abnormality	2	19
Clinical reason/Clinician's decision	1	42
Continuing effects of sedatives	-	13
Family declined donation	-	24
Family pressure not to test	-	15
Hypothermia	-	1
Inability to test all reflexes	-	20
Medical contraindication to donation	-	11
Other	-	30
Patient had previously expressed a wish not to donate	-	5
Patient haemodynamically unstable	1	100
Pressure of ICU beds	-	8
SN-OD advised that donor not suitable	-	7
Treatment withdrawn	-	18

If 'other', please contact your local SNOD or CLOD for more information, if required.

Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2020 - 31 March 2021

	Health Board	UK
Unknown	-	7
Total	**4**	**320**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2016 - 31 March 2021

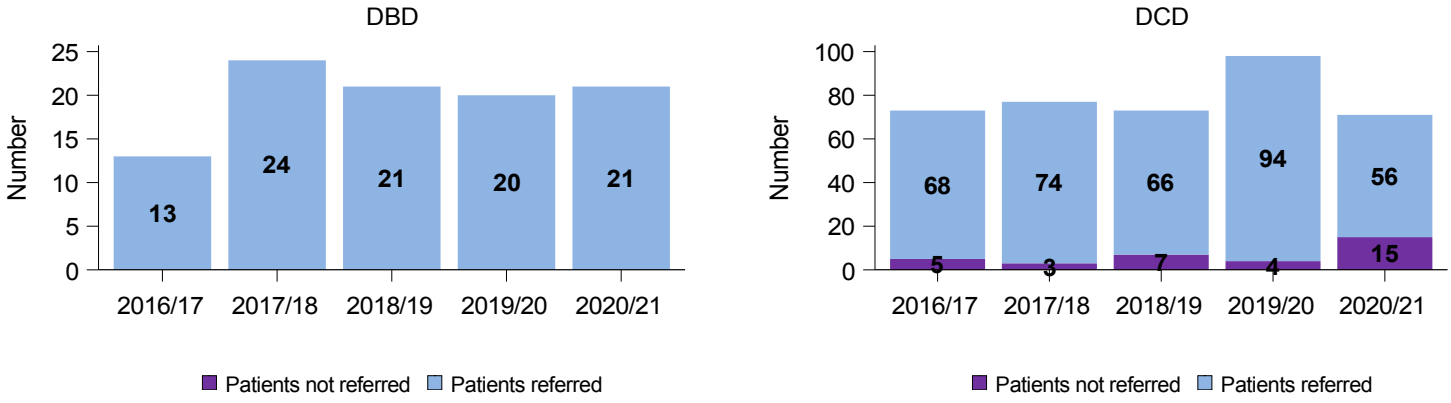


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2020 - 31 March 2021

	DBD		DCD	
	Health Board	UK	Health Board	UK
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	2
Coroner / Procurator Fiscal reason	-	-	-	1
Family declined donation following decision to remove treatment	-	-	-	10
Family declined donation prior to neurological testing	-	2	-	1
Medical contraindications	-	3	2	423
Not identified as potential donor/organ donation not considered	-	19	5	478
Other	-	3	-	86
Patient had previously expressed a wish not to donate	-	-	-	1
Pressure on ICU beds	-	-	-	17
Reluctance to approach family	-	-	-	1
Thought to be medically unsuitable	-	2	8	224
Thought to be outside age criteria	-	-	-	3
Uncontrolled death pre referral trigger	-	4	-	10
Total	**-**	**33**	**15**	**1257**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3 Contraindications

In 2020/21 there were 34 potential donors in your Health Board with an ACI reported, 2 DBD and 33 DCD donors. Please note, the number of potential DBD and DCD donors with an ACI reported may not equal the total stated as a patient can meet potential donor criteria for both DBD and DCD donation.

3.4 SNOD presence

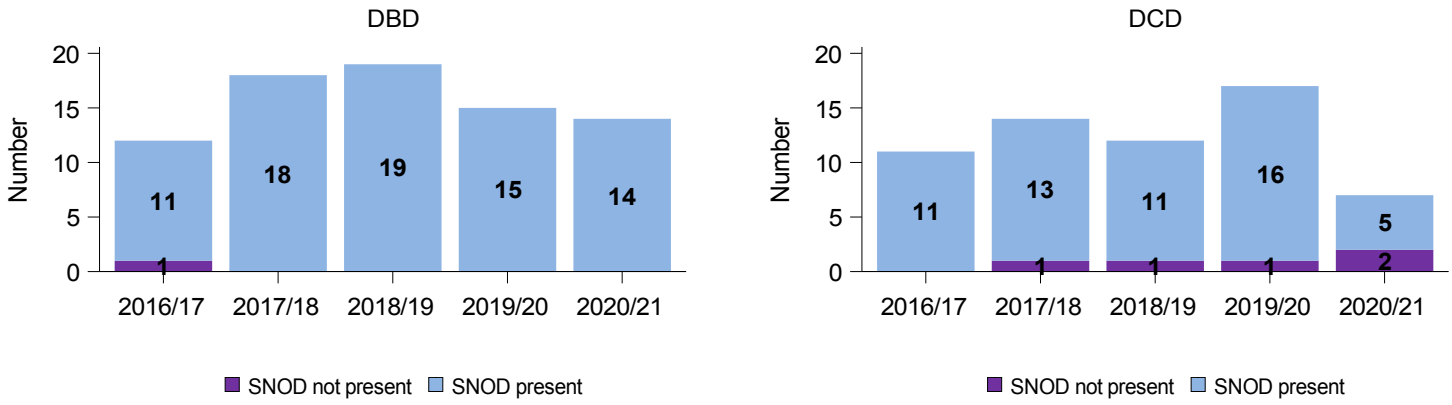
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

In the UK, in 2020/21, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 43% and 23%, respectively, compared with DBD and DCD consent/authorisation rates of 75% and 69%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known wishes of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2016 - 31 March 2021



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 10 May 2021]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 10 May 2021]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 10 May 2021]

3.5 Consent

In 2020/21 the DBD consent rate in your Health Board was 100%, less than 10 families of eligible DCD donors were approached therefore this consent rate is not presented.

Figure 3.4 Number of families approached, 1 April 2016 - 31 March 2021

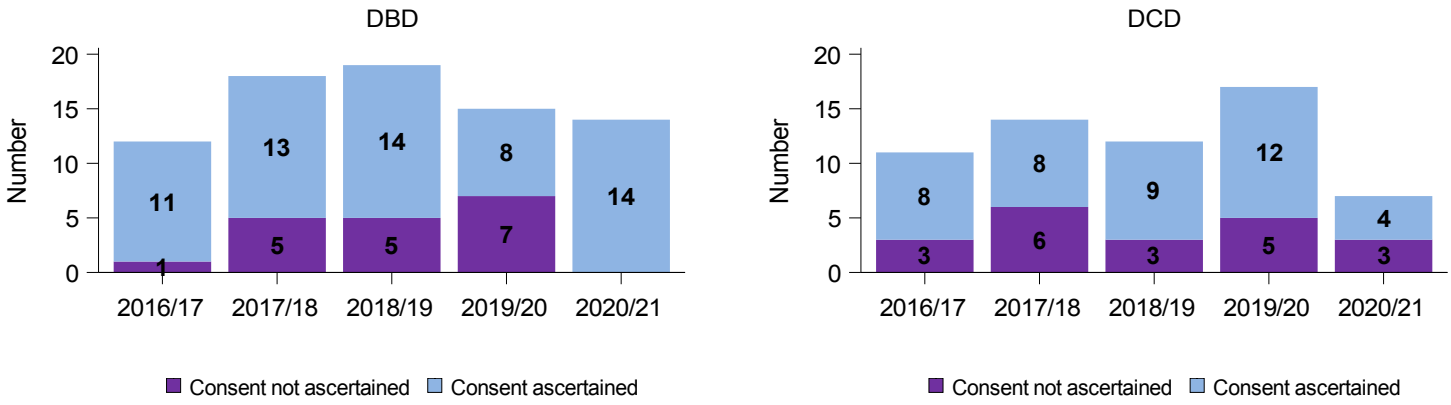


Table 3.3 Reasons given why consent was not ascertained, 1 April 2020 - 31 March 2021

	DBD		DCD	
	Health Board	UK	Health Board	UK
Family believe patient's treatment may have been limited to facilitate organ donation	-	1	-	-
Family concerned donation may delay the funeral	-	1	-	-
Family concerned other people may disapprove/be offended	-	3	-	2
Family concerned that organs may not be transplantable	-	1	-	1
Family did not believe in donation	-	10	-	13
Family did not want surgery to the body	-	29	-	35
Family divided over the decision	-	13	-	16
Family felt it was against their religious/cultural beliefs	-	38	-	13
Family felt patient had suffered enough	-	16	-	34
Family felt that the body should be buried whole (unrelated to religious/cultural reasons)	-	12	-	9
Family felt the length of time for the donation process was too long	-	9	-	48
Family had difficulty understanding/accepting neurological testing	-	2	-	-
Family wanted to stay with the patient after death	-	1	-	2
Family were not sure whether the patient would have agreed to donation	-	35	-	36
Other	-	22	-	34
Patient had previously expressed a wish not to donate	-	112	2	108
Patient had registered a decision to Opt Out	-	6	1	13
Strong refusal - probing not appropriate	-	8	-	11
Total	**-**	**319**	**3**	**375**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.6 Solid organ donation

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted.

Table 3.4 Reasons why solid organ donation did not occur, 1 April 2020 - 31 March 2021

	DBD		DCD	
	Health Board	UK	Health Board	UK
Clinical - Absolute contraindication to organ donation	-	8	-	3
Clinical - Considered high risk donor	-	5	-	2
Clinical - DCD clinical exclusion	-	-	-	1
Clinical - No transplantable organ	-	8	-	13
Clinical - Organs deemed medically unsuitable by recipient centres	-	35	-	73
Clinical - Organs deemed medically unsuitable on surgical inspection	-	15	-	1
Clinical - Other	-	8	-	3
Clinical - Outside of donation criteria at referral	-	-	-	3
Clinical - PTA post WLST	-	-	1	109
Clinical - Patient actively dying	-	4	-	5
Clinical - Patient asystolic	-	2	-	1
Clinical - Patient expected to die before donation could take place attendance not required	-	6	-	7
Clinical - Patient's general medical condition	-	2	-	4
Clinical - Positive virology	-	4	-	1
Consent / Auth - Coroner/Procurator fiscal refusal	1	10	-	12
Consent / Auth - Family placed conditions on donation	-	1	-	-
Consent / Auth - NOK withdraw consent / authorisation	-	1	-	11
Logistical - No critical care bed available	-	-	-	1
Logistical - Other	-	5	-	10
Total	**1**	**114**	**1**	**260**

If 'other', please contact your local SNOD or CLOD for more information, if required.

4. Comparative Data

A comparison of performance in your Trust/Board with national data

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section compares the quality of care in the key areas of organ donation in your Health Board with the UK rate using funnel plots. The UK rate is shown as a green dashed line and the funnel shape is formed by the 95% and 99.8% confidence limits around the UK rate. The confidence limits reflect the level of precision of the UK rate relative to the number of observations. Performance in your Health Board is indicated by a black cross. The Gold, Silver, Bronze, Amber, and Red colour scheme is used to indicate whether performance in your Health Board, when compared to UK performance, is exceptional (gold), good (silver), average (bronze), below average (amber) or poor (red).

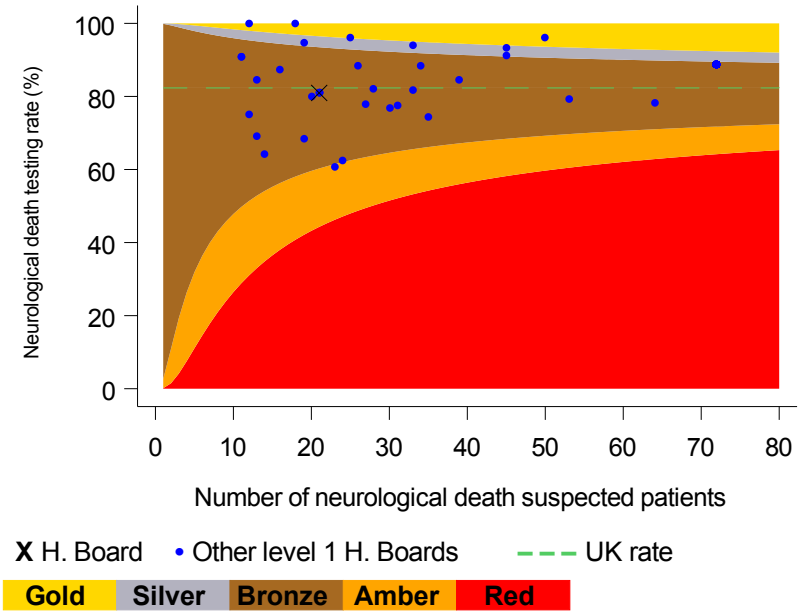
It is important to note that the differences in patient mix have not been accounted for in these plots. Further to these, separate funnel plots for DBD and DCD rates are presented in Section 7.

Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

4.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2020 - 31 March 2021

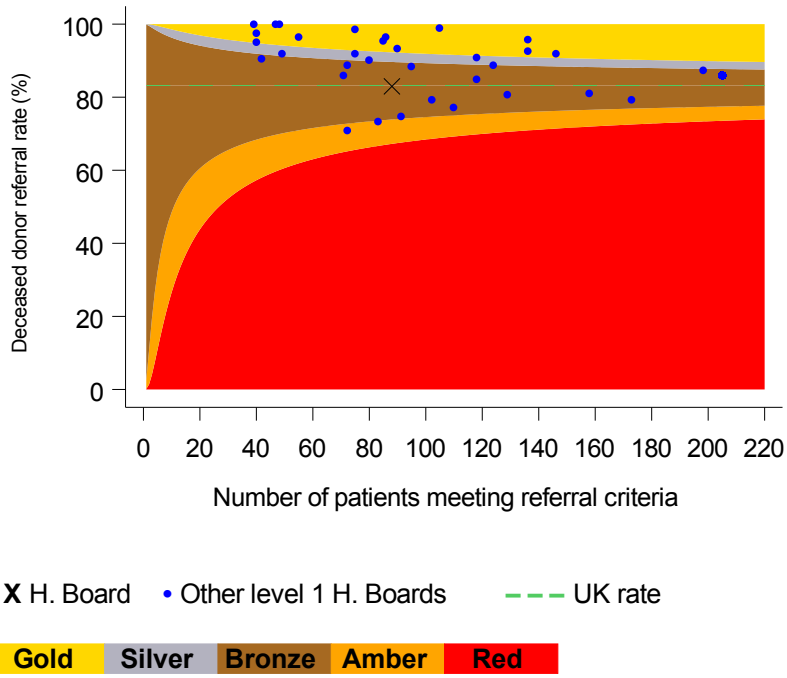


When compared with UK performance the neurological death testing rate in Betsi Cadwaladr University Health Board was average (bronze).

4.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to NHSBT's Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Figure 4.2 Funnel plot of deceased donor referral rate, 1 April 2020 - 31 March 2021

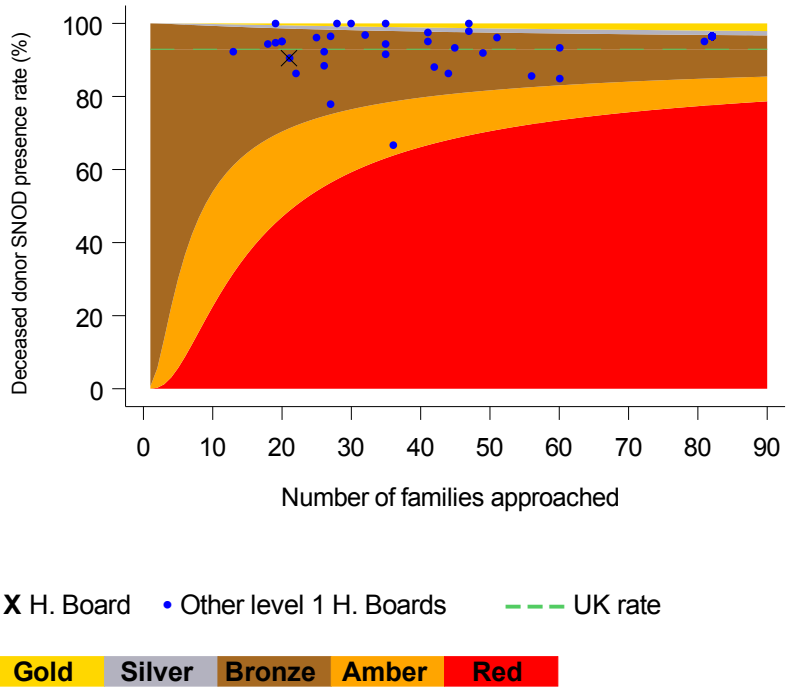


When compared with UK performance Betsi Cadwaladr University Health Board was average (bronze) for referral of potential organ donors to NHS Blood and Transplant's Organ Donation Service.

4.3 SNOD presence

Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

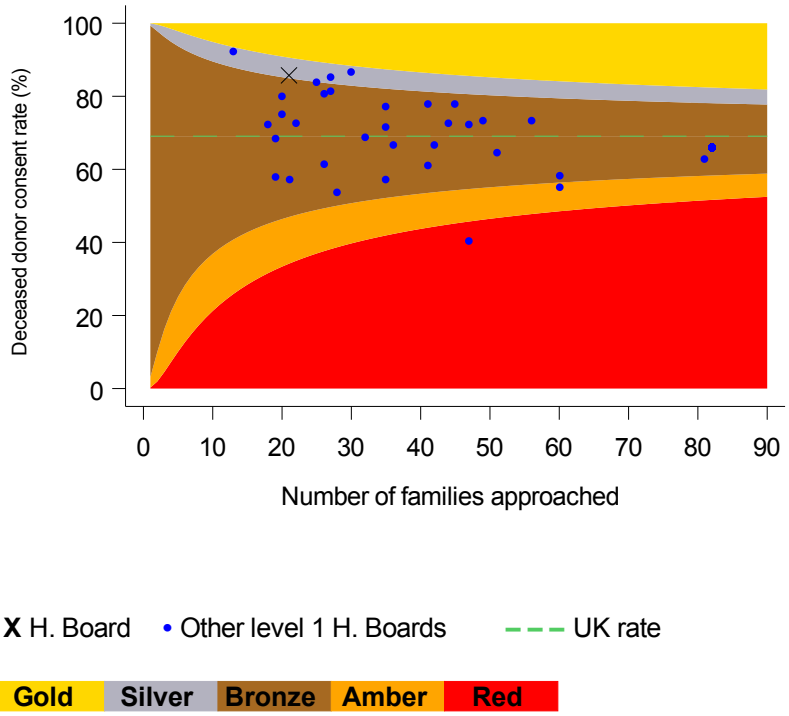
Figure 4.3 Funnel plot of SNOD presence rate, 1 April 2020 - 31 March 2021



When compared with UK performance Betsi Cadwaladr University Health Board was average (bronze) for Specialist Nurse presence when approaching families to discuss organ donation.

