9.30am via Webex video conferencing

1.0	OPENING BUSINESS AND EFFECTIVE GOVERNANCE
1.1	09:30 - QS20/150 Chair's Opening Remarks
1.2	09:32 - QS20/151 Declarations of Interest
1.3	09:33 - QS20/152 Apologies for Absence

Dave Harries - on leave
Gareth Evans - Michael Rees deputising
Jill Newman - on leave
Chris Stockport - Clare Darlington deputising

1.4	09:34 - QS20/153 Minutes of Previous Meeting Held in Public on the 29th July 2020 for Accuracy, Matters Arising and Review of Summary Action Log

QS20.153a Minutes QSE 29.7.20 Public V0.03.docx

QS20.153b Summary Action Log QSE Public.docx

1.5	09:44 - QS20/154 Patient Stories : Matt Joyes

Recommendation:
The Committee is asked to receive the patient stories which help to understand the impact of COVID-19 on the care provided.

QS20.154 Patient Story v2.docx

2.0	FOR DISCUSSION
2.1	09:54 - QS20/155 Quality & Performance Report

Recommendation:
The Quality, Safety & Experience Committee is asked to scrutinise the report and to consider whether any area needs further escalation to be considered by the Board.

QS20.155a QPR summary report.docx

QS20.155b QPR July 2020 FINAL.pdf

2.2	10:09 - QS20/156 Covid-19 Pandemic Update - Gill Harris

Slides to be available on 27.8.20

2.3	10:24 - QS20/157 Serious Incident Report June/July 2020 - Matt Joyes

Recommendation:
The Quality, Safety and Experience Committee is asked to note the report.

QS20.157 Serious Incidents.docx

2.4	10:34 - QS20/158 Make it Safe Process : Updated Rapid Review Process - Matt Joyes

Recommendation:
The QSE Committee is asked to note this report.

QS20.158 Make it Safe Process.docx

2.5	10:44 - QS20/159 Quality Governance Structure Review - Gill Harris

Recommendations:
The QSE Committee is asked to:
1. Approve the formal creation of four permanent groups reporting into the Committee, namely the Patient Safety and Quality Group, Clinical Effectiveness Group, Patient and Carer Experience Group and Strategic Occupational Health and Safety Group (as shown on Appendix A).
2. Approve the requirement that any changes to the structure must have approval of either the Committee for changes to its reporting groups, or the new groups for the sub-structure.
3. Approve the terms of reference for the four groups (Appendix B).
4. Approve standard templates (Appendix D-H) for usage across the quality governance structure (initial draft templates are attached with version control to be maintained by the Corporate Quality Assurance Team).
5. Approve the use of a new Chair's Report template (Appendix G) (replacing the Issues of Significance Report) with the principle that every meeting reports into its parent group through a Chair's Report.
6. Note the cycles of business for the four groups (Appendix C) (which will be further refined by each group).
7. Approve commencement of phase 2 of this work looking at the sub-structure beneath these four groups including divisional quality governance structures (this specifically includes the instruction that the term Committee is not to be used outside of a Board Committee).

QS20.159a Quality Governance Structure Review Paper.docx

QS20.159b Quality Governance Structure Review_Appendix A Proposed sub-structure QSE.docx

QS20.159c Quality Governance Structure Review_Appendix B Terms of Reference of Proposed Groups reporting into QSE.docx

QS20.159d Quality Governance Structure Review_Appendix C Cycles of Business for proposed 4 Groups.pdf

QS20.159e Quality Governance Structure Review_Appendix D Report Frontsheet Template.docx

QS20.159f Quality Governance Structure Review_Appendix E Agenda Template.docx

QS20.159g Quality Governance Structure Review_Appendix F- Minutes Template.docx

QS20.159h Quality Governance Structure Review_Appendix G Standardised Triple AAA Chair's Report Template.docx

QS20.159i Quality Governance Structure Review_Appendix H - Action Log Template.xlsx

2.6	11:04 - QS20/160 Quality Safety Group Assurance Reports July and August 2020 - Gill Harris

QS20.160a QSG Chair's report July.doc

QS20.160b QSG Chair's report August.doc

2.6.1	11:14 - ** comfort break**
2.7	11:24 - QS20/161 Mental Health & Learning Disabilities Division Update Report - David Fearnley

Mike Smith to attend
Recommendation:
The Committee is asked to note the report and seek any further assurances.

QS20.161 MHLDS V2.docx

2.8	11:39 - QS20/162 Holden Report Update - David Fearnley

Mike Smith to attend
Recommendation:
The QSE Committee is asked to note the report.

QS20.162 Holden Report Paper V2.docx

2.9	11:54 - QS20/163 Improvement Group (HASCAS & Ockenden) Chair's Assurance Report - Gill Harris

Recommendation:
The Committee is asked to note the progress against the recommendations to date.

QS20.163 HASCAS Ockenden update report v2.docx

2.10	12:04 - QS20/164 Quality Governance Self-Assessment Action Plan - Matt Joyes

Recommendation:
The QSE Committee is asked to:
1\. Consider and approve this first draft version of the Quality Governance Self\-Assessment Action Plan
2\. Confirm that update reports will be required at each future meeting until such times as the actions are complete and the Committee assured

QS20.164a Quality Governance Self Assessment paper.docx

QS20.164b Quality Governance Self assessment Appendix 1_Action Plan.docx

2.11	12:14 - QS20/165 Mortality Review Update - David Fearnley

Presentation

QS20.165 Mortality updated 25.8.20.pptx

2.12	12:29 - QS20/166 Healthcare Inspectorate Wales Annual Report 2019/20 - Gill Harris

Emma Scott Senior Healthcare Inspector / Relationship Manager to attend. Presentation slides will be available during the meeting.

Recommendation:
The Committee is asked to receive for assurance the report and the presentation from the Healthcare Inspectorate Wales (HIW) Senior Inspector for the Health Board.

QS20.166a HIW annual report.docx

2.13	12:44 - QS20/167 BCUHB Annual Quality Statement 2019/20 - Gill Harris

Recommendations:

The Committee are asked to:

1. Note the Annual Quality Statement Editorial Group, Terms of Reference (Appendix A)
2. Note the Welsh Health Circular titled "Annual Quality Statement 2019 / 2020 Guidance" Welsh Government (Appendix B)
3. Approve the Annual Quality Statement 2019/20 final draft (Appendix C)
4. Take into consideration the fact that prior scrutiny has been challenging due to Covid-19. Subsequently, there has been limited time and resources available for the AQS. Nevertheless, the Business Manager has worked with divisional leads and senior managers to ensure completion of the AQS to a good standard. The AQS has been aligned with and signposts to the Annual Accounts, Quality Improvement Strategy and Putting Things Right Annual Report 2019-20. All data contained in the AQS has been reviewed and confirmed as up to date and relevant.

QS20.167a AQS Cover Paper_reformatted.docx

QS20.167b AQS - Appendix A - ToR.doc

Recommendations:
The Committee is asked to note:
1. the confirmed delivery of essential services across primary care and significant work undertaken by all contractors to ensure access for patients requiring urgent care during the pandemic;
2. the ongoing implementation of the 'amber phase' of the primary care recovery plans;
3. the risks and challenges in the delivery of services across primary care

QS20.168 Primary Care Update.docx

Recommendations:
The Committee is asked to note the progress made with regards to
1. The actions taken to date to support care homes, their residents and staff during Covid 19
2. The requirement to develop a regional care home action plan
3. The measures being taken to help mitigate risks that may exacerbate the fragility of the sector.

QS20.169a Care Homes.docx

QS20.169b Care Homes Appendix 1.pdf

Andrew Kent to attend

Recommendation:
The Committee is asked to note the content of this paper and the progress being made.

QS20.170 essential services.docx

Recommendation:
The Committee is asked to note the progress made by the Vascular Task and Finish Group

QS20.171a Vascular Update July 2020 v1.0.docx

QS20.171b Vascular Appendix 1 Final external review request 13.08.20.pdf

QS20.171c Vascular Appendix 2 TF Group Action Tracker v0.4.pdf

Recommendation:
The Committee is asked to note the findings of the internal Deprivation of Liberty Safeguards (DoLS) audit and recognise the significant improvement to achieve and implement into practice all five (5) recommendations, as well as the continued work and development within the Deprivation of Liberty Safeguards (DoLS),Mental Capacity Act (MCA) and Liberty Protection Safeguards (LPS) arena.

QS20.172a DoLS Paper.docx

QS20.172b DoLS Appendix 1 Final internal audit report.pdf

Recommendation:
The Committee is asked to:
1\. Approve the Occupational Health and Safety \(OHS\) Annual Report 2019\-2020 and Q1 Report
2\. Note the position outlined in the report and support the recommendations therein that the OHS team:
• Implement the 3 year OHS Strategy.
• Ensure adequate staffing is available to provide an appropriate H&S security function to BCUHB.
• Develop further policies and safe systems of work to provide evidence of practice.
• Establish monitoring systems to measure performance including clear KPIs.
• Train senior leaders and develop further competence in the workforce at all levels
• Learn lessons from incidents and develop further the risk profile

QS20.173 H&S Q1 and Annual Report 2019-2020_reformatted.docx

Recommendation:
The Quality Safety and Experience Committee are asked to support the following recommendations :
1. To receive the Independent Review of Fire Precautions at Ysbyty Gwynedd
Stage 1 Report : Prior to Agreement of Action Plan – May 2020
2. To note the contents of the report and support the action being undertaken in developing an action plan to address prioritised risks identified within Appendix B of the independent report.
3. To note commencement of the specialist compartmentation survey to inform the Health Board action plan for completion by 31st of October 2020.
4. To support the inclusion of Ysbyty Gwynedd fire precaution risks being included on the Health Board corporate risk register.
5. To support commencement of discussions with North Wales Fire and Rescue Service (NWF&RS) in regards to the contents of the independent report and actions being taken by the Health Board to reduce fire safety risks.
6. Fire Safety Management was identified as a risk within the Corporate Health and Safety Audit. The report will also be presented to the Strategic Occupational Health and Safety Group for consideration at its next meeting.

QS20.174a Independent Review of Fire Precautions at Ysbyty Gwynedd May 2020 Rev 1.1.docx

QS20.174b Independent Review of Fire Precautions at Ysbyty Gwynedd_Appendix 1.pdf

4.3	QS20/175 Pharmacy and Medicines Management Annual Report - David Fearnley

Recommendation:
The Committee is asked to receive the report for information

QS20.175a P&MM annual report 2019_20 updated.docx

QS20.175b PMM Annual report 2019 Final.pdf

4.4	QS20/176 Annual Organ and Tissue Donation Report 2019-20 - Adrian Thomas

Recommendations:
The Committee is asked to note the report content and the future aims and objectives of the Organ and Tissue Donation Committee.

QS20.176a Organ and Tissue Donation Annual Report paper.docx

QS20.176b Organ and Tissue Donation Appendix 1 annual report.docx

QS20.176c Organ and Tissue Donation Appendix 2 - Summary report.pdf

QS20.176d Organ and Tissue Donation Appendix 3 Health Board plan.docx.pdf

QS20.176e Slides FOR INFORMATION ONLY.pptx

4.5	QS20/177 Care Quality Commission (CQC) report and ratings for Shrewsbury and Telford NHS Trust - Gill Harris

Recommendation:
The QSE Committee is asked to note this report.