4.4 Consent

Figure 4.4 Funnel plot of consent rate, 1 April 2020 - 31 March 2021



When compared with UK performance the consent rate in Betsi Cadwaladr University Health Board was good (silver).

5. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where patient died

Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 5.1 and 5.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 5.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2020 - 31 March 2021

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Bangor, Ysbyty Gwynedd District General Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	6	5	-	6	-	5	4	4	4	-	4	-	3
Bodelwyddan, Glan Clwyd District General Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	5	4	-	5	-	4	2	2	2	-	2	-	2
Wrexham, Maelor General Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	10	8	80	10	100	8	8	8	8	-	8	-	8

Table 5.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2020 - 31 March 2021

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DBD donors
Bangor, Ysbyty Gwynedd District General Hospital											
A & E	3	1	-	3	1	0	0	-	0	-	0
General ICU/HDU	23	23	100	23	16	2	2	-	1	-	1
Bodelwyddan, Glan Clwyd District General Hospital											
A & E	2	2	-	2	1	0	0	-	0	-	0
General ICU/HDU	30	18	60	29	11	4	3	-	3	-	2
Wrexham, Maelor General Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	13	12	92	13	7	1	0	-	0	-	0

Tables 5.1 and 5.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for Betsi Cadwaladr University Health Board in 2020/21 there were 0 such patients. For more information regarding the Emergency Department please see Section 6.

6. Emergency Department data

A summary of key numbers for Emergency Departments

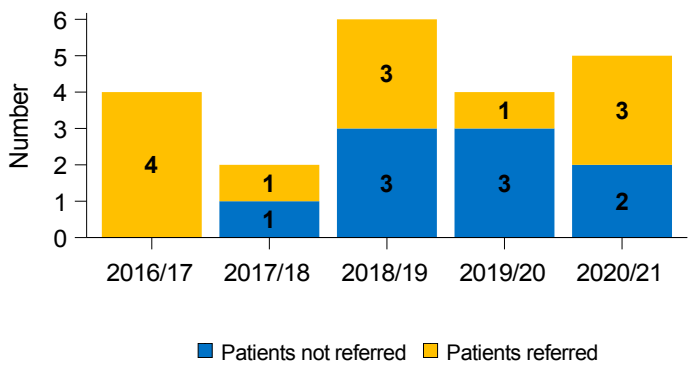
Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a wish in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [4] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

6.1 Referral to Organ Donation Service

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.
Aim: There should be no blue on the following chart.

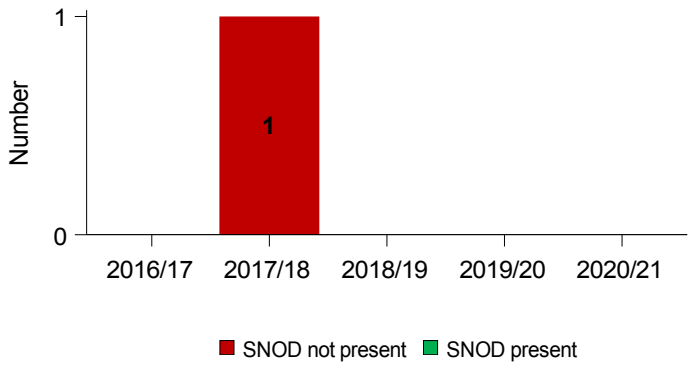
Figure 6.1 Number of patients meeting referral criteria that died in the ED, 1 April 2016 - 31 March 2021



6.2 Organ donation discussions

Goal: No family is approached in ED regarding organ donation without a SNOD present.
Aim: There should be no red on the following chart.

Figure 6.2 Number of families approached in ED by SNOD presence, 1 April 2016 - 31 March 2021



[4] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 10 May 2021]

7. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

7.1 Supplementary Regional data

Table 7.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	Wales*	UK
1 April 2020 - 31 March 2021		
Deceased donors	49	1,180
Transplants from deceased donors	102	2,943
Deaths on the transplant list	17	497
As at 31 March 2021		
Active transplant list	159	4,256
Number of NHS ODR opt-in registrations (% registered)**	1,323,716 (43%)	26,746,406 (41%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 3.1 million, based on ONS 2011 census data

Key numbers and rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

7.2 Trust/Board Level Benchmarking

Betsi Cadwaladr University Health Board has been categorised as a level 1 Health Board. Levels were reallocated in July 2018 using the average number of donors in 2016/17 and 2017/18, Table 7.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 7.2 Trust/Board level categories

		Number of Trusts Boards in each level
Level 1	12 or more (≥ 12) proceeding donors per year	35
Level 2	6 or more but less than 12 (≥ 6 to <12) proceeding donors per year	45
Level 3	More than 3 but less than 6 (>3 to <6) proceeding donors per year	47
Level 4	3 or less (≤ 3) proceeding donors per year	41

Tables 7.3 and 7.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 7.3 National DBD key numbers and rate by Trust/Board level, 1 April 2020 - 31 March 2021

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	21	17	81	21	100	17	14	14	14	100	14	100	13
Level 1	979	818	84	968	99	813	751	677	651	96	479	71	424
Level 2	420	339	81	407	97	330	299	268	260	97	205	76	168
Level 3	283	228	81	276	98	227	206	181	178	98	140	77	125
Level 4	128	105	82	126	98	104	97	84	79	94	67	80	60

Table 7.4 National DCD key numbers and rate by Trust/Board level, 1 April 2020 - 31 March 2021

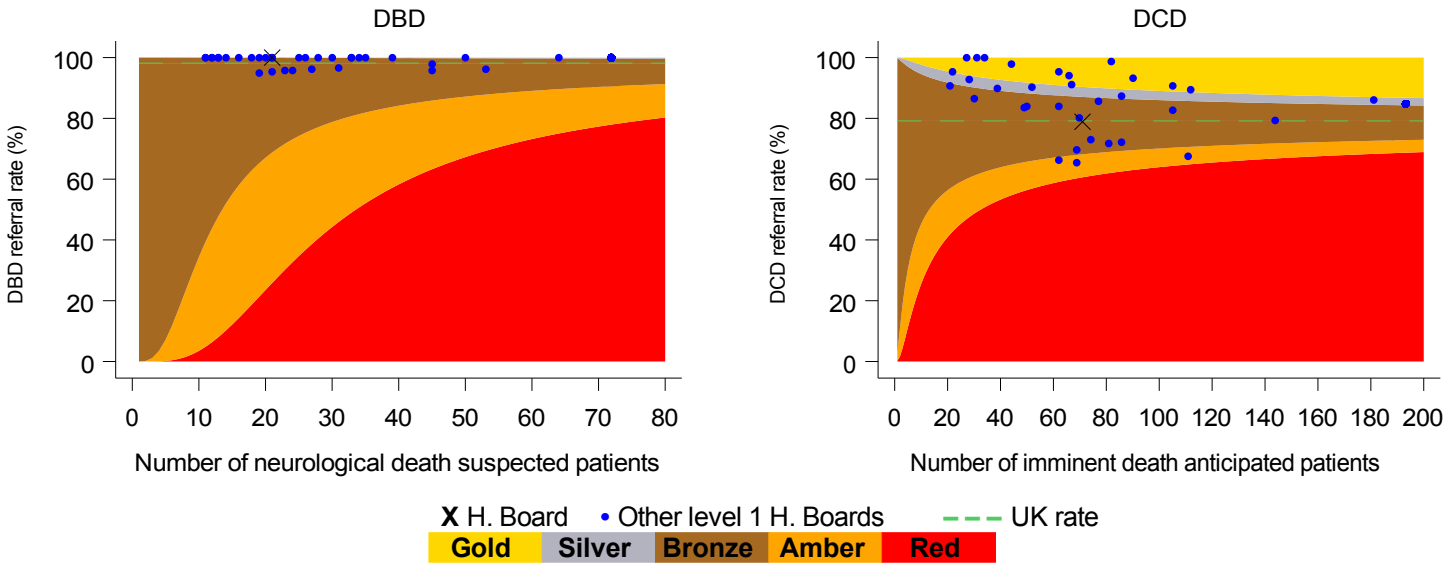
	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Your Trust	71	56	79	70	36	7	5	-	4	-	3
Level 1	2552	2143	84	2350	1366	606	537	89	399	66	252
Level 2	2001	1487	74	1843	852	238	214	90	143	60	84
Level 3	990	785	79	923	407	128	112	88	76	59	45
Level 4	484	355	73	444	235	70	62	89	47	67	23

7.3 Comparative data for DBD and DCD deceased donors

Funnel plots are presented in Section 4 showing performance in your Health Board against the UK rate for deceased organ donation. The following funnel plots present data for DBD and DCD donors separately.

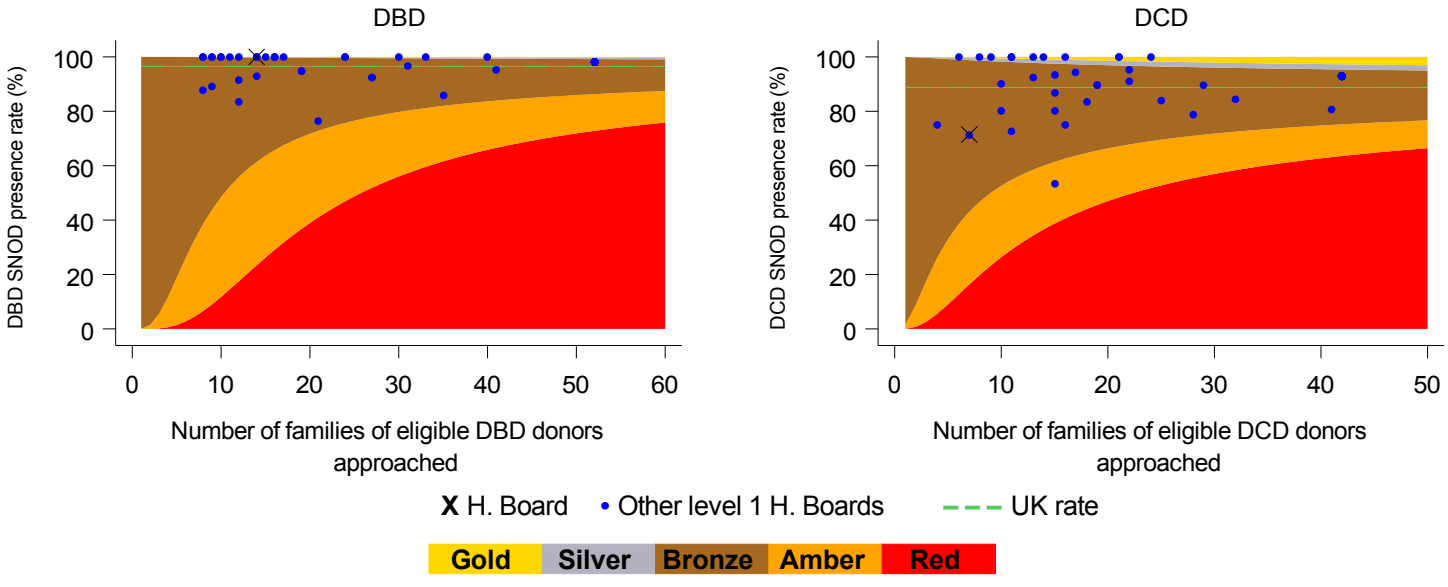
Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

Figure 7.1 Funnel plots of referral rates, 1 April 2020 - 31 March 2021



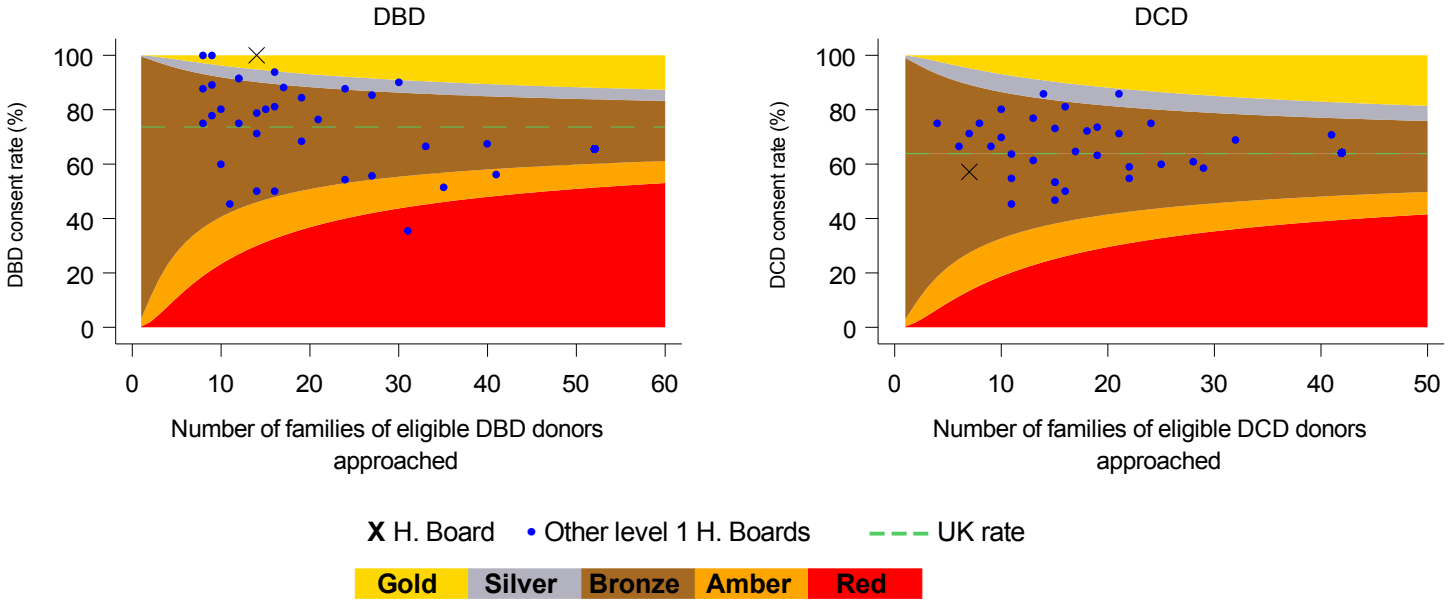
When compared with UK performance Betsi Cadwaladr University Health Board was exceptional (gold) for referral of potential DBD organ donors and average (bronze) for referral of potential DCD organ donors to NHS Blood and Transplant's Organ Donation Service.

Figure 7.2 Funnel plots of SNOD presence rates, 1 April 2020 - 31 March 2021



When compared with UK performance Betsi Cadwaladr University Health Board was exceptional (gold) and average (bronze) for Specialist Nurse presence in approaches to families of eligible DBD and DCD donors, respectively.

Figure 7.3 Funnel plots of consent rates, 1 April 2020 - 31 March 2021



When compared with UK performance the consent rate in Betsi Cadwaladr University Health Board was exceptional (gold) and average (bronze) for DBD and DCD donors, respectively.

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: Apnoea, coma from known aetiology and unresponsive, ventilated, fixed pupils. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term'.
Potential DBD donor	A patient who meets all four criteria for neurological death testing excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term' (ie suspected neurological death, as defined above).
DBD referral criteria	A patient with suspected neurological death
Discussed with Specialist Nurse – Organ Donation	A patient with suspected neurological death discussed with the Specialist Nurse – Organ Donation (SNOD)
Neurological death tested	Neurological death tests were performed
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/6455/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DBD asked to support patient's expressed or deemed consent/authorisation, informed of a nominated/appointed representative, asked to make a decision on donation on behalf of their relative, or informed of a patient's opt-out decision via the ODR.
Consent/authorisation ascertained	Family supported expressed or deemed consent/authorisation , nominated/appointed representative gave consent, or where applicable family gave consent/authorisation
Actual donors: DBD	Neurological death confirmed patients who became actual DBD as reported through the PDA
Actual donors: DCD	Neurological death confirmed patients who became actual DCD as reported through the PDA
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested
Referral rate	Percentage of patients for whom neurological death was suspected who were discussed with the SNOD
Consent/authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
SNOD presence rate	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present
Consent/authorisation rate where SNOD was present	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present where consent/authorisation was ascertained

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within a time frame to allow donation to occur, as determined at time of assessment
DCD referral criteria	A patient in whom imminent death is anticipated (as defined above)
Discussed with Specialist Nurse – Organ Donation	Patients for whom imminent death was anticipated who were discussed with the SNOD
Potential DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours
Eligible DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/6455/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DCD asked to: support the patient's expressed or deemed consent/authorisation decision, informed of a nominated/appointed representative, make a decision themselves on donation, or informed of a patient's opt-out decision via the Organ Donor Register
Consent/authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
SNOD presence rate	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present
Consent/authorisation rate where SNOD was present	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present where consent/authorisation was ascertained

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

1 Donor outcomes	
Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

2 Key rates in potential for organ donation	
Figure 2.1	Key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented in a bar chart, using data from the Potential Donor Audit (PDA). The comparative UK rate, for the same time period, is illustrated by the pink line. The key rates labels are coloured using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below.
Figure 2.2	Trends in the key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented for the past five equivalent time periods, using data from the PDA.
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Note that caution should be applied when interpreting percentages based on small numbers. Appendix A.1 gives a fuller explanation of terms used. The key rates are highlighted using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below).

3 Best quality of care in organ donation	
Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.

Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 Comparative data	
Figure 4.1	A funnel plot of the neurological death testing rate is displayed using data obtained from the PDA. Each Trust/Board, of the same level, is represented on the plot as a blue dot, although one dot may represent more than one Trust/Board. The UK rate is shown on the plot as a green horizontal dashed line, together with 95% and 99.8% confidence limits for this rate. These limits form a 'funnel', which is shaded using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme. Graphs obtained in this way are known as funnel plots. If a Trust/Board lies within the 95% limits, shaded bronze, then that Trust/Board has a rate that is statistically consistent with the UK rate (average performance). If a Trust/Board lies outside the 95% confidence limits, shaded silver (good performance) or amber (below average performance), this serves as an alert that the Trust/Board may have a rate that is significantly different from the UK rate. When a Trust/Board lies above the upper 99.8% limit, shaded gold, this indicates a rate that is significantly higher than the UK rate (exceptional performance), while a Trust/Board that lies below the lower limit, shaded red, has a rate that is significantly lower than the UK rate (poor performance). It is important to note that differences in patient mix have not been accounted for in these plots. Your Trust/Board is shown on the plot as the large black cross. If there is no large black cross on the plot, your Trust/Board did not report any patients of the type presented. The funnel plots can also be used to identify the maximum rates currently being achieved by Trusts/Boards with similar donor potential.
Figure 4.2	A funnel plot of the deceased donor referral rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.3	A funnel plot of the deceased donor SNOD presence rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.4	A funnel plot of the deceased donor consent/authorisation rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.