QS20.177a SATH CQC Report.docx

QS20.177b Appendix 1 SATH CQC Report.pdf

QS20.177c Appendix 2 RSH CQC Report.pdf

QS20.177d Appendix 3 PRH CQC Report.pdf

4.6	QS20/178 Documents Circulated to Members

18.8.20 Notes of July QSG
19.8.20 Briefing on eyecare services

4.7	QS20/179 Issues of Significance to inform the Chair's Assurance Report
4.8	QS20/180 Date of Next Meeting

27th October 2020 @ 9.30am

4.9	QS20/181 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."

Quality, Safety and Experience (QSE) Committee
Minutes of the Meeting Held in public on 29.7.20 via Webex

Present:
Lucy Reid	Independent Member (Chair)
Jackie Hughes	Independent Member
Cheryl Carlisle	Independent Member

In Attendance:
Andy Burgen	Acting Chair, North Wales Community Health Council (CHC)
Kate Dunn	Head of Corporate Affairs (for minutes)
Gareth Evans	Chair, Healthcare Professionals Forum
David Fearnley	Executive Medical Director
Sue Green	Executive Director of Workforce and Organisational Development (OD)
Gill Harris	Executive Director of Nursing and Midwifery / Deputy Chief Executive (part meeting)
Emma Hosking	Hospital Medical Director, Ysbyty Glan Clwyd (observing)
Fflur Jones	Audit Wales (observing)
Matthew Joyes	Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience
Melanie Maxwell	Senior Associate Medical Director/Improvement Cymru Clinical Lead (part meeting)
Amanda Miskell	Assistant Director of Nursing – Infection Prevention (part meeting)
Jill Newman	Director of Performance (part meeting)
Adrian Thomas	Executive Director of Therapies and Health Sciences

Agenda Item Discussed	Action By
QS20/128 Chair's Opening Remarks **QS20/128.1** The Chair welcomed observers Emma Jane Hosking and Fflur Jones to the meeting, and also to Andy Burgen who was attending the Committee for the first time. She reminded members that the meeting had been arranged to predominantly pick up those agenda items which were deferred from the meeting held on 3rd July 2020.	
QS20/129 Declarations of Interest **QS20/129.1** Gareth Evans declared an interest in item QS20/137 as he was a member of the vascular services task and finish group.	
QS20/130 Apologies for Absence Received for Lyn Meadows, Dave Harries and Teresa Owen	

QS20/131 Minutes of previous meeting held in public on the 3.7.20 for accuracy, matters arising and review of summary action log

QS20/131.1 The minutes were agreed as an accurate record and updates were received for incorporating into the summary action log.

QS20/131.2 The Chair referred to the mortality paper on the agenda for later which related to a long-standing action, and was disappointed to note that what had been received did not include a plan setting out how mortality reporting would be undertaken in future and how inconsistencies across the Health Board would be resolved. The Executive Medical Director accepted that the paper did not address what the Committee had previously requested and apologised that the impact of Covid-19 had meant the matter had not been fully progressed.

[Melanie Maxwell and Amanda Miskell joined the meeting]

QS20/132 Infection Prevention Report

QS20/132.1 The Assistant Director of Nursing – Infection Prevention confirmed that the paper had been updated since it had been prepared for the meeting on the 3rd July 2020, and she invited comments and questions from members.

QS20/132.2 A question was asked around the routine testing of BCU staff for Covid-19 as this seemed inconsistent with the testing of care home staff. he Assistant Director of Nursing – Infection Prevention confirmed that staff testing was currently focused on any clusters of infection or where there was evidence of a transmission other than patient to patient. This was then carried out across the whole ward. This principle was to ensure testing was focused and that capacity was maintained. The Executive Director of Nursing and Midwifery added that work was ongoing with Public Health Wales (PHW) and Workforce and OD colleagues to consider when and if testing for all asymptomatic staff should be triggered. She confirmed that patient movements were restricted and segregation in place until test results were known, with any hospital acquired infections being subject to a full root cause analysis. The Executive Director of Workforce and OD confirmed that the policy on mass testing was clearly set out by PHW within Chief Medical Officer (CMO) guidance and had been discussed at length by the Executive Team (ET). A member asked whether the Board had the ability to override PHW advice if it thought this was required. The Executive Director of Nursing and Midwifery reiterated that the decisions for undertaking wider staff testing remained around the capacity to ensure testing could be maintained where necessary.

QS20/132.3 A question was raised with regards to the wearing of face coverings and whether this could be made mandatory on BCU sites. The Executive Director of Nursing and Midwifery confirmed she was currently in conversation with Welsh Government (WG) on this subject. She gave her personal view that the wearing of face coverings was evidence-based and provided a visible reminder to all visitors to sites of the risks within the health system from Covid-19. She confirmed that there was currently an expectation that they be worn within the Wrexham Maelor site. The Executive Director of Workforce

and OD reported that staff and staff movement was being mapped for the outbreak wards in Wrexham. [The Executive Director of Nursing and Midwifery left the meeting]. The Independent Member who had raised the question indicated she felt very strongly about the matter and that she intended to follow it up with the Health Board Chair in terms of whether an extra-ordinary Board meeting could be convened if required. Other members were supportive of the wearing of face coverings and felt that inconsistencies with other parts of the UK were not helpful. The Chair felt it was important to acknowledge that the report was written before the implementation of additional controls, and that a review had subsequently been requested on the health acquired Covid-19 cases. The Executive Director of Workforce and OD wished to clarify that up until now all staff had been required to wear appropriate PPE in appropriate settings, whereas now this could be mandated on a risk basis.	CC
QS20/132.4 A member highlighted reference within the paper to the use of disciplinary measures regarding non-adherence to infection prevention control practises and would have preferred to have seen a softer approach of educating and reminding first. The Assistant Director of Nursing – Infection Prevention clarified that disciplinary measures would only be taken after other approaches had been utilised. In response to a further question around the recruitment of domestic cleaning staff she reported she had received assurances from Estates colleagues that vacancies were falling. The Executive Director of Workforce and OD added that there had been an additional 200+ staff recruited to the bank and there was a need to ensure they were usefully deployed.	
QS20/132.5 The Chair referred to the post infection review process for health acquired infections and felt it should be noted that it had subsequently been identified that not all of the cases were health acquired. An error was also noted on page 3 of the report in that the narrative regarding patient cohorts and behaviours should read one false negative and not one false positive. The Chair noted ongoing issues within Ward 19 at Ysbyty Glan Clwyd (YGC) which appeared to be largely related to estates. She was concerned that patients were being put at risk and enquired as to what was being done and within what timescale. The Assistant Director of Nursing – Infection Prevention was aware that patients were due to be moved to another ward but this had been delayed due to other Covid-19 management work. She undertook to follow this up as a matter of urgency with the hospital management team and estates colleagues and would report back to the Committee Chair.	AM
QS20/132.6 The Chair noted that the governance section within the paper made reference to an internal audit report on decontamination. She asked how the recommendations of this limited assurance report around governance and escalation had been addressed. The Assistant Director of Nursing – Infection Prevention confirmed that the terms of reference for the local infection prevention groups had been refreshed to ensure decontamination was a standing item. The Chair expressed concern that previously the local groups had not been escalating relevant issues.	
QS20/132.7 The Chair reflected that there had been several sections within the paper that members had had to seek clarity on, inaccuracies had been noted and some parts of the	