5 PDA data by hospital and unit	
Table 5.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 5.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

6 Emergency department data	
Figure 6.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 6.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

7 Additional data and figures

Table 7.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. Your region has been defined as per former Strategic Health Authority. A UK comparison is also provided.
Table 7.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 7.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 7.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Figure 7.1	A funnel plot of the DBD and DCD referral rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.2	A funnel plot of the DBD and DCD SNOD presence rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.3	A funnel plot of the DBD and DCD consent/authorisation rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.

Betsi Cadwaladr University Health Board (BCUHB)

Appendix 3

Key Achievements 2020-2021	
1	Virtual Organ Donation Memorial (as no access to St Asaph Cathedral)
2	SNOD Workforce mobilised to ITU to assist our Critical Care Coleagues
3	16 Proceeding Donors achieved in Pandemic Conditions
4	Consent Rate above UK and Wales average (86%)
5	Continuing to increase embeded SNOD prescence again post-pandemic
6	High levels of support from all ITU's and Theatres despite pandemic pressures

Missed Opportunities and Opportunities to Develop Practice 2021-2022	
1	Eradicate pre-approaching families; 2 Consistent Cons Pre-Approaching
2	Run our Organ Donation Simulation Course again - subject to pandemic pressures
3	Potential to re-introduce our Link Nurse Study Day across the 3 sites - subject to pandemic pressures
4	Early Identification and Referral of all potential donors
5	Tissue Donation Referrals have significantly decreased over the last 18 months across BCUHB but remain the highest in Wales

Key Strategic and Performance Priorities 2021-2022	
1	Continue use of Cardiac Output Monitoring for potential donors
2	Focus on Donor Management; Introduction of Donation Pathway ITU Chart and new NDT Pathway for Consented Donors
3	Report of ODC activity to Trust Board
4	Good performance in NHSBT audit cycle
5	Increased media profile of organ donation in north Wales; 1st event in Sep for Organ Donation Week

Please submit with NHS Blood and Transplant Actual and Potential Deceased Organ Donation Summary Report :
April - Sept
April - March

Taking Organ Transplantation to 2020 Theme	Key Action Plan – 2021-2022	Responsible Individual	Measurable Outcome	Target Date	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Comments (Optional)
Action by society and individuals will mean that the UK's organ donation record is amongst the best in the world and people donate when and if they can	**Organ Donation Promotion, Public Engagement & Education**		**Aim for consent rate above 80%**						
	Develop education programme for schools (Pandemic Pressures Allowing)	CLODs/SNODs	Visit at least one school in each area of BCU	Apr-22					
	Transplantation Community Liaison Group	Abi Roberts	Biannual meeting	31.12.22					
	Contribute to all-Wales reports on organ donation	CLODs/SNODs	Inclusion of performance data in National report	Annually					
	Report activities of ODC to BCU Trust Board	CLODs	Attendance at Trust executive meeting	Annually					
Action by NHS hospitals and staff will mean that the NHS routinely provides excellent care in support of organ donation and every effort is made to ensure that each donor can give as many organs as possible	**Hospital Engagement**		**Aim for 26 deceased donors PMP**						
	Promote early identification and referral of potential organ donors	All staff	PDA Data	ongoing					
	Promote education of staff involved with management of potential donors, re-introduction of education pathways	SNODs/CLODs	SIM day annually and annual study day	Apr-22					
	Ensure SNOD present in all PD approaches	All ITU Consultants	Potential Donor Audit	Monthly report					
	Prevention of pre-approaching the organ donation question with families	CLODs	Potential Donor Audit	ongoing					
Action by NHS hospitals and staff will mean that more organs are usable and surgeons are better supported to transplant organs safely into the most appropriate recipient	**Donation Process**		**Aim to transplant 5% more of the organs offered from consented, actual donors**						
	Optimise organ donors wiith use of cardiac output monitoring	CLODs	Equip YG/YGC/WMH with cardiac output monitors	ongoing					
	DCD withdrawal in theatre where appropriate	All ITU Consultants	PDA Data	ongoing					
	Good performance in NHS BT potential donor audit	All staff	NHS BT audit	Monthly report					
Action by NHSBT and Commissioners means that better support systems and processes will be in place to enable more donations and transplant operations to happen	**Supporting NHSBT and Transplant Activity within Wales**		**Aim for a deceased donor transplant rate of 74 PMP**						
	Regional colloborative to lead local improvement in organ donation, retrieval and transplant practices and in local peomotion of	NHSBT	PDA data/National data	ongoing					
	Representation form NWODCM to BCU Clinical Legal & Ethical Group	CLODs	CLEG membership	ongoing					

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 2nd November 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Public Services Ombudsman for Wales (PSOW) Annual Letter 2020/2021
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing & Midwifery/Deputy CEO
Awdur yr Adroddiad Report Author:	Carolyn Owen, Acting Assistant Director Of Patient Safety & Experience Denise Williams, Senior Complaints Manager (Ombudsman)
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Acting Associate Director of Quality Assurance Gill Harris, Executive Director of Nursing & Midwifery/Deputy CEO
Atodiadau Appendices:	1. PSOW Annual Letter 2020/2021

Argymhelliad / Recommendation:

The Committee is asked to receive and note the report and appended PSOW Annual Letter

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

The purpose of this report is to share the Public Services Ombudsman for Wales Annual Letter with the Committee and subsequently with the Health Board, via the QSE Committee Chair's report.

Cefndir / Background:

Each year the Public Services Ombudsman for Wales (PSOW), following the publication of their Annual Report, provides each organisation with an Annual Letter that summarises activity and issues specific to that organisation. It should be note this report relates to 2020/21.

The letter describes how, last year, the Ombudsman saw a 22% reduction in new complaints relating to all Health Boards – a predicted reduction given the circumstances of the year during the Covid-19 pandemic. However they intervened slightly more frequently in complaints involving Health Boards, 33%, compared to 31% in 2019/2020.

Specific to Betsi Cadwaladr University Health Board, the Ombudsman considered a total of 194 complaints of which:

- 2 were public interest reports
- 36 other reports were upheld in whole or part
- 13 were not upheld
- 3 cases were discontinued
- 30 were resolved by Early Resolution / voluntary settlement
- 57 other cases were closed after initial consideration
- 23 were considered premature
- 30 other cases were out of jurisdiction (out of time).

As with previous years, the Health Board has a higher referral rate and a similar intervention rate when compared to other health bodies.

The Committee is already aware of the improvement work underway in regards to complaint handling and management, as detailed in previous reports. This improvement work is directly relevant to issues identified in this letter.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.

Ombwdsmon
Ombudsman
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU
PUBLIC SERVICES OMBUDSMAN FOR WALES

Ask for: Communications

01656 641150

communications@ombudsman.wales

Date: September 2021

Mark Polin
Betsi Cadwaladr University Health Board

By Email only: mark.polin@wales.nhs.uk

Annual Letter 2020/21

Dear Mark

I am pleased to provide you with the Annual letter (2020/21) for Betsi Cadwaladr University Health Board.

This letter discusses information from a year unlike any other in recent memory, and as such may not be useful for establishing trends or patterns. Information received during this remarkable year will, however, bring insights on how Public Services reacted in the face of unprecedented demand and the most difficult of circumstances.

Despite the challenges brought by the Covid 19 pandemic, I'm pleased with the engagement shown by the Health Board, with both my Improvement Officer and my Complaints Standards staff. I'm also very pleased with the amount of training sessions my complaints standards staff have delivered to the Health Board.

During the past financial year, we have intervened in (upheld, settled or resolved at an early stage) the same proportion of complaints about public bodies, 20%, compared with 2019/20.

Last year, we saw a 22% reduction in new complaints relating to Health Boards – a predictable reduction given the circumstances of the year. However, my Office intervened slightly more frequently in complaints involving Health Boards, 33% compared to 31% in 2019/20.

During 2020/21, despite challenges caused by the pandemic, my office made great strides in progressing work related to Complaints Standards and Own Initiative Investigations. The theme and consultation period of the first wider Own Initiative Investigation – into Local Authority Homelessness Assessments - was

launched in September 2020 and the report is due in the coming months. We also commenced 4 extended Own Initiative Investigations, where we extended the scope of our work on a complaint already under investigation.

Last year, my office also pushed ahead with two new publications – 'Our Findings' and our first Equality Report.

'Our Findings' will be accessed via the PSOW website and replaces the quarterly casebooks. Our Findings will be updated more frequently and will be a more useful tool in sharing the outcomes of investigations. Our first Equality Report highlights the work done to improve equality and diversity, and to ensure that our service is available to people from all parts of society.

A summary of the complaints of maladministration/service failure received relating to your Health Board is attached.

I ask that the Health Board takes the following actions:

- Present my Annual Letter to the Board to assist Board members in their scrutiny of the Health Board's complaints performance and their consideration of any actions to be taken as a result.
- Engage with my Complaints Standards work, accessing training for your staff and providing complaints data.
- Inform me of the outcome of the Health Board's considerations and proposed actions on the above matters by 15 November.

This correspondence is copied to the Chief Executive of your Health Board and to your Contact Officer. Finally, a copy of all Annual Letters will be published on my website.

Yours sincerely,

Nick Bennett
Ombudsman

cc. Gill Harris, Chief Executive, Betsi Cadwaladr University Health Board
By Email only: gill.harris@wales.nhs.uk

Factsheet

Appendix A - Complaints Received

Health Board	Complaints Received	Received per 1000 residents
Aneurin Bevan University Health Board	96	0.16
Betsi Cadwaladr University Health Board	184	0.26
Cardiff and Vale University Health Board	62	0.12
Cwm Taf Morgannwg University Health Board	86	0.19
Hywel Dda University Health Board	64	0.17
Powys Teaching Health Board	16	0.12
Swansea Bay University Health Board	79	0.20
Total	587	0.19

Public Services Ombudsman For Wales | Ombwdsmon Gwasanaethau Cyhoeddus Cymru, 1 Ffordd yr Hen Gae, Pencoed CF35 5LJ
www.ombudsman-wales.org.uk | www.ombwdsmon-cymru.org.uk
01656 641150 01656 641199 ask@ombudsman-wales.org.uk | holwch@ombwdsmon-cymru.org.uk

Appendix B - Received by Subject

Betsi Cadwaladr University Health Board	Complaints Received	% Share
Ambulance Services	0	0%
Appointments/admissions/discharge and transfer procedures	9	5%
Clinical treatment in hospital	114	62%
Clinical treatment outside hospital	21	11%
Complaints Handling	17	9%
Confidentiality	0	0%
Continuing care	5	3%
COVID19	3	2%
Disclosure of personal information / data loss	0	0%
Funding	0	0%
Medical records/standards of record-keeping	1	1%
Medication> Prescription dispensing	2	1%
NHS Independent Provider	0	0%
Non-medical services	2	1%
Other	8	4%
Patient list issues	2	1%
Poor/No communication or failure to provide information	0	0%
Rudeness/inconsiderate behaviour/staff attitude	0	0%
	184	

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Appendix C - Complaint Outcomes
(* denotes intervention)

Local Health Board/NHS Trust	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution/ voluntary settlement*	Discontinued	Other Reports- Not Upheld	Other Reports - Upheld*	Public Interest Report*	Total
Betsi Cadwaladr University Health Board	30	23	57	30	3	13	36	2	194
% share	15%	12%	29%	15%	2%	7%	19%	1%	

Appendix D - Cases with PSOW Intervention

	No. of Interventions	No. of Closures	% Of Interventions
Aneurin Bevan University Health Board	38	106	36%
Betsi Cadwaladr University Health Board	68	194	35%
Cardiff and Vale University Health Board	21	72	29%
Cwm Taf Morgannwg University Health Board	19	83	23%
Hywel Dda University Health Board	33	74	45%
Powys Teaching Health Board	5	17	29%
Swansea Bay University Health Board	25	80	31%
Total	**209**	**626**	33%

Public Services Ombudsman For Wales | Ombwdsmon Gwasanaethau Cyhoeddus Cymru, 1 Ffordd yr Hen Gae, Pencoed CF35 5LJ
www.ombudsman-wales.org.uk | www.ombwdsmon-cymru.org.uk
01656 641150 01656 641199 ask@ombudsman-wales.org.uk | holwch@ombwdsmon-cymru.org.uk

Information Sheet

Appendix A shows the number of complaints received by PSOW for all Health Boards in 2020/2021. These complaints are contextualised by the number of people each health board reportedly serves.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows outcomes of the complaints which PSOW closed for the Health Board in 2020/2021. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix D shows Intervention Rates for all Health Boards in 2020/2021. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

Public Services Ombudsman For Wales | Ombwdsmon Gwasanaethau Cyhoeddus Cymru, 1 Ffordd yr Hen Gae, Pencoed CF35 5LJ
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01656 641150 01656 641199 ask@ombudsman-wales.org.uk | holwch@ombwdsmon-cymru.org.uk

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 2nd November 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Clinical Audit Annual Report 2020-21
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Nick Lyons, Executive Medical Director
Awdur yr Adroddiad Report Author:	Jane Christmas, Interim Head of Clinical Effectiveness Dr Melanie Maxwell, Senior Associate Medical Director/ Improvement Cymru Clinical Lead
Craffu blaenorol: Prior Scrutiny:	Clinical Effectiveness Group (CEG) October 2021
Atodiadau Appendices:	1. Clinical Audit Annual Report

Argymhelliad / Recommendation:

The Committee is asked to consider and approve the annual report.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

The draft Clinical Audit Annual Report 2020/2021 was presented to the Clinical Effectiveness Group in October 2021. The Committee is asked to review this Report as an overview of clinical audit activity carried out across the Health Board for this period.

Cefndir / Background:

This report provides an overview of clinical audit activity carried out across Betsi Cadwaladr University Health Board (BCUHB) from 1st April 2020 to the 31st March 2021.

BCUHB audit activity is described within the Clinical Audit Annual Plan. This includes mandated projects identified by the National Clinical Audit and Outcomes Review Advisory Committee, relevant to BCHUB as well as local priority projects.

Due to the pandemic the 2021 mandated list of audits remains unchanged from 2019-20. Within the report there will be highlights of where services have improved care compared to previous years and the national position where available; also describing where more improvement is required. There are updates for areas where work was delayed or stood down due to increased pressure in services due to the COVID 19 pandemic. It is of note that this report describes activity for the period 2020/21 only. Progress against milestones scheduled for the current year (2021/22) are being reported through quarterly reports to the Clinical Effectiveness Group.

The new Clinical Audit Policy is currently being reviewed to ensure that it is in line with changes that have occurred within BCUHB processes over the last year. The Clinical Effectiveness Strategy and NICE policy are

also in development. This review provides a timely opportunity to align BCUHB policy, practice and strategy to drive forward the Clinical Effectiveness agenda across the Health Board.

Clinical Audit is an important element of Clinical Effectiveness and we recognise that Audit activity during 2020/21has been undertaken in the context of the significant and ongoing operational challenge of the COVID pandemic. We recognise the need for continued focus in 2021/2022 and the road map to achieve this is described within the draft Clinical Effectiveness Strategy.

Our focus going forward is on ensuring that the audit cycle is completed and the right audits are undertaken at the right time (directed to the right subjects) to drive forward required improvement. Work is in progress 2021/22 to secure assurance that audit activity is sufficiently aligned and resourced to respond adequately to areas of risk / suboptimal clinical outcome and litigation. Progress will be reported to the CEG and will feature within the next Annual Audit Report cycle (2021/22).

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications:

Audit is an important element of Clinical Effectiveness; as such it must take a central position alongside Patient Safety and Experience, to drive the delivery and assurance of Quality across BCUHB. The audit activity described within this report responds to the priorities identified at a National (NCAORP - NHS Wales National Clinical Audit and Outcome Review Plan), BCUHB and Local (Speciality) level. By providing evidence of compliance or deviation from identified clinical standards, Audit should be integrated into all areas of BCUHB clinical practice, to define required improvement and provide a framework within which to monitor and assure necessary improvement action. In this way audit supports strategic decision making and supports service evaluation, thereby informing Board and local decision making.

This report acknowledges that the strength of audit as an assurance and improvement tool is realised when used within an improvement cycle and when aligned to the Darzi domains of quality (alongside safety and patient experience). Within this we also recognise the importance of developing a strong evidence based culture, ensuring resource to deliver required audit activity and promoting strong leadership, sufficient to ensure that audit outcomes are heard and acted on. We recognise that as a Health Board we are on an important and ongoing journey to fully achieve this.

Opsiynau a ystyriwyd / Options considered:

Report for noting.

Goblygiadau Ariannol / Financial Implications:

Through the measurement of care delivery against evidence-based standards, Clinical Audit promotes optimum use of limited resources and the identification of required additional resource for improvement. The financial implications are identified within the individual context of each project.

The report highlights the importance of securing adequate resource to undertake the audit activity that BCUHB has committed to within the Health Board Audit plan. Insufficient resource is identified within this report as an underlying reason for non or partial participation in audit activity during 2021 which includes some mandated tier 1 activity. The report highlights the need for additional resource, specifically identifying the importance of staff resource and skill development supported by a workforce model which provides the right skills at the right place. At the time of writing a business case has been developed and this is subject to current consultation led by the Office of the Medical Director.

Dadansoddiad Risk / Risk Analysis:

The BCUHB Audit plan reflects priorities identified by a) Welsh Government within NCAORP, through tier 1 and b) responds to assurance requirements of accreditation, regulation and licensing; management of risk, quality, safety and patient experience through tier 2.

While the majority (81%) of mandated tier 1 audits were undertaken in 2020/21, there was some non or partial participation across BCUHB services. Significant and ongoing operational pressures continue to impact on data collection, with some audits recurrently not participating in data collection. The majority of specialities attributed this to insufficient clinical and administrative capacity within their service / division, compounded by continued operational challenge of the COVID pandemic.

The audit cycle is not yet consistently or sufficiently completed in all cases, therefore the full benefit of current audit activity is not yet being fully realised. The introduction of an audit management tool (AMaT in April 2021) is anticipated to strengthen the oversight and monitoring of audit activity in the coming year (2021/22) and through this deliver improvement. This work is additionally supported by a review of resources within the Clinical Effectiveness Team, as referenced above.

It is acknowledged that participation in audit or indeed any quality improvement activity is not exclusively a matter of resource, it requires the fostering of a culture which recognises and values its contribution as a productive tool to achieve continual improvement. Strong leadership and engagement are vital to drive forward this important agenda. Development within primary care is in the early stages and this work requires further development in 2021/22. Closer matrix working between Corporate Clinical Effectiveness, Patient Safety and Patient Experience (Clinical Governance Teams) is anticipated to further support this cultural journey.

Based upon the benchmarking assessment tool, the following projects have been identified as areas of concern for results published in 2020/21:

- National Paediatric Diabetes Audit –PREM Report (Low levels of compliance against national scores). This is the first report
- Adult Asthma (low levels of compliance against national scores)
- National Early Inflammatory Arthritis Audit (NEIAA). (Low levels of compliance against national scores)
- National Heart Failure Audit (NAHF). Limited improvement on previously reported BCUHB compliance
- National Audit of Cardiac Rhythm Management (NACRM).Low levels of compliance against national scores

Actions to address this are predominantly within the remit of the secondary care Hospital Medical Director (HMT) and include ensuring audit leadership is supported through robust job planning, embedding audit reporting within the governance structures from speciality to Board. Increased visibility of audit activity through continued embedding of the quarterly audit reporting introduced in December 2020 and (subject to successful business case) greater alignment of corporate audit capacity to the localities and divisions, are anticipated to support effective audit activity going forward. Fundamentally, additional resources are required to mitigate the underlying resource risk.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

The Tier 1 element of the 2020/21 Clinical Audit Annual report relates to mandatory projects as prioritised by Welsh Government within their NCAORP. Progress is reported to the Clinical Effectiveness Group (CEG) on a quarterly basis leading to a full annual report. This report describes audit results published within 2020/21 only. Progress against audit actions (arising from these publications) are reported to the CEG quarterly, ultimately reporting to QSE within the next cycle of the Annual Audit Report (2022).

Asesiad Effaith / Impact Assessment:

The premise of Clinical Audit is to establish the extent to which evidence-based standards are delivered in practice in a manner that reduces variance and optimises standardisation of excellent care and treatment for all.

The BCUHB Clinical Audit Policy and related Equality Impact Assessment (EqIA) are currently being reviewed and updated to reflect the learning accrued since their development in 2020. These policy documents relate closely to participation with the Tier 1 and Tier 2 elements within this annual report. The Audit Policy will:

- Promote good practice by identifying and addressing unwanted variance in practice and encouraging adherence to National guidance and standards
- Promote standardisation and equality of access to good practice
- Encourage patient and public involvement in clinical audit activity

Clinical Audit Annual Report

Report Authors:
Jane Christmas: Interim Head of Audit & Clinical Effectiveness
Dr Melanie Maxwell: Senior Associate Medical Director/ Improvement Cymru Clinical Lead

Executive Lead: Dr Nick Lyons, Executive Medical Director

Table of Contents

INTRODUCTION

Welcome to the Annual Audit report for 2020/2021.

"Auditing is a vital part of clinical practice. An audit is an assessment of local practice and performance against an established standard... ***a quality assurance and improvement process."*** NICE definition of clinical audit: Principles of Best Practice in Clinical Audit (2002, NICE/CHI).

This report provides an overview of clinical audit activity carried out across Betsi Cadwaladr University Health Board (BCUHB) from 1st April 2020 to the 31st March 2021. BCUHB audit activity is described within the Clinical Audit Annual Plan. This includes mandated projects identified by the National Clinical Audit and Outcomes Review Advisory Committee, relevant to BCHUB as well as local priority projects. Due to the pandemic the current mandated list of audits remains unchanged from 2019-20.

Within the report there will be highlights of where services have improved care compared to previous years and the national position where available; it also recognises where more improvement is required. There are updates for areas where work was delayed or stood down due to increased pressure in services due to COVID 19 pandemic.

The new Clinical Audit Policy is currently being reviewed to ensure that it is in line with changes that have occurred within BCUHB processes over the last year. The Clinical Effectiveness Strategy and NICE policy are also in development. This review provides a timely opportunity to align BCUHB policy, practice and strategy to drive forward the Clinical Effectiveness agenda across the Health Board.

Audit activity during 2020/21 has been undertaken in the context of the significant and ongoing operational challenge of the COVID pandemic. Nevertheless, important work has been delivered. We recognise that there is more work to do to and the road map to achieve this is described within the draft Clinical Effectiveness Strategy.

Clinical audit is an important element of clinical effectiveness. Our focus going forward is on ensuring the right audits are undertaken at the right time to drive improvement. Furthermore, it is important that the audit cycle is completed to fully realise its value in terms of driving forward change, identifying and addressing risk, and thereby supporting best patient outcomes and experience.

CLINICAL AUDIT ACTIVITY 2020-2021

Recognising that audit activity will be in different phases of the audit cycle we have focused this report on those audits that are in the improvement planning stage (predominantly those that have received their findings and are taking action to secure required improvement).

Figure 1 – Clinical Audit Cycle

This report describes audit activity in three distinct sections to provide focus on:

1. Mandated national audit (described as tier 1)
2. BCUHB priority audit (described as tier 2)
3. Local audit (described as tier 3)

SECTION 1 TIER ONE AUDIT:

NHS WALES NATIONAL CLINICAL AUDIT AND OUTCOME REVIEW PLAN (NCAORP)

Each year, the Health Board receives notification of the NCAORP. This describes priority areas for completion by all Health Boards. The BCUHB audit plan includes these required audits.

Due to the pandemic Welsh Government did not provide a new list of priorities consequently the BCUHB 2019/20 annual audit plan has been maintained throughout the 2020/21 period.

For 2020/21 BCUHB identified 37 audit projects relevant to the Health Board. Some of these require continuous data collection across years, others data collect at specific times. NCAORP projects are described as Tier 1 projects.

Almost all of these projects, by their nature, relate to secondary care services, and may include information from one or all our acute sites.

Of the 37 audits on the NCAORP audit programme, 27 published their findings (reports) during the reporting period 2020/21.

We did not achieve full participation by all services in 2020/21. We **participated in 81% of tier one audits across BCUHB services.** The audits which achieved partial or no participation are described below:

Partial participation
There was partial participation in 4 x tier one audits. The following audits were not completed on all required sites:

1. **Chronic Obstructive Pulmonary Disease, Wrexham Maelor (WXM)** did not data collect in 2020/21. **Ysbyty Glan Clwyd (YGC)** did participate in 2021 but not fully, ceasing data collection due to operational pressures of the Covid pandemic. While one of the sites **Ysbyty Gwynedd (YG)** have participated throughout this period, all sites have identified insufficient staff resource for data collection to be a risk to future delivery.
2. **Children & Young People Asthma from Ysbyty Gwynedd (YG).** These are continuous audits requiring clinicians to collect the data. YG has been unable to identify resource to participate since December 2019.
3. **National Early Inflammatory Arthritis Audit (NEIAA) minimal data submission. Wrexham Maelor (WXM).** Historically data entry was undertaken by the corporate clinical effectiveness team. From 2019 the service assumed responsibility for collecting and managing their own data. Data submission has been limited since.
4. **The National Clinical Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)** leads did not submit data in 2021 due to COVID pandemic pressures, and have not re instigated it in full due to insufficient resource / competing clinical pressure. Escalation discussions within the service are leading to a managed way forward for the future. The process and resource to deliver this mandated activity has been reviewed.

No Participation:
There was no participation in 3 x tier one audits.

1. **Adult Asthma.** None of the 3 sites have submitted data for this audit in 20/21. Wrexham Maelor (WXM) and Ysbyty Gwynedd (YG) have not submitted data since the audit commenced. YGC initially data collected but not since November 2019. Non-participation is attributed to the service having insufficient clinical and administrative capacity, compounded by COVID Pandemic operational pressure.
2. **The Fracture Liaison Service**. This service is undertaken from Llandudno (YGC). The service has not participated in this audit since it began in January 2016. Insufficient clinical and administrative capacity is identified by the service as prohibiting required participation.
3. Non-participation in the **National Diabetes Inpatient Audit** was outside the control of BCUHB. None of the Health Boards were able to participate due to an Information Governance issue.

THE TIER ONE AUDIT PROCESS:
Reflecting the requirement of Welsh Government, all nationally mandated projects are expected to complete a 2-stage proforma. This proforma summarises their improvement plans and documents any progress between data collection and reporting. The COVID pandemic has brought significant and ongoing operational pressures and in October 2020, Welsh Government provided an extended timeframe for completing this 2 stage proforma for reports published during 2020/21.

The first part of the form (Part A) should be completed within 8 weeks of the report being published; this identifies the standards or quality statements that the Health Board will focus on including any measures where we are identified as an outlier.

The second part (Part B) should be completed within 16 weeks of publication; this is an improvement plan which describes the actions needed to address Part A.

A process for monitoring and escalating delays in Part A and B responses was developed and introduced by BCUHB in December 2020. The introduction of this monitoring approach is expected to improve required completion of part A and B going forward.

Part A and B return status

Process	Number returned within deadline (8wks for Part A, 16 wks for Part B)	Numbers returned After deadline (8wks for Part A, 16 wks for Part B)	No response received*	Total expected: (1 project does not require reporting to WG)
Part A	13 (50%)	10 (38.5%)	3 (11.5%)	26
Part B	13 (50%)	8 (20.8%)	5 (19.2%)	26

Table 1 – Part A & B return rates

While there is further work to be undertaken on timeliness it is noted that performance (submission of A and B within deadline) has improved since the 2019/20. This may be attributable to a number of factors, which include strengthened leadership at Area Medical Director (AMD) level, introduction of a monitoring and escalation process (described above) and an extended timeframe for completion that was provided by Welsh Government 2020/21.

The escalation process for response to WG following National Audit publication can be found in Appendix 1.

WHAT ARE THE TIER ONE AUDIT RESULTS TELLING US?

THIS SECTION FOCUSES ON:

I) How tier 1 performance benchmarks against All Wales / and where relevant UK peers?

II) Detailed description of Audit Progress (see table)

III) Comparison of audit results with the previous BCUHB audit cycle (where available)

(I) Comparison with National Benchmarking of Tier 1 2020/21

When compared with national benchmarking BCUHB performance reported, 37% (n=10) of BCUHB audits are at or above the national benchmarks for 75% or more of the measures included.

(n= 27 audits published in year).

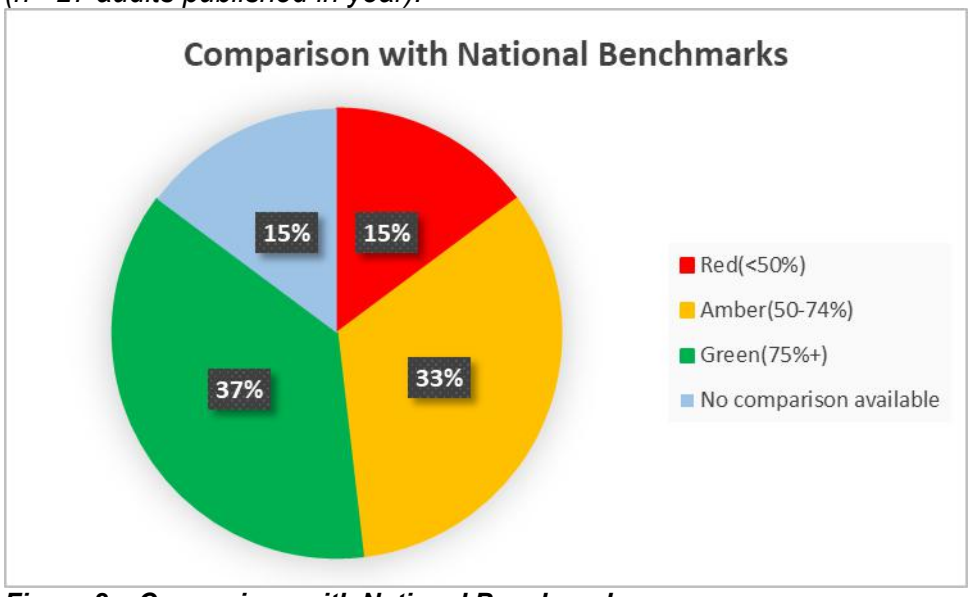

Figure 2 – Comparison with National Benchmarks

Key for figure 2:

Red	Partial or non-participation or, the measures where BCUHB is at, or above the benchmark is less than 50% of the opportunities to achieve the measures or standards ie. if there are 10 measures/standards in the audit. There are 3 opportunities to achieve each standard when applied to the acute sites in BCUHB so the denominator is 3x10 = 30 Suppose the sites achieve the national averages or standards in the following way: YG achieves 3/10: YGC achieves 4/10: WMH achieves 3/10 then across BCUHB there were 10 (3+4+3)/30 opportunities to meet or surpass the national average - 33% compliance has been achieved.
Amber	The measures where BCUHB is at, or above the benchmark is 50-74% of the opportunities to achieve the measures or standards. Using the methodology above.
Green	The measures where BCUHB is at, or above the benchmark is 75% or more of the opportunities to achieve the measures or standards. Using the methodology above.

(ii) PROGRESS REPORT – National Clinical Audit and Outcome Review Programme (NCAORP)

Progress is being monitored and reported quarterly. Progress against each of the tier 1 audits is described within the following table.

Keys for benchmarking:

	***Comparison to National Benchmark*:**
	Partial or non-participation or, the measures where BCUHB is at, or above the benchmark is less than 50% of the opportunities to achieve the measures or standards i.e... if there are 10 measures/standards in the audit. There are 3 opportunities to achieve each standard when applied to the acute sites in BCUHB so the denominator is 3x10 = 30 Suppose the sites achieve the national averages or standards in the following way: YG achieves 3/10: YGC achieves 4/10: WMH achieves 3/10 then across BCUHB there were 10 (3+4+3)/30 opportunities to meet or surpass the national average - 33% compliance has been achieved.
	The measures where BCUHB is at, or above the benchmark is 50-74% of the opportunities to achieve the measures or standards. Using the methodology above
	The measures where BCUHB is at, or above the benchmark is 75% or more of the opportunities to achieve the measures or standards. Using the methodology above

	***Comparison to Last BCUHB Report*:**
	Partial or non-participation or, The measures or standards where BCUHB has maintain or improved compared to the last report is less than 50% of the opportunities to do so. i.e... if there are 10 measures/standards in the audit. There are 3 opportunities to improve or maintain the score from the previous report when applied to the acute sites in BCUHB so the denominator is 3x10 = 30 Suppose the sites achieve the same or improved scores in the following way: YG achieves 3/10: YGC achieves 4/10: WMH achieves 3/10 then across BCUHB there were 10 (3+4+3)/30 opportunities to meet or surpass the previous score; across BCUHB 33% improvement has been achieved.
	The measures where BCUHB has maintain or improved is 50-74% of the opportunities to do so using the methodology above.
	The measures where BCUHB has maintain or improved is 75% or more of the opportunities to do so using the methodology above.

Key for action status:

Actions	
	Cause for concern. No progress to completion reported. Needs evidence of action
	Delayed, some action in progress; date may be reported as “ongoing”
	Progressing on schedule

(ii) PROGRESS REPORT – National Clinical Audit and Outcome Review Programme (NCAORP)

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues: by whom, by when*
		National Benchmark Overall position (Key on pg 8)	***Last BCUHB report / overall position (key on pg 8)***		
ACUTE CARE: • **National Joint Registry** • **National Emergency Laparotomy Audit**					
NCAORP /2020/01	National Joint Registry (NJR) (27 standards)			Compliance rate has improved. Key issues such as wrong filing/inaccurate data submission have now been rectified and work continues on improving the deficiencies. The service attributes improvement in revision rates in the most recent years for BCUHB are due to strong local actions taken by their Clinical Leads and BCUHB has not been identified as an outlier since 2015. The annual publication is an annual report on Hip, Knee, Shoulder, Ankle and Elbow Replacement Arthroplasties. It assesses implants, their longevity and the failures. It also provides data on patient demographics. It helps clinicians understand how implants compare with each other and how much their particular implant is used by other colleagues in the country. Therefore, it assists each clinician learn about implants when offering advice to individual patients.	NB Welsh Government do not require an update (Part A or Part B) for this audit. the report did not provide the level of data or recommendation which health services can measure against. No return report required at this stage to Welsh Government.

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
NCAORP /2020/02	National Emergency Laparotomy Audit (NELA) (13 standards)	G	G	• Part B returned for published national report. • All actions for clinical areas either achieved or on target for agreed deadlines (i.e. local audits arising from recommendations currently still in progress)	**BCUHB Wide Actions:** The service identifies insufficient resource to meet the national recommendation of involving geriatricians in perioperative journey. Escalation undertaken – details of mitigation sought. Limited assurance for COTE input for patients 80+ years/65 years and frail escalated to CEG April 2021.
LONG TERM CONDITIONS: • **National Diabetes Audits (Adult) including pregnancy/insulin pumps/ footcare** • **National Paediatric Diabetes Audit** • **National Respiratory Audits (COPD/Asthma (Adult & Child)** • **National Early Inflammatory Arthritis Audit**					
NCAORP /2020/08	National Core Diabetes Audit: (39 standards)	G	G	Maintained compliance level when compared to previously reported period and in line with national average.	Welsh Government reporting form identifying specific issues and action plan due April 2021. Areas reports not completed due to work pressures. Escalation as SOP.
NCAORP/ 2020/09	National Paediatric Diabetes Audit (NPDA) (17 standards)	R	1st report of Patient Reported Experience Measures (PREM), no previous data to compare	**YGC** - Child and Adolescent mental health care practitioner joined the diabetes team. Parents and carers trained on glucagon use at diagnosis and yearly refresher at annual review clinic. Prompt and documentation box added to diabetes clinic pro-forma to ask about insulin pump and give info on new technology. **YG** - Circulated own feedback form to whole caseload to gain wider views and opinions from CYP & families.	**WMH & YGC** - National Diabetes Network to provide access to specialist diabetes advice to patients and their families 24 hours per day and 7 days per week (in progress with completion date scheduled March 2022) **WMH** –To improve training for parents and carers to competently administer intramuscular glucagon (due Sep 2021). Escalation to the diabetes planning and delivery group and audit lead in progress.