report were written as incomplete sentences. She reminded the Assistant Director of Nursing – Infection Prevention that this report was in the public domain and needed to be written with this in mind. She asked that these comments be taken into account for future reports.

QS20/132.8 It was resolved that the Committee approve and take assurance from the Infection Prevention report.

[Amanda Miskell left the meeting]

QS20/133 Health and Safety Briefing

QS20/133.1 The Executive Director of Workforce and OD presented the briefing paper and provided an update on some key areas. She confirmed that as at 29th July 2020, 6698 staff had been tested for Covid-19 with 968 positive results and 477 pending. A new dashboard had been developed which would help support this work. Secondly, she reminded the Committee that for any positive result following a staff test, if there was a potential that the transmission could have been work related this was reportable through Datix. A review was then undertaken within 72 hours and a decision made as to whether the criteria had been met for a reportable incident under Health and Safety Executive (HSE) legislation. Scrutiny of RIDDOR reporting data by area had identified low numbers in the East and following a validation exercise this had increased from 47 to 133. She gave assurance that the focus was not purely on the Wrexham Maelor site and that close observation of other sites and clusters was being maintained. The Executive Director of Workforce and OD went on to explain that representations continued to be made in terms of the usefulness of the WG risk assessment process for certain cohorts of staff eg; those shielding. She noted that letters were due to be issued to line managers of staff who are shielding setting out the expectations around risk assessments and phased returns. Finally, the Executive Director of Workforce and OD made reference to health acquired infections and the recognition that this was not purely a patient issue and related to staff movements too. With regards to the number of social distancing / staying safe visits undertaken across the Health Board estate it was noted this was now at 106. In addition, it was intended to find a sustainable model to retain the staff health and well-being hubs.

QS20/133.2 Members then raised a range of points and questions. Thanks were extended to the Health and Safety team who were currently dealing with a significant amount of work as a result of the pandemic. Support was given for pushing for the development of a fit for purpose risk assessment from WG that focused on the clinical situation of individuals. With regards to the earlier discussion on face coverings a member felt that violence and aggression incidents could increase if staff were required to ask visitors to comply. The value of the staff health and well-being hubs was acknowledged and it was felt they would be even more important for shielding staff who were returning to work. The Chair sought clarification as to how the risk assessment would address additional protections for those individuals whose shielding circumstances are less than straightforward. The Executive Director of Workforce and OD confirmed that

some specific risk assessments had been established at the outset to cover these scenarios.

QS20/133.3 It was resolved that the Committee:

1. Note the work undertaken to date, the impact that the COVID-19 response has had on progression of the Improvement Plan actions and plans to reintroduce "business as usual" alongside continued focus on COVID-19 safe systems.
2. Note the requirement for investment to bring Health and Safety standards up to the basic level required to mitigate the risks identified through the Gap analysis.

QS20/134 Serious Incident Report : April and May 2020

QS20/134.1 The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience presented the report which provided the Committee with information and analysis on serious incidents and Never Events occurring during April and May although it was noted that 14 months of trend data had been included to allow for period on period comparison in the last year. He drew attention to the charts within section 3 which provided overall numbers of serious incidents and those with major or catastrophic outcomes. In terms of themes, patient falls continued to be the most frequent. A revised timeframe for a comprehensive review of the serious incident process was now being put in place for the early autumn. Finally, the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience made reference to section 4 of the paper which detailed specific serious incidents.

QS20/134.2 Members then raised a range of points and questions. A member asked when Committee members would see the outcome of the investigation into the Never Event in urology, YGC. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience did not have a timeframe for the report as a second expert had only just been sourced, however, members would be able to review the documentation when available. Reference to learning was made and that an adverse outcome might not necessarily be clinical, for example it could relate to a loss of confidence in health services. It was acknowledged that outcomes may relate to long term harm, clinical or non-clinical. A member noted that "proactively ensuring family contact was made and maintained" had been stated as a learning outcome and she felt that this should already be normal practice. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience indicated that there had been an unacceptable set of events in this particular case but did feel that family contact was maintained in the majority of cases. The Chair suggested that the offices of the Medical and Nursing Directors had a role to play in terms of driving reminders around professional duty of candour. Finally, the Executive Director of Workforce and OD confirmed that since the production of this paper there had been a further staff death from Covid-19 which had been reportable to the HSE.

QS20/134.3 It was resolved that the Committee
1. Note the report
2. Note the changes of Welsh Government serious incidents reporting requirements
3. Note the implementation of the Make it Safe process

QS20/135 Draft Annual Quality Statement (AQS) 2019/20 **QS20/135.1** The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience confirmed that this first draft was being provided for the Committee to provide input and feedback, and that the final AQS would be submitted to the August Committee meeting. It was noted that a statement from the Committee Chair was required, and all members would provide any comments directly to the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience. **QS20/135.2 It was resolved that** the Committee note the draft AQS and the appendices	LR All
QS20/136 Mortality review update **QS20/136.1** The Senior Associate Medical Director/Improvement Cymru Clinical Lead presented the paper, apologising that due to significant redeployment within the Office of the Medical Director during the pandemic, it had not been possible to deliver the report that the Committee had requested. She hoped that the paper which had been provided did provide some reassurance around outcomes and that overall mortality rates had not significantly worsened during the pandemic. It was reported that a recent workshop had incorporated a discussion with the medical examiner for Wales around how to move the agenda forward to develop the learning. A similar meeting had been planned for primary care but unfortunately had been cancelled. Other interim work included a rollout of Datix reporting and some specific pieces of work around the Wrexham area. **QS20/136.2** Members then raised a range of points and questions. A query was raised around the statement that mental health and learning disabilities (MHLDS) would be included in work to explore the ONS data. The Senior Associate Medical Director/Improvement Cymru Clinical Lead confirmed that the pandemic situation had enabled access to valuable ONS data regarding community services which had yet to be explored. In response to a question around the triggers for stage 2 reviews, the Senior Associate Medical Director/Improvement Cymru Clinical Lead confirmed these related to outstanding reviews which was a deteriorating situation due to Covid-19 and reflected that some people could be in more than one category as Stage 1 and 2 weren't mutually exclusive. A key issue was that there was not a consistent process in specialties for capturing and sharing learning. **QS20/136.3** The Chair stated that she again found the mortality report to be lacking in clarity in its content and included incomplete sentences and paragraphs that did not make sense. This was not acceptable for reports to the Committee, particularly as it was also within the public domain. She was also concerned that the report did not tell the Committee what it needed to know, did not provide assurances around what actually was happening in terms of mortality reviews, where the gaps were and what was being done to address them. She was disappointed that this had not been addressed as there had been a meeting held in early January 2020 to agree the way forward in terms of mortality reporting to the Committee, which was before the pandemic. She stated her clear	

expectation that this be addressed by the next Committee meeting. She also suggested that the reporting format for statistical process charts used by the patient experience team were a good example of how data could be helpfully presented. **QS20/136.4** The Chair referred to the recommendation within the paper and proposed it could not be accepted given the discussion. **It was therefore resolved** that the Committee note the paper.	DF MM
QS20/137 North Wales Vascular Review update **QS20/137.1** The Executive Medical Director presented the paper. He indicated that the first two meetings of the Task and Finish Group had concentrated on clarifying the group's role and developing the action/improvement plan for which the timescales were now going to need a refresh. He was pleased to report a positive level of engagement and feedback within the group and that there was a good relationship with the CHC. A key focus for the group now was to develop and agree the engagement plan and develop work around the diabetic pathway. In addition, he undertook to share a copy of the draft terms of reference for the Royal College of Surgeons' external review, once agreed with the CHC. **QS20/137.2** Members then raised a range of points and questions. The Healthcare Professionals Forum Chair was able to report that the level of engagement with stakeholders had to date been excellent. In general, members felt that the paper did not provide them with up to date progress as it appeared not to have been substantially updated since them seeing an earlier version. In particular they requested that the action/improvement plan is refreshed for the next submission to the Committee in August. The Executive Medical Director noted that the action/improvement plan would be fast moving and become updated quickly however he accepted that it needed a review in terms of deadline dates and progress. **QS20/137.3** With regards to the terms of reference for the Task and Finish Group the Chair raised a number of points that needed to be addressed and asked that appropriate version control also be used. The Executive Medical Director agreed to address the following: • To make explicit that the group would look at compliance with any national standards • To amend reference to the Chair of the Clinical Effectiveness Committee as this did not exist • To clarify the statement against "admin support" • To clarify the statement against "authority" • To reflect that the QSE Committee did not meet on a monthly basis • Review the core membership to ensure that it does not become too unwieldly. **QS20/137.4 It was resolved that t**he Committee 1. note the progress made by the Vascular Task and Finish Group 2. approve the draft terms of reference for the Group	 DF DF DF

QS20/141 Essential Services during Covid-19
[Agenda item taken out of order at Chair's discretion]

QS20/141.1 The Director of Performance presented the paper which provided an update on the delivery of essential services during the Covid-19 pandemic. She highlighted that essential services were not the same as core services, but were those that needed to continue throughout the pandemic and if they didn't there would be a risk of harm, either life threatening or life changing. This was based on World Health Organisation (WHO) definitions published in March 2020 and further guidance had been received from Welsh Government (WG) in May 2020 by which time the organisation had undertaken a service status review. The Director of Performance confirmed that the report was based on a further commissioned review in June 2020 and that reviews would continue. She stated that as the Covid-19 environment continued the challenges to essential services would become greater and more capacity would be needed. There were also challenges in maintaining the enablers to the essential services such as diagnostics, phlebotomy and screening.

QS20/141.2 Members then raised a range of points and questions. In response to a concern raised about cardiac care, the Director of Performance confirmed that cardiac essential services had expanded greatly within the new framework and she assured members that primary percutaneous coronary intervention (PPCI) had been maintained throughout the pandemic and that services had continued to be received from the Liverpool Heart and Chest hospital. She noted there had been challenges around maintaining the second cath lab and cardiac CT scanning, however, the Central Area Team have actively moved to re-establish the second cath lab to tackle this backlog. In addition, radiology were actively engaged in prioritising their limited capacity for cardiac angiography.

QS20/141.3 A concern was raised about the 5 week wait for phlebotomy appointments and the Director of Performance acknowledged that the status of this service had remained as a largely due to challenges within the workforce. She reported that the service had been recruiting and there was a move to enable the service to use the temporary hospitals to increase capacity. In response to a point raised around challenges due to social distancing requirements the Director of Performance confirmed that the statement within the paper was not meant to imply that staff were not complying. The Executive Director of Therapies and Health Sciences explained that the added requirements of social distancing and infection prevention, including donning and doffing of PPE and cleaning down of rooms, will have a significant impact on capacity across a range of departments. The Executive Director of Workforce and OD reminded the Committee that bloods could be taken by individuals other than phlebotomists and it was important to recognise the skill not the job.