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
					WMH –To improve appointments times and delays (due Sep 2021). Escalation to the diabetes planning and delivery group and audit lead in progress.
					YGC – Improve patient experience by improving the environment of the Clinic Waiting area (due March 2022).
					YG - To improve patient access to information around technologies and diabetes management (clinic-based discussion, handouts, pointers to websites and e-learning, to diabetes mobile tool, organising a North Wales Tech Day with industry, using Seren exercise module). Q3-4 2021
					YG – Improve access to transition clinic from paediatric to adult service Q3-4 2021. In progress.
					YG - Improve patient access to required MDT members in clinic Q3-4 2021. In progress.
					YG - Address training needs on ward during after-hours to enable to train parents and carers to competently administer intramuscular glucagon Q3-4 2021.
NCAORP /2020/11	NACAP: Adult Asthma (37 measures)	R	G	YGC report relates to patient care provided in 2018/19	**WMH & YG**: Non-participation due to resource. This has been unresolved since 2019. Escalation in progress as SOP.
					YGC: participation has been put on hold for the time being due to COVID. Part A action plan not completed due to consultant leads response/workload

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
					due to COVID 19. – Part B was overdue and not received to date. Escalation in progress as SOP.
NCAORP/ 2020/12	NACAP: COPD (37 measures)	A	G	Report reflects data submission from 2 of the three sites, YG and YGC. This report relates to patient care delivered in 2019/20. Compliance level has improved against previous report, reporting above the All-Wales Average for current smokers being referred to behavioural change intervention and/or prescribed a stop smoking drug during their admission.	**WMH**: Non-participation due to being under resourced for administrative staff to input the data. This has been unresolved since the start of the continuous audit in 2017. Escalation in progress as SOP.
				This report relates to patient care provided in 2017/18. Compliance level increase in availability of spirometry.	**YGC**: The numbers are small as data was from 2017/18 which is before the audit administration assistant was in post to support the data collection. This administration support was also temporarily re-deployed during Covid 19. No data collected since August 2020, attributed by the service to insufficient administrative capacity.
				Smoking cessation specialists and Non Invasive Ventilation (NIV) nurse post are now funded posts. Smoking cessation specialists were re-deployed during C-19 and Non-Invasive Ventilation (NIV) nurse were occupied with non-COPD patients.	**YGC**: participation has been put on hold for the time being due to Covid 19 and no administrative support (see also above).
				Prior to COVID-19, there had been a significant improvement in terms of data collection and other interventions such as the use of the discharge bundle.	**YGC**: Some interventions were put on hold due to Covid 19, many such as pulmonary rehabilitation and singing for breathing cannot be held due to the interactions needed. Oxygen nurses and respiratory nurse specialists (who provide supported discharge) have

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
					returned following temporary re-deployment during covid-19, marking resumption of normal activity.
					YGC: The focus of the respiratory teams will now be channeled into catching up with the waiting list for clinic and as things open up again, putting the interventions back in place from the previous report. Clinics have resumed but at reduced face-to-face capacity.
NCAORP /2020/13	NACAP: Pulmonary Rehabilitation (42 measures)	A	1st report since 2017 new reporting methodology	WXM and YG services have resumed and their first patients are currently going through their re-start programmes. The programme runs for 7 weeks, therefore data will be inputted at the end of the 7 week period. YG are ahead of the team in WXM as they were able to re-start sooner.	BCUHB wide draft action plan has been produced and is now with BCUHB Audit Lead/Consultant for finalising. This is now overdue.
					YGC: The team in YGC are yet to restart sessions.
NCAORP /2020/15	National Early Inflammatory Arthritis Audit (NEIAA) (7 standards)	R	A	Need to have dedicated Early Inflammatory Arthritis clinics at all 3 sites as those with Early Inflammatory Arthritis perform better.	Restarted data collection in June 2021 but not capturing all patients need support to increase participation. No audit lead identified by the service. Escalation as SOP.
				Need to ensure that there is the right skill mix and support at each site with regards to Nurse specialists/Allied Health Professional to deliver treatment, education and appropriate follow up for Inflammatory Arthritis patients.	
				Need to explore triage mechanisms e.g. to reduce referral for conditions more appropriately managed in primary care, promote first contact practitioners where	The service report that there is a requirement to recruit more Rheumatology Consultants which is still outstanding. Escalation as SOP.

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
				appropriate. There are disparities across the 3 sites which is demonstrated by the different waiting times across the units and this needs to follow a single triage process to bring together good practices that are evident but need further work.	
OLDER PEOPLE: • **Sentinel Stroke National Audit (SSNAP)** • **National Audit of Inpatient Falls (NAIF)** • **National Hip Fracture Database** • **National Audit of Dementia** • **National Audit of Breast Cancer in Older people**					
NCAORP /2020/17	Stroke Audit (SSNAP) (33 standards)	A	G	Significant improvement with patients' thrombolysed on all three sites and scores are well above average. Group therapy sessions were implemented which has assisted with compliance of this target for therapy sessions. The recruitment of multi-professional rehabilitation assistants will further assist with compliance of average minutes of therapy sessions.	Action plan outlines improvements against the audit's key indicators/targets, including Thrombolysis, Specialists assessments, therapy services (Occupational Therapy, Physiotherapy & Speech & Language Therapy) and discharge. A business case has been approved which will support required improvement. Recruitment to new posts anticipated December 2021 – actions anticipated completion March 2022.

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
NCAORP /2020/18	National Hip Fracture Database (NHFD) (32 standards)	A	G	**YGC:** The service reported significant improvement on perioperative medical assessment since appointing Orthogeriatric team. Delirium & Falls assessment compliance have also significantly improved. **YG**: The service reported that their documentation compliance has improved and the service provided is amongst the best. Monthly meetings round table, well attended. **WMH:** The service was the best performing unit in Wales and were invited to share their experience/success with the Welsh Fragility Fracture Network to help improve outcomes in other units.	Actions completed.
NCAORP /2020/22	National Audit of Breast Cancer in Older Patients (NABCOP) (9 standards)	G	There is no comparative data – reported over rolling 4 years.	Maintained compliance in line with national average.	Radiotherapy rates post breast conserving surgery need improving: Local audit completed September 2021 and further work identified to include data from external providers to ensure a complete clinical picture is included in the national audit which will be reported 2022. Chemotherapy treatment for early invasive breast cancer need improvement: Local audit completed September 2021 and results to be assessed at next national annual report in 2022.

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
END OF LIFE CARE: • **National Audit of Care at End of Life**					
NCAORP /2020/23	National Audit of Care at the End of Life (NACEL) (14 standards)	A	No data submission last year	Participation in all elements achieved in Year 2.	Evaluation of advanced care planning for health care professionals, patients and carers completed; Undertake a review of wider End of Life decision making and submit proposal with recommendations regarding strategic, governance and operational structures, together with supporting programme of training and education. (In progress due to complete Q4 2020/21). Develop a BCUHB Organisational Metrics Dashboard for Palliative and End of Life Care. (In progress due to complete Q4 2020/21). To develop and coordinate delivery of end-of-life care training and education to hospital staff to support them to deliver high quality end of life care - (in progress due to complete Q4 2020/21).
HEART: • **National Audit of Heart Failure (NAHF)** • **National Audit of Cardiac Rhythm Management (NACRM)** • **National Audit of Percutaneous Coronary Interventions (NAPCI)** • **Myocardial Infarction National Audit Programme (MINAP)** • **National Vascular Register (NVR)** • **National Audit of Cardiac Rehabilitation (NACR)**					
NCAORP /2020/24	National Heart Failure Audit	A	R	Project Management Office heart failure money was secured as being recurrent in	Action plan **YG**: (Audit lead responsible: Consultant Cardiologist).

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
	(NAHF) (14 standards)			2021. Ysbyty Gwynedd is reported as compliant with the standards in the published NAHF report (data is from 2018/19). In **YG**: • Medication titration, education, monitoring and troubleshooting is undertaken by an experienced Community Heart Failure (HF) nurse specialist, who liaise with the Cardiology lead when further Cardiology input required. • Additional HF specialist nurse employed at YG to maintain ward in-reach. In **YGC**: • Two new HF nurses were appointed in April 2021. Anticipated improvement in-hospital reach to HF patients. • New process agreed for all clinical teams to refer HF patients to HF nurse and cardiology team for follow up. In **WXM**: • In response to reduced number of in-patient echocardiograms and as part of the development of a local acute heart failure pathway, an agreement has been made that wherever possible the echo team will endeavour to scan within 48 hours of request.	Risk are being mitigated by: Consultant Cardiologist • Data Entry Clerk role for HF in YG is vacant. Action: recruitment process is underway (Oct 2021). Action plan **WXM**: • In response to reduced number of in-patient echocardiograms and as part of the development of a local acute heart failure pathway, an agreement has been made that wherever possible the echo team will endeavour to scan within 48 hours of request. Likely maximum capacity 2 in-patient echocardiograms per day (staff allowing). • Heart Failure team to provide some support to acute wards when Heart Failure Nurse capacity increases mid-October. • An SBAR report has been written for NT pro BNP (a serum marker for heart failure). This has the potential to assist in triaging more appropriate patients for echo during admission. The speciality report Board decision awaited (Sept 2021). • There is a draft pan BCUHB business case for additional Heart Failure (HF) nurses to allow for a more consistent approach to in reach HF team support. Submission anticipated following confirmation of costings.

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
					YGC actions • Business case being written currently (September 2021) to employ a second cardiologist with interest in HF and CRM. Deadline for implementation: May 2022.
NCAORP /2020/25	National Audit of Cardiac Rhythm Management (NACRM) (7 standards)	R	A	• True performance in WXM is not reflected. This is due to lack of essential training from software provider. Issue resolved by April 2021 • **WXM** data for the next NACRM Annual report due on 14/10/2021 has been validated. General Medical Council (GMC) data currently complete and data inputters have been trained to enter coding correctly. • **In YG** drive through pacemaker follow up checks set up during pandemic to reduce footfall through the Electrocardiogram (ECG) Department and enhance patient confidence. 90 patients so far (In April 2021). • Appointment of a Senior Cardiac Physiologist Pacing Lead. Responsible to improve data completion and overall quality of reporting. • New process measures to ensure improvements in pacing percentage for sinus node disease without Atrioventricular (AV) block and also in patients in Sinus rhythm with AV block. Cardiac physiologist to challenge pacing choice before procedure if outside of	• All YG actions are listed the completed actions column. • All WXM actions are listed the completed actions column. • All YGC actions are listed the completed actions column. NB: Poor performance against national standard is due in part to low levels of data submission and long-term problems with CCW workflow software in WXM and YGC. The underlying issue has been addressed an anticipation of the next audit cycle.

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
				BHRS recommendations. Implants falling outside of BHRS (British Heart Rhythm Society) recommendations to be brought to attention of Clinical Lead to address circumstances through pacing team Multi- Disciplinary Team. • **In YGC:** Senior Cardiac Physiologist Pacing Lead has returned to work and is responsible to improve data completion and overall quality of reporting. • An escalation process has been established to ensure that implants falling outside of BHRS standard are brought to the attention of the Clinical Lead.	
NCAORP /2020/26	National Audit of Percutaneous Coronary Interventions (NAPCI) (8 standards)	G	G	Maintained compliance level when compared to previously reported period. Maintained compliance in line with national average. BCUHB is already meeting the national targets for Primary Percutaneous Coronary Intervention (PPCI) and will continue to monitor and review all cases in conjunction with Welsh Ambulance Service NHS Trust (WAST).	All actions complete
NCAORP /2020/27	Myocardial Ischeamia National Audit Project (MINAP) (10 standards)	G	G	**YG** actions: • Data collection rectified to accurately reflect practice regarding secondary prevention medication. Improvements to be seen in MINAP report on 2019/20 data. • Acute Coronary Syndrome Specialist Nurses provide outreach service for ST Elevation Myocardial Infarction/Non-ST	**YG** actions: Audit lead responsible Consultant Cardiologist: • MINAP Data entry clerk vacant and two Chest Pain nurses are going on maternity leave. Confirmation received that recruitment process is underway. • **WXM** response: Consultant Cardiologist lead. Cardiac Strategic

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
				Elevation Myocardial Infarction patients nursed on other wards. Data collection reviewed to ensure accurate reflection of practice which shows improvements in MINAP report on 19/20 data. • Echo provided in YGC for YG PPCI patients. • Department reports that echocardiogram (echo) staffing issues at Ysbyty Gwynedd being addressed but there is a national shortage of echocardiogram physiologists. Department reports that weekend echo service is unlikely for foreseeable future. However, current data suggests improvements in Post Myocardial Infarction echo imaging during hospital stay, since previous annual report. **YGC** actions: • Continue current pathways and protocols for Non-ST elevation Myocardial Infarction patients, as Ysbyty Glan Clwyd (YGC) is performing 21% above the national average for meeting the 72-hour target. • Continue to follow the agreed protocol to discuss reasons for breaching patients with Welsh Ambulance Service NHS Trust (WAST) to reduce pre-hospital delays for Primary Percutaneous Coronary Intervention (PPCI) patients • Continue current pathways and protocols to ensure isolation of PPCI and potential Covid 19 patients.	manager for BCUHB reports that there is a BCUHB wide piece of work ongoing currently on capacity and demand being undertaken around Cardiac Diagnostics, from which a 3 to 5 year workforce plan will be produced. This action is current and expected to improve BCUHB performance in 3 to 5 years.

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
				• Continue to implement further training in YGC Emergency Department to reduce delays for self-presenting PPCI patients. **WXM** action • One physiologist changed her working hours to provide an improved rate of echocardiography pre-discharge. (From July 2021 to Oct 2021 89% of patients had an echo pre discharge).	
NCAORP /2020/28	National Vascular Registry Audit (25 standards)	A	A	Maintained compliance level when compared to previously reported period.	Action plan agreed and identified areas of improvement in relation to Data entry to the National audit, Interventional Radiology service, Abdominal Aortic Aneurysm (AAA) Care pathways & waiting time to investigations, Major amputation mortality, non-elective admissions with CLTI, carotid endarterectomy and lower limb bypass. (Dec 2020 - Dec 2021 - partial completion of actions, progress monitored by the Vascular Audit Lead).
NCAORP /2020/29	National Audit of Cardiac Rehabilitation (NACR) (9 standards)	G	G	Maintained compliance level BCUHB wide when compared to previously reported period (based on 2018/19 data) in NACR published report 2020. **YG:** YG met or exceeded all of the targets in the latest NACR report (based on 2018/19 data) but now has significant staffing problems. • Team decided to not offer Cardiac Rehabilitation (CR) to angina patients who are medically managed even where	**YGC: Action for Cardiac Rehabilitation Physiotherapist Oct 2021**: Recently appointed Band 6 nurse to identify missed referrals and improve participation of medically managed Myocardial Infarction patients and liaise with those areas where referrals are not sent consistently to provide a robust referral system. **Update is overdue for some actions. WXM: Cardiac Rehabilitation Nurse Lead. Actions:** Extending virtual input

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
				the patient is defined as being symptom limited, following valve surgery and a diagnosis of Heart Failure because of staffing situation for 4 months. These patients have been included again since June 2021. • Since June 2021 clinics were established enabling F2F contact with patients and a full CR Core assessment 1. The majority of patients have had this Core assessment 1, fewer than 5 from earlier than June remain waiting their appointments. For a minority of patients from 2021 we have started to offer CR Core assessment two as F2F appointments. These F2F appointments are particularly important to enable physical examination and submaximal exercise assessment. Department report that their performance will be lower in published NACR report referring to the current period and will likely affect ability to achieve certification with the National Audit of Cardiac Rehabilitation (NACR). **YGC Actions:** to improve Heart Failure (HF) median wait time actions commenced April 2021: • New process where initial contact is via letter inviting patients to make appointment for telephone discussion instead of clinic appointments and initiate Heart Failure telephone clinic • Utilise Reach-HF plan – evidence-based	to provide, for select and appropriate patient groups. a. supervised exercise sessions, b. other peer support group sessions by June 2021. Action for Community Cardiac Health Officer; Cardiac Rehab Nurse Specialist: 1. Target to create an educational, short film(s) to complement individual and group face-to-face and virtual input. Due April 2021, follow up in progress. Action for Advanced Cardiac Rehabilitation Nurse: 2. After a successful pilot, putting in a business case for improving pts' timely access to cardio-protective medications and cardiology management through use of Advanced Practitioner skills in Cardiac Rehabilitation (CR) due April 2021. Action for: Advanced Cardiac Rehabilitation Nurse, follow up in progress. 3. Business case planned for offering CR to all eligible patients (to extend to all inclusion criteria) – more HF, stable angina, adult congenital heart disease, arrhythmia (atrial fibrillation, others) those with devices: Implantable cardioverter defibrillator (ICD). April 2021, follow

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
				self-help manual facilitated remotely by trained facilitators reducing need for face-to-face appointments – funded for 50 patients. It has been reported on the Host website Oct 2021: **YGC** and **WXM** have met all seven KPIs in the as yet unpublished 2021 NACR report and are reported as Green Certified. **YG** met 6 of the 7 KPIs but collected too few feedback forms post assessment. It is acknowledged in the report that this was because of the Pandemic and they are recognised as Green/Not certified	up in progress. 4. Business case planned for appropriately meeting the mental health needs of patients going through CR. Submitted April 2021 awaiting outcome, follow up in progress. 5. Business case for a Process Manager (target for August 2021 start) within CR to streamline service delivery and improve marketing of CR, and thereby: a. Improve accuracy of data collection b. Increase return of data from patients c. Minimise duplication and increase prudency in CR delivery d. Improve general uptake of CR input All actions above to be complete by June 2021: Cardiac Rehabilitation Nurse Lead with Specialty Manager. Follow up in progress. 6. Progress towards moving from paper CR patient notes to electronic by May 2022 Assistant Operational Manager. 7. When Covid-19 pandemic allows, supporting staff in accessing good quality, appropriate, internal and external learning opportunities for service review and improvement by Sept 2021, follow up in progress. 8. Reducing unnecessary non-clinical

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
					duties performed by clinical staff by increasing administrators in order to mobilise current available clinical time. By Dec 31st 2021, follow up in progress. a. Cost-negatively convert Band 6 (B6) staff funds within CR Multidisciplinary Team (MDT) to provide more CR sessions for people with HF. b. Band 5 Exercise physiologist and c. Band 4 Technical instructor/Senior Support Worker by Sept 2021, follow up in progress. (i) Increase staffing to improve availability for HF patients to receive core CR in a timely fashion by Dec 2022, follow up in progress. **YG Lead post is vacant but role is supported by Community Cardiac Rehabilitation Nurse and Exercise Physiologist in Cardiac Rehab Actions all updated Oct 2021:** • A business case to enable recruitment of new staff was resubmitted January 2021 1 WTE Band 7 lead to be interviewed October 2021 as a result follow up in progress. • Business case for recruitment to be reviewed following appointment of lead and a thorough review of all aspects of governance to enable the