QS20/141.4 It was resolved that the Committee:
1. Note the content of the report
2. Recognise that the Health Board had taken steps to understand its ability to comply

with essential services and in doing so had identified areas of particular challenge that need to be addressed as priority areas in the Q2 operational plan 3. Note the need to continue to monitor, escalating as appropriate, compliance with revised Essential Services guidelines in order to mitigate the risk of harm	
QS20/142 Quarter One Plan monitoring report (Q1PMR) *[Agenda item taken out of order at Chair's discretion]* **QS20/142.1** The Director of Performance presented the report. The Chair indicated she did not find the report particularly informative as it was very task orientated with a lack of clear milestones, detail of progress or outcomes. In addition, there was no narrative to provide context to those tasks that have not been completed. She indicated she had made similar comments at the recent Health Board meeting and was of the view that the report in its current format was limited use in terms of assurance. The Director of Performance accepted these points and referred to a related discussion at the Finance and Performance (F&P) Committee where it was suggested that future assurance would be by exception rather than a standard narrative for each one, but equally requiring the actions to be more specific and measurable. **QS20/142.2 It was resolved that** the Committee to note the report	
QS20/143 Quality and Performance Report *[Agenda item taken out of order at Chair's discretion]* **QS20/143.1** The Director of Performance presented the report noting it was the first time that the Committee had received the report in the revised format. She observed that performance monitoring had been stood down on a national basis and therefore the report for May 2020 was for management information purposes only. Secondly, she stated that it reflected the structure of the national delivery framework published in April 2020 by WG and which was aligned to 'A Healthier Wales Quadruple Aims'. Locally there had been sections added on Covid-19 and on essential services. **QS20/143.2** Members then raised a range of points and questions. Continued concerns were noted around Child Adolescent Mental Health Services (CAMHS) performance however the member raising the point had discussed these concerns directly with the leads of the service. In general, the format of the report was welcomed, together with the useful appendix detailing the full list of measures, although some graphs were very difficult to read, for example the infection prevention graph. The Director of Performance explained the challenge of working with a nationally agreed format but the team would endeavour to improve the readability. In response to a point around the resetting of services, the Director of Performance set out the importance of undertaking a risk stratification of waiting lists to ensure patients were managed on a risk basis rather than just a length of wait basis. This had been done on all acute sites for in-patient and day case waiting lists against a principle of pan-BCU capacity being utilised for those at	

greatest risk. She assured the Committee that appropriate checks were part of the process to ensure safety before any service recommenced. **QS20/143.3** It was resolved that the Committee note the report. *[Jill Newman left the meeting]*	
QS20/138 Nursing Workforce **QS20/138.1** The Chair indicated that the paper had been agendered for the 3rd July 2020 meeting but was deferred although a range of related issues had been picked up as part of the annual nurse staffing report. **QS20/138.2 It was resolved** that the Committee acknowledge the report and assurance regards the escalation triggers and receive further reports should the need arise to vary Nurse Staffing levels from those previously reported	
QS20/139 Corporate risk register **QS20/139.1** The Chair indicted that it had been agreed with the other Committee Chairs and the Board Secretary that the Committee owned risks would not be reviewed whilst the corporate risk register was undergoing a review. In the interim she advised that the Committee would still be sighted on any new risks or any significant changes to existing risks. Members were content with this arrangement. The Chair noted that the Committee was being asked to agree to closing actions attached to the risks. Members agreed that this was an operational issue and whilst the Committee should be aware of the progress of actions, it was not within its authority to approve closure of such actions. **QS20/139.2** In terms of the risk register report **it was resolved that** the Committee noted the report and approve the request to extend the target risk dates for the Health and Safety risks, CRR20, CRR21, CRR23, CRR24, CRR25 and CRR26.	
QS20/140 Management of Waiting Lists Deferred until the August meeting as there was no representation to present the report.	
QS20/144 Summary of business considered in private session **QS20/144.1 It was resolved that** the Committee note the report *[David Fearnley left the meeting]*	
QS20/145 Documents circulated to members between meetings 1.7.20 QSG escalation report	

QS20/146 Issues of significance to inform the Chair's assurance report To be determined with the Chair	
QS20/147 Date of next meeting 28th August 2020	
QS20/148 Exclusion of the Press and Public It was resolved that representatives of the press and other members of the public be excluded from the remainder of the 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.	
The Committee then met in **private** session. Those in attendance were Lucy Reid, Adrian Thomas, Cheryl Carlisle, Gareth Evans, Jackie Hughes, Matt Joyes, Sue Green and Kate Dunn. The only business discussed was: **QS20/149** To approve the minutes of the meeting held in private on the 5.5.20 as an accurate record and to note the summary action log with proposals to close or defer actions.	

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
21st May 2019				
~~E Moore~~ M Maxwell	**QS19/74.2** Reflect on comments regarding format and flow of mortality report including the need to ensure a single author/owner for next submission.	Sept	17.9.19 A revised format has been submitted and agreed at Quality Safety Group, and will inform the next report to Committee. 24.9.19 Committee agreed to re-open the action until next mortality report received. 12.11.19 Mortality report agendered for discussion at November Committee meeting. Members' feedback invited on format and flow. 19.11.19 Further report requested for January. Meeting set up for January between QSE Chair and Office of Medical Director. 6.1.20 Meeting held and clarification/steer provided on how to improve and strengthen mortality reporting, with agreement the paper be deferred to the March meeting. 28.1.20 QSE Chair confirmed her expectation that the paper in March will be a plan of action as to how mortality will be addressed and reported. 04.03.20 A plan for the development of mortality reporting was submitted to the March meeting Update: item deferred 10.06.20: Action was deferred due to Covid 19 pandemic. Stage 1 have continued to be completed and some Stage 2 reviews. Meeting planned with sites and also community / primary care / MHLD to review process to extract learning. ME posts currently being advertised – this role will include part	~~Closed~~ ~~November~~ ~~January~~ March

			1 review and direction on the need for further investigation internally. 03.07.20 mortality report deferred from July meeting, action to remain open until report presented to future meeting. 22.7.20 Mortality paper on agenda for 29.7.20 12.08.20 This action is now being taken forward as set out in the action below (QS20/136.3)	Closed
28th January 2020				
~~D Carter~~ G Harris	**QS20/7.1** Circulate briefing note already prepared on awards and achievements.	February	Deferred until further notice during revised COVID-19 pandemic arrangements in place 03.07.20 further clarification sought from Chair of specific requirements for bulletin 29.7.20 Discussion not yet taken place. GH to link in with the communications team also. 24.8.20 Discussion initiated with communications team	August
~~D Carter~~ J Newman M Maxwell M Joyes	**QS20/12.3** Meet to discuss how more consistent data reporting could be achieved across various department from different software packages and systems.	May	Work in progress – further update to be provided 05.05.20 discussions are ongoing in relation to standardising the presentation of graphical information in the use of SPC charts across the Health Board. SPC tools have been shared however the Health Board standard has not yet been established due to a range of products currently in use. Further update to be presented to August meeting 03.07.20 further update to be provided to August meeting. 19.8.20 Matter has been discussed by M Joyes and J Newman. As reported previously, different software packages are used across different teams, and moving towards standardisation would	August

			require investment in terms of licensing and training. It was suggested a set of principles be agreed to help consistency and this will be taken forward.	October
L Singleton	**QS20/13.2** Work to develop increased visibility around actual lessons learnt for the next routine report from the MHLDS Division.	May	09.03.20 Work is underway to include lessons learnt within May report 22.7.20 May agenda was refocused due to the Covid-19 pandemic. Scheduling and content of next report to the Committee from the MHLDS Division to be agreed. 29.7.20 LR was aware of discussions outside of the Committee regarding improving reporting from the Division. She assured members that the Board was sighted on key issues within the Division including some HIW safeguarding issues around Heddfan. A paper would be coming to the August Committee meeting. 19.8.20 Paper in public session on agenda for 28.8.20	August Closed
M Joyes	**QS20/16.1** Provide action plan against the All-Wales Self-Assessment of Quality Governance Arrangements at next meeting	March	Was deferred during revised COVID-19 pandemic arrangements in place. 22.7.20 On forward plan for August QSE meeting. 17.8.20 Paper on agenda for August.	August Closed
17th March 2020				
G Harris	**QS20/27.2** further details to be provided in relation to the number of 'unavoidable' infections	May	Avoidable infections are those whereby the infection should not have occurred. These may be in relation to health care, device care and/or exposure to an organism in the environment. Avoidable infections reduced over Q1 and Q2 with innovations and deep dive analysis. However, it is expected to achieve a position where avoidable infections are	

			minimal/zero and any occurrence is reported by exception. (e.g. 79 infections in January of which 61 (77%) were unavoidable, issues include contaminated blood cultures, catheter infections, relapse and attributable to another Trust. 05.05.20 – further update requested see action QS20/85.3 below 03.07.20 infection report deferred from July meeting, action to remain open until report presented to future meeting (29th July). 29.7.20 Addressed within paper and discussion	July Closed
G Harris	**QS20/27.5** provide further details on the difficulties in cleaning the environment on Ward 19 referred to within the report	May	Ward 19 experiences the most outbreaks of infection in the Health Board, and is the most difficult to terminally clean. It is not possible to HPV the ward due to ceiling voids and square footage. In addition the two rooms available are not en-suite and one is at the end of a bay. There is a toilet shared between 2 bays that opens out onto the reception area of the ward. Ward 19 is still waiting to move to Ward 2. During April 2020 whilst COVID 19 is occurring Ward 19 has had a further Norovirus outbreak. 05.05.20 – further update requested see action QS20/85.8 below 03.07.20 infection report deferred from July meeting, action to remain open until report presented to future meeting (29th July). 29.7.20 Amanda Miskell to reflect on discussion and discuss further with Committee Chair as per action 20/132.5 below.	 July August
5th May 2020				

| G Harris A Miskell | **QS20/85.4** Clarify triangulation of urology data with removal of catheters and confirm details of work programme. | July | From the catheter audit carried out across inpatient beds, we learnt that trail without catheters (TWOCs) was not necessarily taking place as frequently as it could be. Daily review of devices was launched in November 2020 as part of safe clean care and a need to reinvigorate device management. A community audit across the continence and district nursing teams was planned for Spring 2020, but this has had to be postponed. Some patients with catheters were awaiting Trans urethral resection of the prostate (TURP), and some patients catheterised in ED for acute retention were reliant on Urology day care services for TWOC as there is no formal TWOC service in the community. IPC would want to commence the community review as soon as able.
03.07.20 further update to be presented to future meeting
9.7.20 no further progress to report
29.7.20 GH confirmed that there was work ongoing but she would need to confirm the timeframe outside of the meeting.
17.08.20 AM has confirmed this has been delayed due to the Covid 19 pandemic and will be picked up again as soon as possible. It is also an agenda item at IPSG. | August |
| G Harris A Miskell | **QS20/85.8** Further to response to action QS20/27.5, difficulties in cleaning Ward 19 YGC to be discussed at QSG and further confirmation required that the ward is fit for purpose in respect of cleaning difficulties. | July | Ward 19 is currently a Care of the Elderly ward. Due to the environment we are unable to carry out a HPV clean. Although we are able to use UV and carry out an amber clean. HPV is the gold standard to destroy any bioburden in the environment. There are shorter distances between the beds and limited (to be | |