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
					team to provide the best service possible for patients with the resources provided. The service advice that it is likely they will achieve even less patient contact while the service is set up.
CANCER: • **National Lung Cancer Audit** • **National Prostate Cancer Audit** • **National Oesophageal – Gastric Cancer Audit** • **National Bowel Cancer Audit**					
NCAORP /2020/30	National Lung Cancer Audit (8 standards)	A	G	Maintained compliance level when compared against audit standards.	**YG** – identified as an outlier for low Non-Small Cell Lung Cancer (NSCLC) chemotherapy rates. The project lead reports that the data has been revalidated and resubmitted. BCUHB action plan received (Sept 2021), clinical effectiveness team are seeking further assurance on the planned improvements. Ongoing.
NCAORP /2020/31	National Prostate Cancer Audit (10 standards)	G	G	Maintained compliance level when compared against audit standards. Maintained compliance in line with national average.	Action plan outlines local audits to review overtreatment of low-risk localised disease, 90-day emergency readmissions rate and sexual function score following radical prostatectomy. (to be completed by Oct 2021). Led by project leads - in progress.
NCAORP/ 2020/32	National Gastrointestinal Cancer Audit Programme: Oesophago-Gastric Cancer:	G	G	Maintained compliance level when compared to previously reported period. Maintained compliance in line with national average.	**WXM** - To develop a robust validation of data. - Regular fortnightly data validation meetings between Cancer Service & Upper Gastrointestinal (UGI) team in place, results to be assessed at next national annual report in Dec

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
	(13 standards)				2021. Review of pathway for cancer waiting times - as of 1st January 2021, Wales has moved to a single cancer pathway. Project lead reports that tracking and reporting mechanisms are in place in cancer services and all patients prospectively tracked against timed pathway.
NCAORP/ 2020/32	National Gastrointestinal Cancer Audit Programme: Bowel Cancer (15 standards)	G	G	Maintained compliance level when compared to previously reported period. Maintained compliance in line with national average.	**YGC** - Outlier status for 2 year mortality rate. A review has been undertaken (authored by lead colorectal cancer lead and Hospital Medical Director YGC). Report states in conclusion "unlikely to be due to systemic problems with the service. It is more likely to have been a one-off event, given the particular circumstances of case mix and individual patient factors". Review laparoscopic and Abdominoperineal resections (APER) rates. Local prospective audit to be completed (March 2022).
WOMEN & CHILDREN: • **National Neonatal Audit Programme (NNAP)** • **National Maternity & Perinatal Audit (NMPA)** • **National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)**					
NCAORP /2020/33	National Neonatal Audit Programme	A	G	**WXM** completed actions: • Nov 2019 – Feb 2020 an audit of	**Department.YG lead: Consultant Paediatrician**

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
	(NNAP) (13 standards)			BadgerNet (software) entries done, which established that majority of missed entries were due to poor recording of the information in BadgerNet. • Spring 2020: Aide-memoire produced and introduced on Special Care Baby Unit (SCBU) and postnatal ward to facilitate collection of information for BadgerNet. • Mid 2020 – nurse champion and ward clerk champion of BadgerNet introduced on SCBU. • September 2020 onwards: weekly quality control check of all BadgerNet discharge summaries by an experienced registrar. **YGC completed actions:** **Temp control:** • At the beginning of 2020, a thermoregulation bundle was introduced in YGC. Following this change data has shown improvement. • Breast-feeding on discharge is 18%. UK average is 58%. The unit is working towards UNICEF (United Nations Children's Fund) Baby Friendly Initiative (BFI) accreditation and have already achieved stage one accreditation. Continue towards full accreditation. • 2-year follow up rate has dropped from 75% to 52.4 %. Unit is changing to a paper-based parent questionnaire system with telephone follow up which should result in improvement.	YG actions: 1. Retinopathy of Prematurity (ROP): Delay in ROP screening is due to non-availability of local ophthalmologist and babies require transfer to other hospitals for ROP. This is ongoing issue and had been addressed at highest level within trust. There is an alternative plan but would require bit longer time to establish (Use of Retinal Photography (ret cam) training for local staff. Due: March 2022 Improvement to 95% or above. 2. Temperature on admission at less than 32 weeks: we have already completed retrospective audit in 2020 and now ongoing prospective Audit, with use of British Association of Perinatal Medicine (BAPM) thermoregulation bundles, simulations and teaching. Results of prospective audit to be discussed in May 2021 in Joint meeting with Maternity team to combine with labour ward room temperatures and theatre temperatures. Review in Sept 2021; improvement to 70% or above. 3. Parents presence during ward rounds. We have increased number of ward rounds by consultants and also parents are encouraged to attend ward rounds, this had been challenging over last 1 year due to

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
					Covid and lack of accommodation on site. It is hoped that this will improve post Covid in Sept 2021 – 85% and above. 4. Follow up at 2 years, this was due to some babies lost to follow up also partly due to system of referrals to local community team, it has been discussed with management team. Online, telephone assessments due to COVID now offered. March 2022 - Up to 80 % and above. **WXM responsible lead: Consultant Paediatrician** **WXM Actions:** Expressed breast milk (EBM)/breast feeding on discharge: 28.6%. The service advise that this may be to do with the fact that babies that are born in Wrexham under 32 weeks get transferred and on discharge will be nil by mouth (to ensure safe transfer), which will come up as “not receiving breast milk on discharge”. To be audited by 25/05/2021, follow up in progress. **YGC Responsible lead: Consultant Neonatologist.** **YGC Actions: All in Completed Actions column**

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
NCAORP /2020/34	National Maternity & Perinatal Audit	Only National recommend ations provided	One off sprint report looking at data quality for Multiple Births	• From April 2021, the electronic maternity outcome captures data with regards to fetus 1, fetus 2 fetus 3 etc. Therefore, they should now be accurate with regard to the number of babies born for each pregnancy in BCUHB. • Chorionicity/amnionicity and planned actual mode of birth has been added to the electronic maternity outcome form. • The electronic maternity outcome form did not capture whether the pregnancy began as a multiple pregnancy therefore, this has been added to the maternity outcome form. Discussions have been held with Informatics and this has been implemented.	There is currently no Maternity Information System in Wales and the Maternity/Neonatal Network are leading actions to improve on this development. Currently BCUHB record all National Insurance (NI) numbers in the birth register. **Action for the Maternity/Neonatal Network.**
NCAORP /2020/34	National Maternity & Perinatal Audit Evaluating perinatal mental health services using linked national maternity and mental health data sets.	Only National recommend ations provided	No comparable previous report available		Action Plan was confirmed by deadline on 6th May 2021. They require Welsh Government input and therefore are pending. Officials in the Government Perinatal Mental Health Policy Team are going to be discussing this report with the National Lead for Perinatal Mental Health and correspondence on the report will be sent to all specialist perinatal mental health teams in Wales.
NCAORP /2020/36	The National Clinical Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) (12 Standards and	66% of the KPIs are the same or higher than national mean. However, the data submitted in	Low data levels for BCUHB means that this report is not comparable with any previous	• A new Specialist Children's Epilepsy Nurse has been recruited in YGC • Non participation due to COVID pressures. BCUHB Audit lead has escalated to clinical lead the following needs: i. The need for a member(s) of staff to be trained to input data from case	**Actions in progress. Update has been provided by YG Lead: Consultant Paediatrician** **Actions** - plan to improve referral process for epilepsy surgery – Jan 2022 - Teaching scheduled every 6 months to improve obtaining Electrocardiogram (ECG) for CYP

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
	8 National Recommendations)	this period 2018-19 was very low for all areas because of work pressures so this information is inconclusive. Actions written in response to National recommendations.	report.	notes. ii. The Neurophysiology department will need someone to input new patients who have had Electroencephalogram (EEG) and fulfil criteria. **Completed WXM actions:** • Children's Epilepsy Surgical Service (CESS) include Children with refractory epilepsy and structural lesions. Identification of cases is done in clinics and then a proforma provided by Alder Hey is filled for referral. • Additional hours for Epilepsy Specialist Nurse have been agreed if Wrexham specific data can be separated. ESN has been informed how to ensure that data is identifiable. **Completed YGC actions:** • Ongoing discussions with CEAG (Children's Epilepsy Advisory Group) at a Health Board level. Within YGC ongoing processes are robust with children being able to be seen within 4 weeks of referral. • MRIs under General Anaesthetic has recommenced, however, significant ongoing waiting times for routine MRIs under GA. Urgent MRIs under GA available if child is admitted to children's ward • Ongoing – YGC team are exploring several validated tools including the SDQ. To be discussed at next CEAG	(Children and Young People) with convulsive seizures - Dec 2021. - Proforma to be created to improve process to obtain Magnetic Resonance Imaging (MRI) where indicated – Jan 2022. **YGC Actions:** • Discuss with management and Children's psychology to improve access. **Update Oct 21:** At present significant capacity issues within health psychology. Awaiting outcome of review and business case for children's psychology services – currently ongoing **WXM actions: (action plan received after deadline) Consultant Paediatrician:** • Local pathways to include routine 12-lead ECG for children with convulsive seizures. First seizure guideline is in place on intranet (**Oct 2021**). Audit under way to be completed December 2021. • Proforma to be created for MRI indications to improve obtaining MRI for those who require it. **Update:** Widespread training ongoing with all professionals. No need for separate proforma as NICE guidance is explicit. An audit underway and will be completed by December 2021. • Mental Health validating tool to be discussed at Children's Epilepsy Advisory Group (CEAG) Update:

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCUHB report*		
				meeting and in YGC area peer review meeting.	Needs to be escalated for All Wales discussion.
OTHER: • **National Clinical Audit of Psychosis**					
NCAORP /2020/42	National Clinical Audit of Psychosis (8 Standards, 21 Measures)	G	G	82% maintained or improved compared to previous reported period.	Outlier due to BCUHB Early Intervention Psychosis (EIP) being too small to offer care co-ordination (Standard 1). The service is currently being developed to a new stand-alone model, with 8 new care co-ordinators, which will bring it much more in to line with Early Intervention Psychosis services nationally.

Table 2 - Progress update on National Clinical Audit and Outcome Review Programme

Progress summary:
Based upon the benchmarking assessment tool (page 8), the following projects have been identified as areas of concern for results published in 2020/21:
**NB data reported in 2020/21 can relate to an earlier data collection period, the timeframe of which can vary between project areas.*

- National Paediatric Diabetes Audit – PREM Report (Low levels of compliance against national scores). This is the first report so no previous BCUHB data to compare
- Adult Asthma (low levels of compliance against national scores)
- National Early Inflammatory Arthritis Audit (NEIAA). (Low levels of compliance against national scores).
- National Heart Failure Audit (NHFA). Limited improvement on previously reported BCUHB compliance.
- National Audit of Cardiac Rhythm Management (NACRM). Low levels of compliance against national scores.

Of additional note:

- National Lung Cancer Audit. Although not flagging red on the assessment tool this audit identified BCUHB as an outlier for low Non-Small Cell Lung Cancer (NSCLC) chemotherapy rates. The project lead reports that the data has been revalidated and resubmitted.
- National Gastrointestinal Cancer Audit Programme: Bowel Cancer. YGC - Outlier status for 2 year mortality rate. A review has been undertaken (authored by lead colorectal cancer lead and Hospital Medical Director YGC). The BCUHB report states in conclusion “unlikely to be due to systemic problems with the service. It is more likely to have been a one-off event, given the particular circumstances of case mix and individual patient factors”.

(iii) Comparison of audit results with the previous BCUHB audit cycle

When compared to previous reports, 55% (n= 15) of the tier 1 audits showed maintenance or improvement against the previous audit for 75% or more of measures:

(n= 27 tier 1 audit publications in year)

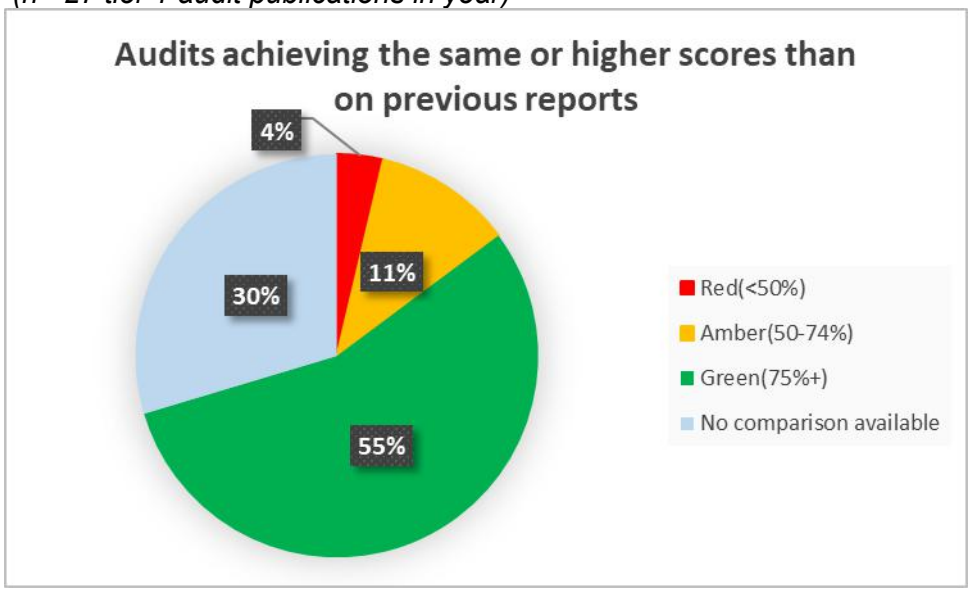

Figure 3 – Benchmarking against previous BCUHB performance

Key for Figure 3:

Red	Partial or non-participation or, The measures or standards where BCUHB has maintain or improved compared to the last report is less than 50% of the opportunities to do so. ie. if there are 10 measures/standards in the audit. There are 3 opportunities to improve or maintain the score from the previous report when applied to the acute sites in BCUHB so the denominator is 3X10 = 30 Suppose the sites achieve the same or improved scores in the following way: YG achieves 3/10: YGC achieves 4/10: WMH achieves 3/10 then across BCUHB there were 10 (3+4+3)/30 opportunities to meet or surpass the previous score; across BCUHB 33% improvement has been achieved.
Amber	The measures where BCUHB has maintain or improved is 50-74% of the opportunities to do so using the methodology above.
Green	The measures where BCUHB has maintain or improved is 75% or more of the opportunities to do so using the methodology above.

Progress against Tier 1 actions
We recognise that completion of actions between audit cycles is an important factor in securing required improvement. Tier 1 progress against required actions is described below.

164 actions were identified within all the improvement plans. Sixty of these were completed (37%). This is comparable with performance reported within the annual report for the previous year 2019/20 (38%).

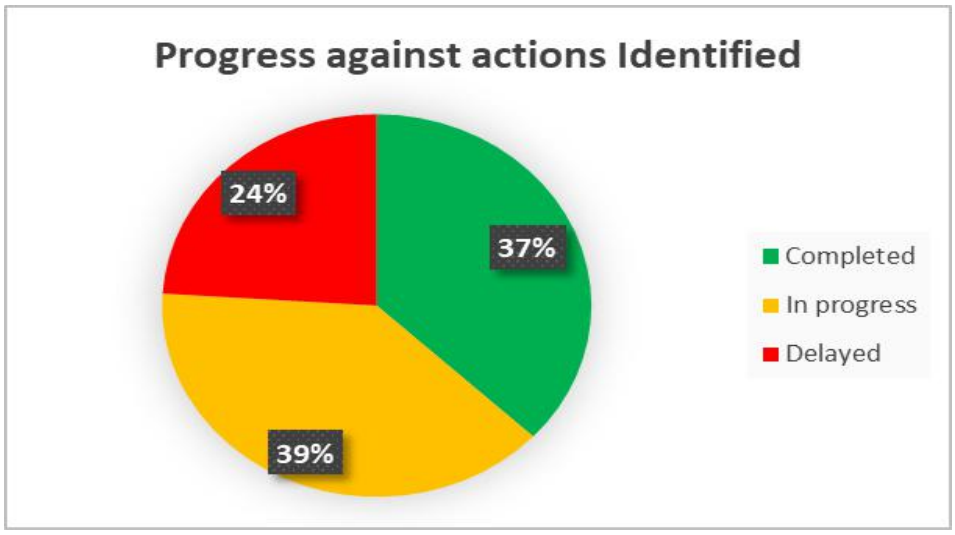

Figure 4 – Progress against Tier 1 actions

Five audits had no or incomplete improvement plans in 2020/21:
NB this includes response to national audit findings / still required when local data collection has not been undertaken.

- National Adult Asthma (all sites)
- Chronic Obstructive Pulmonary Disease (WXM & YGC)
- Pulmonary Rehabilitation (all sites)
- National Lung Cancer Audit (All sites)
- National Core Diabetes Audit (Primary Care – all areas)

SECTION 2 – TIER 2 BCUHB PRIORITY AUDITS

Executives and Divisional Management Teams identify local priority audits that become part of the annual audit plan. These are referred to as Tier 2 audits. These projects are risk assessed against organisational objectives.

In 2020/21 38 audits were identified to be started within the year, of which 10 are considered ongoing as they relate to continued accreditation. It is of note that audit projects can include multiple audits under a single overarching topic heading. For example, the blood science departments delivered multiple audits this year to provide assurance with the Blood Safety and Quality Regulations. The status of tier 2 projects is described below:

Tier 2 Audit Status
(n=38 audits)

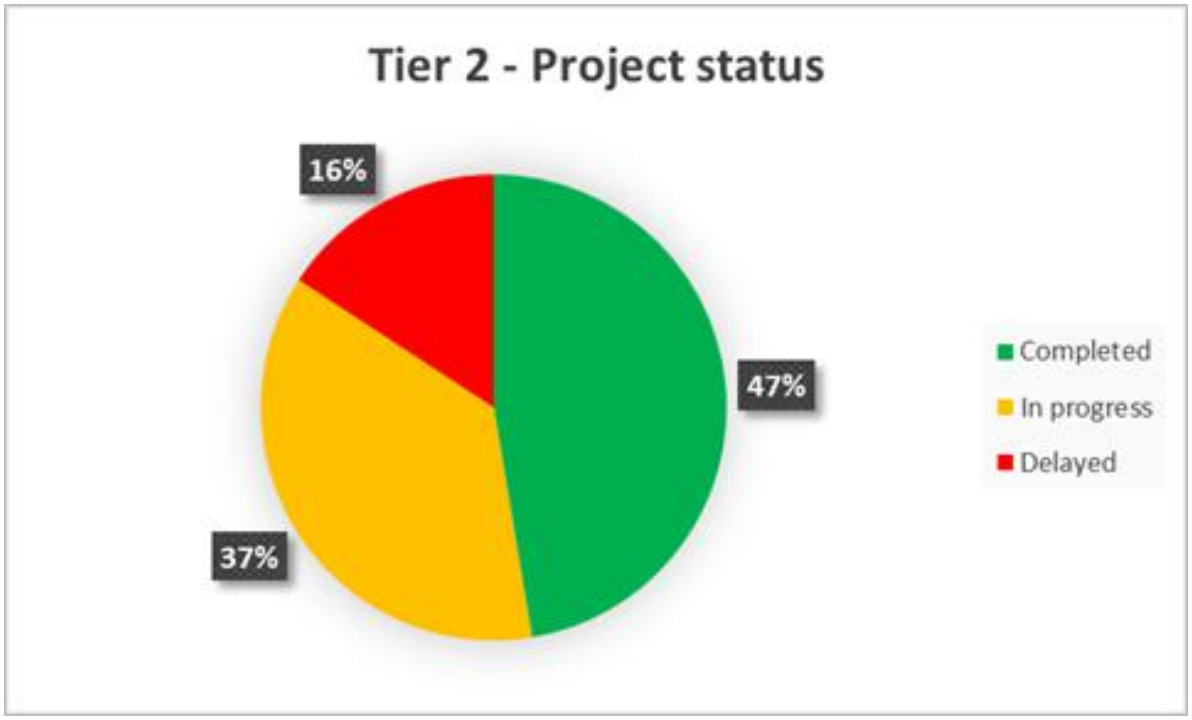

Figure 5 – Status of Tier 2 audits

SECTION 3 - TIER 3 LOCALLY INITIATED PROJECTS

Locally initiated audits are undertaken within specialties and departments by local agreement. A corporate database has been developed to hold this audit activity. Project leads self-register their audits and upload completed audit reports. The audit is considered closed when the audit report has been uploaded.

During this year, 433 projects were registered of which 53 were completed (12.2%). This is a decrease in performance compared with last year where 17.6% (n = 78) of tier 2 audits (total n = 442) were completed.

There are a range of different audits within tier 3, these include but are not limited to:

- audits which check quality or safety issues (in specialities) where there is no national priority audit
- audit of actions to ensure required Tier 1 audit actions have been completed
- audit in response to localised risk or assurance issue such as compliance with national guidance

See below more detailed analysis for 2020/21 tier 3 audit activity:

Triggers for Tier 3 Audits registered

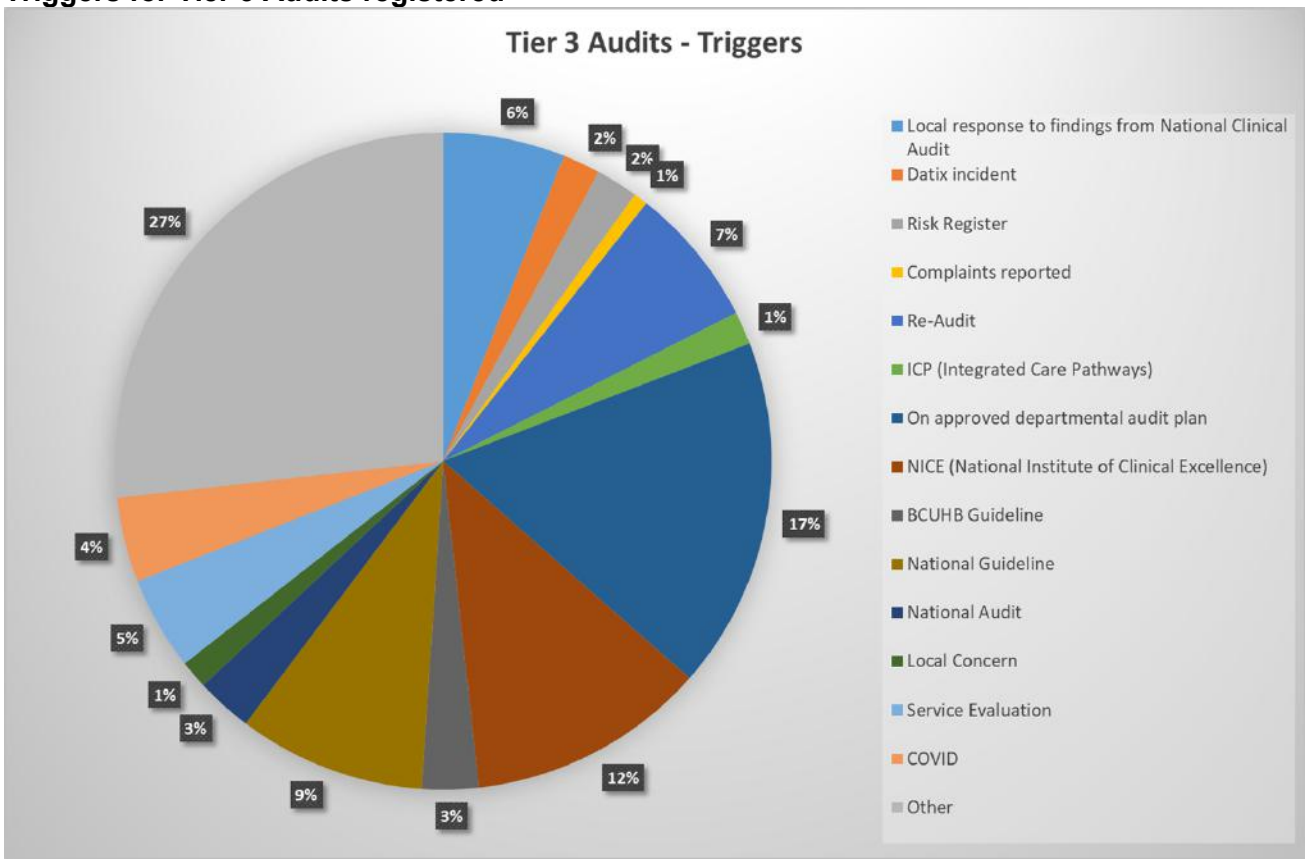

Figure 6 – Triggers for Tier 3 audits

During 2020/21 the largest proportion of tier 3 audit topics were linked to identified risk (accounting for 27% of the audit activity). Of the remainder: 17% responded to National Audit; 12% reflected response to NICE (12%); 9% to National Guidelines. Response to

service evaluation and COVID accounted for 5% and 4% respectively.
The “other” category on the chart captures all other reasons not listed on the registration form, which includes audit undertaken as part of education (MSc and/or dissertation work) or in response to other evidence-based guidelines.

There were 51 Audits registered by the audit project lead as measuring against NICE guidance in 2020/21, of these 10 (20%) have been completed. The table below provides a breakdown of audits where NICE Guidance was the trigger for undertaking audit during 2020/21.

	YG	YGC	WXM	Total
Technological Appraisal (TA)	0	2	0	**2**
Clinical Guidelines (CG)	3	6	5	**14**
Interventional Procedure (IPG)	0	0	0	**0**
Quality Standard (QS)	0	1	2	**3**
NICE Guidance (NG)	4	4	4	**12**
Diagnostic Guidance (DG)	0	1	0	**1**
Not identified	8	3	8	**19**
Overall Numbers	**15**	**17**	**19**	**51**

Table 3 - audits against NICE guidance

The introduction of new data management tool (AMaT) April 2021 provides the facility to track and manage audit activity more effectively. This will strengthen the Health Boards ability to link NICE guidance with audit response. AMaT is being piloted within Womens Services 2021 with a view to potential Health Board roll out in 2022.

AUDITS IN PRIMARY CARE
There are primary care audits within the NCAORP programme relating to topics such as chronic obstructive pulmonary disease and aspects of diabetes care.

All practice submitted data for the tier 1 core diabetes audit in 2021. Data was extracted electronically and our focus going forward is to work with primary care stakeholders to ensure that audit findings are used to drive forward improvement. This work is at an early stage led by Office of the Medical Director, the Area Medical Directors and supported by the Corporate Clinical Effectiveness Team.

Key themes arising from audit activity in 2020/21:

- The majority (81%) of mandated tier 1 audits were undertaken in 2020/21.
- There was however some non-participation or partial participation across BCUHB services. Significant and ongoing operational pressures continue to impact on data collection, with some audits recurrently not participating in data collection.
- The majority of specialities attributed this to insufficient clinical and administrative capacity within their service / division, compounded by continued operational challenge of the COVID pandemic.
- While there are some strong examples of quality improvement following audit in 2020/21, there is still much more to do.
- The audit cycle is not yet consistently or sufficiently completed in all cases, therefore the full benefit of current audit activity is not being fully realised. The introduction of an audit management tool (AMaT in April 2021) is anticipated to strengthen oversight / monitoring of audit activity and through this support future improvement. This work is additionally supported by a review of resources within the Clinical Effectiveness Team, leading to the submission of a business case.
- It is however acknowledged that participation in audit or indeed any quality improvement activity is not exclusively a matter of resource, it requires the fostering of a culture which recognises and values its contribution as a productive tool to achieve continual improvement.
- Strong leadership and engagement are vital to drive forward this important agenda. Development within primary care is in the early stages but developing, most recently evidenced by the establishment of Area Clinical Effectiveness Group and this work is anticipated to further develop in 2021/22. Closer matrix working between Corporate Clinical Effectiveness, Patient Safety and Patient Experience (Clinical Governance Teams) is anticipated to further support this cultural journey.

RECOMMENDATIONS:

1. Review and update the Clinical Audit Policy and NICE Policy. Robustly implement across the Health Board.

2. Review and ratify the Clinical Effectiveness Strategy to provide a strong road map to strengthen the impact and effectiveness of audit across BCUHB.

3. Review and confirm the process for developing and delivering BCUHB audit plan – ensure that audit activity is invested into BCUHB priority areas.

4. Review audit capacity (staff resource) – both clinical and administrative. Submit business case to respond to capacity gap within Corporate Clinical Effectiveness Team.

5. Review business model to deliver capacity in the right place at the right time, reflecting BCUHB priorities and recognising required development at Area as well as at secondary care level and BCUHB wide.

6. Corporate Clinical Effectiveness Team to continue monitoring identification of Clinical Audit leads at local level, recognising their important role in driving quality improvement, ensuring appropriate allocation of resource to successfully deliver the audit cycle.

7. Corporate Clinical Effectiveness Team to continue the ongoing development of the Audit exception report (piloted since December 2020), for presentation at the Clinical Effectiveness Group meetings, providing timely information to address delivery risks and to maximise the positive impact of audit on quality and safety.

8. Corporate Clinical Effectiveness Team to work with specialities with specific focus on action planning in 2020/21 - working with speciality stakeholders to ensure specific and measurable action plans, delivered to time, thereby maximising their positive impact.

9. Pilot the audit management and tracking database (AMaT) - with full implementation 2022 subject to successful evaluation and agreement. Through this, engage clinical and corporate stakeholders to deliver increased visibility of audit activity and strengthened real-time reporting.

10. Build audit capability – Corporate Clinical Effectiveness Team to review and confirm training and coaching model / identifying current and required resource, exploring feasibility of virtual learning tools to maximise effective use of resources.

APPENDIX 1 – Flowchart
Escalation for Response to WG following National Audit Report publication

Following National Audit Lead Audit Report publication

✉ Part A (Recommendations) and Part B (Quality Improvements)

⇩

Part A (Localised Care Recommendations)

✉ **2 weeks** after National Audit Report publication follow up if no response:
FOR ACTION email to Site/Area Medical Directors & Directors of Nursing.

✉ **1 week** prior to deadline email to Site Leads & SCLs
FOR URGENT ACTION
(Copy email to Site/Area Medical Directors, Directorate General Manager & Directors of Nursing)

✉ **1 week** prior to deadline email to Senior Associate Medical Director & Executive Medical Director
ALERT DEADLINE IMMINENT - Part A submission deadline will breach in seven days.

⇩ ⇩

Part A received

Share Part A response for information with Site/Area Medical Directors, Directorate General Managers & Directors of Nursing
Sign off of Part A required from Secondary

Escalation

Overdue **Part A** responses to be notified to: Senior Associate Medical Director & Executive Medical Director

⇩ ⇩

Part B (Care Improvement Plan)

✉ **4 weeks** prior to Part B response deadline:
FOR ACTION email to National Audit Leads, Clinical Audit Leads & Clinical Directors to request BCUHB/Site local improvement actions response

✉ **3 weeks** prior to deadline:
FOR ACTION email to Site/Area Medical Directors, Directorate General Managers & Directors of Nursing

✉ **2 weeks** prior to deadline:
FOR URGENT ACTION email to Site Leads & Secondary Care Leads
(Copy email to Site/Area Medical Directors, Directorate General Managers & Directors of Nursing
~ DEADLINE IMMINENT)

⇩ ⇩

Escalation
Overdue **Part B** responses to be notified to:

Senior Associate Medical Director & Executive Medical Director

⇩

Part B received
Share Part B response for information with Site/Area Medical Directors & Directors of Nursing.
Final sign off of Part B required from
Secondary Care Medical Director / Senior Associate Medical Director **prior** to return to WG.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Chair's Report

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting or area reporting in	Patient Safety and Quality Group
Chair of meeting or lead for report	Debra Hickman (on behalf of Gill Harris)
Date of meeting	14 September 2021
Version number	V1.0
Appendices	N/A

Reporting To	
Name of meeting	Quality, Safety and Experience (QSE) Committee
Date of meeting	02 November 2021
Presented by	Matthew Joyes, Acting Associate Director of Quality Assurance

1. Alert – include all critical issues and issues for escalation

No significant issues

2. Assurance – include a summary of all activity of the group for assurance

- **Personal Protective Equipment (PPE) Group:** No critical issues at present. The group are continuing to work closely with fit testing colleagues and have good staff side support. There has been an increase in FFP3 masks due to change in guidance.
- **Infection Prevention Control (IPC) Group:** Evident when chairing the outbreak meetings that behaviours and understanding are an issue. Going forward, the group will report direct into QSE however IPC will remain a standing agenda item at the group so alignment with the wider quality and patient safety agenda can be ensured.
- **Safe Medications Group:** A detailed update was received. Flu vaccination Patient Group Directives (PGDs) finalised, no issues identified. Risk identified that a number of drug charts needed re-writing; this is a timely job and introduces a level of risk, the group discussed further and agreed that this is a risk and cannot wait until electronic charts come into effect.

- **Quality Systems Management Group:** The meetings now will take place every 2 weeks to focus on implementation on the concerns system and real time feedback system for the next 6-8 months.

- **Falls Sub Group:** Working hard as a group on the Health & Safety Executive (HSE) findings, the investigation showed that there is variation in the system/process. The group have reviewed the policy, training, education, data and reporting

- **Medical Gasses Group**: Report received from the Healthcare Safety Investigation Branch regarding a major incident on an acute site in England whereby the pipeline system was not able to meet demand, report details the key findings, including the review of all medical gases groups, the findings were considered at the group for learning.

- **Safeguarding Governance and Performance Group:** The Social Wellbeing Act is currently under review with Welsh Government (WG). In respect of the Holden Report – the engagement with North Wales Safeguarding Board is concluded with the task group reporting back to the Board.

- **Divisional Reports:** Each division submitted and presented a report. Of note, ***Secondary Care*** is taking forward a revised improvement plan with regards to fall prevention and management. A urology paper went to QSE and it was agreed to commission a Royal College Review, which is currently going through Executive sign off. ***West Area*** reported an outbreak in Ysbyty Eryri which is taking a lot of staff time and adding pressures to the system, the service are concentrating on essential audits. ***Central Area*** reported there is a 67 bedded care home that has been embargoed due to their staffing position, currently supporting to do welfare checks, and not taking any further admissions at present. The area have managed to reduce the complaints backlog by holding weekly complaints review meetings which are chaired by the governance staff and band 7 staff attend to present the case of investigation and ask for any support needed. This helps to keep up focus, and allocation of new complaints takes place at the daily safety huddle to the investigation officer within the appropriate service. ***Womens Services*** reported a Regulation 28 issued regarding an early neonatal death in England, and noted the sharing of learning and recommendations. Ongoing concerns with the Countess of Chester contract regarding high infection rates – the service have asked for assurances and action plans, which have not been received, there is a meeting arranged with their Director of Contracting to open discussions. Next steps will be to escalate through Executives.

- **National Review of Maternity Services action plan:** Completed 22 out of the 31 recommendations, which means we are 72% compliant, also progressing the 9 open. Working with partners, users and groups.

- **Child, Adolescent Mental & Health Service (CAMHS) patients being held on Paediatric wards – review of risk assessments:** Acuity in acute areas has been looked at since March 2021, daily SITREPS were set up along with safety meetings being held 3 times a week, to monitor and be responsive.

- A number of **procedural documents** were approved:

    - Falls
    - Animals in Health Care
    - Care after death : Care of the deceased patient
    - Infection prevention in Design, Construction and Renovation Refurbishment and Projects
    - Notifiable Diseases
    - Food Safety In Ward Kitchens
    - Safeguarding Governance & Performance Reporting Framework [updated July 2021]
    - Corporate Safeguarding Communication & Learning from Safeguarding Practice Reviews Standard Operational Procedure
    - Procedure for Safeguarding Children and Young People Admitted to Adult Based Wards and Environments
    - Augmented care areas Protocol for Prevention and Management of Pseudomonas aeruginosa
    - Criteria Led Discharge

3. Achievement – include any significant achievements and outcomes

- **Medical Gases & Medical Devices Sub-groups** – EBME team were noted across the Health Board as performing very well in keeping equipment safe and maintained during the pandemic.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Chair's Report

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting or area reporting in	Patient Safety and Quality Group
Chair of meeting or lead for report	Adrian Thomas (on behalf of Gill Harris)
Date of meeting	12 October 2021
Version number	V1.0
Appendices	N/A

Reporting To	
Name of meeting	Quality, Safety and Experience Committee
Date of meeting	02 November 2021
Presented by	Adrian Thomas, Excutive Director of Therapies & Health Sciences

1. **Alert –** include all critical issues and issues for escalation

The group noted that staffing challenges was a key theme from reports across many areas and represented a high risk entering the winter period.

2. **Assurance** – include a summary of all activity of the group for assurance

- Due to meeting dates, a formal report from the **Infection Prevention and Control Group** was not available however, a verbal update was provided. It was reported that the Health Board is not an outlier for infection rates, and Welsh Government had issued new targets for 2021/22. Concerns were raised in regards to issues finding decant space, patient and staff (outside of clinical area) mask compliance, poor compliance with care bundles and inadequate ventilation in many areas. An update was also provided on the Safe Clean Care campaign and that a full suite of up to date policies and procedures is now available.
- **Personal Protective Equipment (PPE) Group:** The FIT testing badge remains in progress with plans in place for full roll out. National PPE supply remains robust. PPE operational hubs remain under review as non-NHS colleagues reliant at times on stock. Primary Care Contractors and the access to FIT testing requires consistency across BCUHB. Further review of arrangements is underway. Clear mask supply

continues via USA supply chain. Awaiting Senior Leadership Management Team (SLMT) decision regarding UK product provider and route supply.

- **Safer Medications Group:** The group updated on work undertaken to analyse the recording of correct harms levels for medication incidents. A separate update is being prepared for the QSE Committee. Assurance was received on Patient Group Directive (PGD) compliance.

- **All divisions provided a report to the group.** Of note, **Secondary Care** reported a series of wrongly listed elective theatre procedures by Wrexham Maelor Hospital for Orthopaedic, General Surgery and Breast theatre lists. There was no harm to patients as the correct theatre procedure was completed and identified the error. An internal review has commenced to determine key themes for reasons for the listing errors and safeguarding processes. The review is also being supported by a task and finish group to examine the pathway step by step. All three acute sites are experiencing site pressures, reporting level 4 escalation routinely; this is being exacerbated by a number of factors including staffing, COVID, patient acuity, increased occupancy and reduced flow. **Central Area** reported there is an increased risk of failure to monitor primary care compliance with legislative and national standards as quality assurance visits have not been carried out for a significant period of time (2015) due to lack of resources and following disbanding of the Primary Care Support Unit (PCSU). They also reported inadequate staffing levels in the Minor Injuries Unit and IV suite in Denbigh. **East Area** reported a significant delay in treatment provision to HMP Berwyn dental patients. **West Area** reported that in addition to highlighting the pressures on community hospitals in terms of the pressure on staffing due to clinical staff needing to isolate as a result of Covid-19, the children's and young adult services are seeing significant pressures on overall staffing with clinical staff currently being very supportive and understanding and swapping sifts to cover deficits but there are concerns that this is not sustainable and is a concern going into the winter. The **Women's Directorate** continue to actively support the vaccination programme for pregnant women across North Wales. The number of vaccinated pregnant women within BCUHB to date is 1,977. The Women's Directorate have been working closely with the Head of Children's Services (Central) & the Children's Representative at the Women's Service Board in view of ongoing pressures in both Maternity and Neonatal Services, both locally and nationally. **Mental Health & Learning Disabilities (MHLD)** reported that following a review of themes from serious incidents, the Divisional Directors have supported a programme of work to increase safety on the adult inpatient wards particularly in relation to management of risk, therapeutic engagement and an evidence-based pathway of care. The Ligature & Anchor Point Risk Reduction Procedure for Mental Health and Learning Disability Services has progressed through governance process to ratification. The teams have completed high quality ligature risk reduction audits. There is some variation in relation to attendance from Health & Safety and estates but on the whole, the audits are multi-disciplinary as per policy. The Ligature Risk Reduction Group are currently identifying dates in advance for next year and allocating a team of staff to ensure the management of the audits is efficient and timely in 2022.

- The **Resuscitation Team** highlighted concerns regarding training accommodation in the central area, which has significantly impacted on training availability. Options are being considered.

- Following an incident on 24 of February 2021 where an insulin pen was unavailable in an Emergency Drug Room, the pharmacy department have changed the way this room is managed

- A number of procedural documents were approved:

    - Pregnancy Testing in the Substance Misuse Service
    - Ligature and Anchor Point Risk Reduction Procedure for MHLD Services
    - Guidelines for the inpatient management of acute pain or opioid withdrawal in adults dependent on opioids

3. Achievement – include any significant achievements and outcomes

- **World Pharmacists Day** was held on 25 September 2021, which was celebrated across BCUHB to recognise their vital role in healthcare.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Chair's Report

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting	**Clinical Effectiveness Group (CEG)**
Chair of meeting	**Dr Nick Lyons**
Date of meeting	**12/10/2021**
Version number	**1**
Appendices	

Reporting To	
Name of meeting	**Quality, Safety and Experience Committee**
Date of meeting	**02/11/2021**
Presented by	**Dr Melanie Maxwell (Senior Associate Medical Director)**

1. Alert – include all critical issues and issues for escalation

The backlog of mortality reviews remains a concern – it was agreed an option appraisal document will be presented to the next CEG meeting.

Assurance of NICE compliance remains low across the Health Board. Detailed analysis is in progress and actions will be reported in future AAA reports

Slenyto® – a modified release melatonin preparation licensed for the treatment of insomnia in children and adolescents aged 2-18 years with autism spectrum disorder and/or Smith-Magenis syndrome – was added to the BCUHB formulary in line with its recent All Wales Medicines Strategy Group (AWMSG) approval. This will cause a significant cost pressure - an estimated £1,050,000 per annum.

2. Assurance – include a summary of all activity of the group for assurance

Reports were received from the following subgroups:

1. Reducing Avoidable Mortality Steering Group – Much discussion about how the Once for Wales Mortality Review Framework can be introduced at pace across BCUHB. A new process is being developed by Dr Damian McKeon (Clinical Lead for Mortality). Surveillance report based on IRIS and CHKS data was presented; the Health Board continues to benchmark favourably against other Health Boards. There were no new causes for concern noted that require action. Previous issue with fractured hips appears to be a data issue as non-operative rates are in line with other organisations. There was a presentation of a digital audit for cardiopulmonary resuscitation that is being set up that should provide significant assurance going forward. A task and

finish group is being set up to improve death notification between primary and secondary care led by Dr Jim McGuigan

2. Nice Assurance Group – Chairmanship of the group has changed to Dr Liz Bowen. The NICE policy is being reviewed to revisit process and a business case has been submitted to secure essential additional administrative capacity to support this work.
3. Drug and Therapeutics Sub-Group (DTSG) – the group considered new medicines applications; reviews to the formulary and independent patient funding requests and formulary categorisation review request were discussed. Ten written controlled documents were also endorsed pending corporate approval. Subgroup updates were heard.
4. Secondary Care - discussed issues with recruitment; The Health Board has established a Medical Resourcing Delivery Group, comprising a number of the Executive Team to oversee the recruitment of staff (clinical and non-clinical, senior and junior). The officers of the group have developed a more agile recruitment function which seeks to reduce the time taken to convene Advisory Appointments Committees; the new Concerns and Complaints process; a plan to reduce delays in ERPC/endoscopy and a number of issues with tier 1 Audits. The group think the new electronic audit system AMaT will support easier data capture in future.
5. Pan BCU Resuscitation Committee – the environmental challenges to delivering training in Centre were discussed with work ongoing to look at options; other sites are delivering to pre Covid levels. Cardiac Arrest audit is incomplete – the development of the electronic audit should address this.
6. Clinical Law and Ethics Sub-group (CLEG) - discussion included the successful pilot of peer review of the consent process that includes assurance for relevant alert implementation. They have recommended this method be used as the Tier 2 consent audit going forward. The DNACPR audit has now been completed across all sites successfully; recommending this methodology is used for Tier 2 audit going forward and an improvement plan is in development. They discussed the role of CLEG during the pandemic, recognising the support this group has given.
7. Research & Innovation Strategic Partnership Sub-group – this group is considering its future with the changes in executive portfolios. A Research & Development strategic group is planned that will report to CEG in the future. The significant amount of research being undertaken and the collaborations across organisations was highlighted.

Audit Annual report 2020/21 was discussed and the Quarter 1 Clinical Audit report. There are continuing concerns about the lack of progress in delivering the mandated respiratory audits. A business case has been developed that includes support for these and is currently in draft.

Quarter 2 mortality report and the Surveillance report were presented.

3. **Achievement** – include any significant achievements and outcomes

DTSG were pleased to receive a report from the pan-BCUHB radiology team that their trial of the Clariscan® MRI contrast agent has been successful. The team will now look to pursue a switch to this more cost effective product.

National Prescribing Indicators 2020-21 to March 2021 showed that BCUHB have achieved a 26.2% reduction in their prescribing of antibacterial items per 1,000 STAR-PUs (Specific Therapeutic group Age-sex Related Prescribing Units) compared to the same quarter in

2018-19. A reduction of 14% was seen across the same time period in the prescribing of four broad-spectrum antibiotics which can cause *C-difficile*, MRSA and promote the growth of other resistant organisms. The hard work and concerted effort of the teams who have helped to achieve these reductions was acknowledged. .

Contraception advice offered to post-natal patients: The Women's Department has managed to increase the number of post-natal women who have received contraceptive advice from single digits to circa 45%. This performance makes BCUHB one of the highest performing Heath Boards for this particular key performance indicator.

My Kit Check electronic resuscitation equipment checking system pan BCU is being introduced; it will provide a robust method of identifying and appropriate escalation of any issues of noncompliance with cardiac arrest equipment checks, providing better governance and assurance

Dr Orod Osanlou is the Interim Director for the developing Clinical Research Facility (CRF); this post will enable the Health Board to move forward on its plans to have a CRF for North Wales.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting or Division/Area reporting in	**Strategic Occupational Health & Safety Group Workshop for Risk Management Escalation**
Chair of meeting or lead for report	**Peter Bohan – Director of Occupational Health Safety and Security, Sue Morgan Head of Health and Safety.**
Date of meeting; only if a Sub-group reporting, otherwise 'Not Applicable' (N/A)	**16th September 2021**
Version number	**1.0**
List Appendices, if applicable	**1.0 Pre HSE Inspection Action Plan**
Reporting To	
Name of meeting	**Quality, Safety & Experience Committee (QSE)**
Date of meeting	**2nd November 2021**
Presented by	**Sue Green – Executive Director of Workforce and Organisational Development**
1. Alert	

The Strategic Occupational Health & Safety Group Workshop for Risk Management Escalation was established to allow for a detailed review of Health and Safety related risks to undertake a deep dive into the specific risks identified for consistency. A group of key staff including Estates, Corporate Health and Safety, Occupational Health, Trade Union Safety Representative, and Risk and Assurance attended the workshop with the focus on risks that have a score of more than 15 on the risk register and those on the Board Assurance Framework. The Risk Management Escalation Group is a separate group that met as agreed as an action from the Strategic Occupational Health and Safety Group. This review was to ensure the current score remained accurate and appropriate. This was the case with the following risks on the risk register and the reasons given are below:

Control of Contractors: remains scored at 20

- No policy in place.
- Overall control of sites is unclear and needs to be agreed as there is no direct point of contact on all sites.
- Consideration for Estates to have formal central control system as currently not in place.

- Clear processes need to be established in all service areas.
- Inconsistency across BCUHB sites, with some having clear safe systems of work and others not being evidenced.
- On occasions the initial controls are put in place but the governance and assurance are not upheld.

Legionella; remains scored at 20

- The Standard Operating Procedure in place for Domestic Services to carry out flushing requires a review.
- There is no consistent documented evidence of flushing being carried out in all service areas.
- Some shower / sluice rooms had change of use to storage areas, which have not gone through the correct process to inform Estates. This means there could be dead legs in the water system.
- The Water Safety Group has been established however the clinical teams are not all represented and the group is deemed inefficient with its current attendance.

Manual Handling; remains scored at 20

- No dedicated training rooms for the team.
- The numbers of staff trained is at 52%.
- Training rooms have been particularly difficult to access on the Bangor site and alternative locations for training in the West have been limited.
- There are a high number of booked attendees on the courses who do not attend approximately 30% Do Not attend rate.

Plans in place include:

- 2 years funding has been agreed by the Executives for the team to look for commercial premises to use as training rooms. This was after a thorough check of BCUHB property and local partners properties had been undertaken. It has taken quite a significant amount of time to find the premises and complete contracts and this is still not complete.
- Funding has been agreed for additional trainers and these posts are now going through the recruitment process but many of these staff are in very high demand due to the backlog of training in many health and social care settings.

Both of these will see a significant reduction in the score once implemented

Fire Safety; remains scored at 16

- The poor condition of the old hospital buildings
- Poor ventilation.
- High cost of renovation.
- The Hospital Management Team in Ysbyty Gwynedd are aware of the risk on this site and although there are risk assessments and mitigation in place this needs to be evidenced in the risk register. Bids for funding have been made to the Welsh Government.

Both the Health and Safety risk on the Board Assurance Framework and the Security Management risk were discussed and the score remained at 20. There has been agreement by the Executive Team to support with funding for both Health and Safety and Security and once the recruitment and strategy process has been implemented the risk to the Health Board will be reduced. It also needs to be considered that the Health and Safety Executive will be

visiting in November and consider the escalation of risks as part of the review of Violence and aggression and manual handling.

The Strategic Occupational Health & Safety Group Workshop for Risk Management Escalation agreed that there was a need to specifically escalate the risks associate with Water Management back to the Strategic Occupational Health & Safety Group. The BCUHB Water Management Group requires reinvigorating to ensure that appropriate clinical staff attend and assurance is given that all water outlets are flushed in all service areas.

The second area for escalation to the Strategic Occupational Health & Safety Group was the management of contractors. This is specifically due to no designated person or area on site to manage contractors and their work activities.

2. Assurance

Risk scores to be reduced

Asbestos Management

Due to the work being carried out including more collaborative work with Information Technology, it was agreed to reduce the score for the Asbestos Management risk from 20 to 16.

Research and support

Although the Gap Analysis identified the initial gaps in health and safety compliance, further assurance was required in some of the more complex areas. Since January 2021 an in-depth check of Asbestos Management, Electrical Safety. Water Safety and Pressure Systems has been undertaken to ensure compliance with the relevant legislation and associated best practice. Any gaps identified have been put into an action plan and the updates against these are monitored through the appropriate Estates Group.

3. Achievements

The Health and Safety team have undertaken considerable work to support staff and Managers during the pandemic undertaking site inspections, training and supporting the risk assessment process for staff at increased health risk. There is still considerable work to be undertaken as part of the 3-year action plan but some progress has been made during the pandemic. Executive support for the Health and Safety and Security business cases will enable the teams to develop and see a reduction in the risk to the organisation.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Chair's Report

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting or area reporting in	Patient and Carer Experience Group
Chair of meeting or lead for report	Matthew Joyes, Acting Associate Director of Quality Assurance
Date of meeting	26.08.2021
Version number	V1.0
Appendices	N/A

Reporting To	
Name of meeting	Quality, Safety and Experience Committee
Date of meeting	02.11.2021
Presented by	Matthew Joyes, Acting Associate Director of Quality Assurance

1. **Alert –** include all critical issues and issues for escalation

- **Triple A reports from Divisions:** The new complaints process was escalated by some divisions with many seeing a significant jump in overdue responses. Divisions confirmed they agreed with the principles and approach but were concerned that overdue numbers are going up. The Complaints Team confirmed they are supporting by providing Investigating Officer (IO) training, daily complaints clinics, supporting staff by reviewing investigations and giving feedback. Work is underway to recruit temporary additional complaint IO capacity. The group noted the challenges of clinical staff undertaking the IO role. The positives of the new process were noted in that the quality of responses is going up and second responses going down. Local Quality/Governance Teams have a significant amount of experience and will continue to support services to own and lead complaints.

2. **Assurance** – include a summary of all activity of the group for assurance

- **Patient Story**: A staff member with Long-COVID gave her story and this highlighted the impact on the lives of staff and the community.

- **Bereavement Quality sub Group**: The group noted they are linking Pathology with Inquest work. There is a large amount of positive work happening across services.

- **Patient Communication and Readers Panels Sub-group**: the work is progressing well to embed the new quality and governance process (involving a Patient and Carer

Readers Panel), with a lot of patient information remaining in services that needs to be catalogued and reviewed; an audit will be conducted which will involve all services.

- **Engagement Team:** The team updated on their work to continue to engage with services and the planning team and part of the Living Healthier, Staying Well refresh.

- **CANIAD:**

  CANIAD provided an update including:

  - Food feedback: at the moment this continues to be a current theme across the units but this is in working progress to improve and the further actions and updates to follow.
  - Another theme that continues to emerge from visiting the units and speaking to inpatients is the lack of suitable activities whilst staying there. The service are linking with Occupational Therapy to look at what actions can be put in place to improve this and how CANIAD can support
  - CANIAD are awaiting access to go on the Hergest wards which has been escalated for guidance.
  - Services have introduced the “Triple AAA” reporting template to document feedback with the 'You Said, We Did' element which is then forwarded on to divisional QSE localities meetings.

- **Community Health Council (CHC):**

  The CHC provided an update including:

  - The CHC are receiving a high volume of correspondence/calls from patients and stakeholders in respect of proposed changes to GP surgeries eg closures, mergers and transfer of management to BCU.
  - Arrangements for ‘Safe Space’ engagement events across North Wales in respect of Speech and Language Therapy.
  - The number of formal complaints dealt with by CHC has fallen again, patients would rather use ‘Call to Action’ than make a formal complaint.

- **Healthcare Inspectorate Wales (HIW):**

  HIW provided an update including:

  - Inspections have re-started, and to reduce additional burden on health bodies the plan is to undertake more quality checks using a remote method for seeking assurance.
  - National reviews are taking place with stroke services, Welsh Ambulance Services Trust (WAST) handover, and maternity services.
  - HIW are monitoring closely access to GPs, mental health services, and the Emergency Department at Wrexham Maelor Hospital.

- **Patient and Carer Experience report: April – July 2021/2022:** this report aims to provide assurance, information and analysis regarding significant issues arising during the period under review, alongside information of the improvements underway. The report is also provided direct to the QSE Committee.

- **Ombudsman Complaints Lessons Learned Report:** This report was shared for learning and related to a pre-natal case highlighting issues around communication and the fundamental effect it has.

3. Achievement – include any significant achievements and outcomes

- **CIVICA realtime feedback**: The CIVICA system went live 09 July 2021, rolling out user IDs to enable ward managers and staff to produce their own reports.
- **Accessible Healthcare Welsh Government Performance Report:** The report was noted and approved and is also provided direct to the QSE Committee.
- **Patient and Carer Experience Champions:** the first bronze and silver award was presented to a Patient and Carer Experience Champion for the commitment shown.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 2nd November 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Kate Dunn, Head of Corporate Affairs
Craffu blaenorol: **Prior Scrutiny:**	None
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

The Committee is asked to note the report

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

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

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:

To report in public session on matters previously considered in private session

Cefndir / Background:

Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

Asesiad / Assessment

The Quality, Safety and Experience Committee considered the following matters in private session on 7.9.21

- Never events and reportable incidents
- Public Service Ombudsman for Wales Public Interest Report (urology)