				clarified) air exchange. The cohort of patients and the interactions, use of medical devices and aids means the environment becomes quite cluttered at times. There are no ensuite facilities and one of the side rooms is accessed via a bay. Ward 19 has experienced the most outbreaks of infection and more recently Covid 19 and norovirus. The ward would be more suited to a more mobile/fit for discharge cohort of patients. 03.07.20 environmental review undertaken and some beds removed to improve distancing, further discussion to be held when report presented to the reconvened QSE Committee meeting on 29th July. 29.7.20 Amanda Miskell to reflect on discussion and discuss further with Committee Chair as per action 20/132.5 below.	August
L Reid G Harris D Fearnley	**QS20/87.7** Circulate a series of questions in response to vascular update to Independent Members, for the Board to respond to and meet further with GH and DF to review what can be done about specific areas of concerns and to agree the best way forward from a governance perspective	July		Questions were circulated and an initial response was provided. Further clarification has been subsequently sought. 03.07.20 responses to questions to be provided in advance of the next meeting 21.7.20 DF advised that due to annual leave of the Secondary Care Medical Director, this detail will be provided in advance of the August meeting. 14.8.20 Chair has been assured that this will be covered off alongside the vascular paper coming to August meeting. 19.8.20 Responses to questions provided for IMs only are part of QSE agenda for 28.8.20	August
L Reid J Newman	**QS20/89.5** Discuss specific requirements for analysis and risk assessment within	July		03.07.20 update to be provided to the August Committee meeting on overdue follow up appointments and centralised waiting lists.	August Closed

	ophthalmology with JN outside of the meeting.		19.8.20 Briefing note circulated to members	
G Harris D Fearnley	**QS20/93.5** present the clinical element of pathways to QSE so the committee is sighted on the level of risk associated including essential services and to ensure governance processes.	July	Risks associated with clinical pathways are being developed to help safely prioritise the implementation. A report on the clinical pathways future developments will be prepared to align with the planning cycles. Progress will be reported at the next QSE meeting. 03.07.20 essential services report deferred from July meeting, action to remain open until report presented to future meeting. 29.7.20 addressed within essential services paper	Closed
3rd July 2020				
G Harris	**QS20/113.7** discuss actions to address non-compliance for mandatory training including medical colleagues with executives	August	Meeting arranged for 21.7.20 with Sue Green to discuss and take forward	
G Harris D Hickman	**QS20/119.2** further report to be presented to QSE Committee providing more comprehensive detail in relation to safe nurse staffing levels	August	A report has been requested for the October Committee meeting.	October
L Reid M Joyes	**QS20/111.8** Discuss minor adjustments and amendments required to PTR report and approve as Chairs Action if more timely.	July	9.7.20 Comments have been provided to M Joyes and a revised draft is underway. 29.7.20 noted that PTR report not due for submission until September. Amendments will be signed off via Chair's Action. 19.8.20 This work is being finalised alongside finalisation of the AQS so it can be published jointly, and will be submitted for Chair's approval as soon as possible.	August September
29th July 2020				

C Carlisle	**QS20/132.3** Escalate concerns over lack of clarity around the wearing of face masks/coverings	August	Matter raised directly with Health Board Chair	Closed
A Miskell	**QS20/132.5** Follow up progress re Ward 19 infection prevention issues with estates and HMT, and feedback to QSE Chair	August	See also 20/27.5 above 17.08.20 Ward 19 is closing w/c 17.08.20 and patients relocating into ward 2 at YGC, with support from Area and Site management teams.	
L Reid	**QS20/135.1** provide Chair's statement for AQS	August		
All	**QS20/135.1** provide comments on draft AQS directly to Matt Joyes	August	Comments incorporated into version agendered for approval on 28.8.20	Closed
D Fearnley M Maxwell	**QS20/136.3** Provide refreshed mortality paper for August Committee	August	Due to annual leave, paper now sought from Arpan Guha. 17.8.20 An overview of the processes for reporting, reviewing and learning from deaths will be provided to enable discussion about governance and assurance, and the development of future reports to QSE Committee. 19.8.20 Presentation slides submitted for August Committee	closed
D Fearnley	**QS20/137.1** share a copy of the draft terms of reference for the Royal College of Surgeons' external review of vascular services, once agreed with the CHC.	August	17.8.20 Draft terms of reference agreed with T&F Group and CHC, shared with QSE Chair. Two additional points considered by T&F Group on 13 August 2020 (review of pathways and education/training) before submission to Royal College of Surgeons.	
D Fearnley	**QS20/137.2** Refresh the action/implementation plan for vascular services for next submission	August	17.8.20 Action plan updated and shared with T&F Group on 13 August 2020, with further updates agreed and revised action plan to be shared with QSE in August 2020.	

| D Fearnley | **QS20/137.3** Revisit the Vascular T&F Group terms of reference to ensure clarity and pick up specific points raised by members | August | 17.8.20 Amendments made and shared with T&F group at the meeting on 13 August 2020. | closed |

25.8.20

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 28TH August 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Patient Stories
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Acting Associate Director of Quality Assurance and Assistant Director of Patient Safety and Experience
Awdur yr Adroddiad Report Author:	Patient and Carer Experience Team
Craffu blaenorol: Prior Scrutiny:	Review by the responsible director
Atodiadau Appendices:	None
Argymhelliad / Recommendation:	
The Committee is asked to receive the patient stories which help to understand the impact of COVID-19 on the care provided.	
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	✓

Betsi Cadwaladr University Health Board

Patient Stories

These patient stories were collected by the Patient and Carer Experience Team (including PALS) across BCUHB. These stories will help to understand the impact of COVID-19 on the care provided.

During the COVID-19 pandemic a selection of patient stories have been selected provided by patients, carers, relatives and other service users who have taken the opportunity to share their experiences and journeys through the Health Board. This journey can vary considerably from patient to patient and can last hours, days or months. Patient stories enable the Health Board and the associated services to view "on the ground feedback" as to was good about a patient's experience, what was not so good and what could be improved to ensure a better patient experience in the future.

During the COVID-19 pandemic the patient stories describe a very different experience. This feedback also reflects the essential quality improvement and benchmarking and the new innovative ways of working that the Health Board has developed during this challenging time. The Patient & Carer Experience Team continue to respond to the population needs by developing new working methods of engaging with patients, carers and their families as well as looking at new ways of gathering feedback.

The imminent development of the Digital Patient Stories Framework is one example, supporting the Health Board to present patient stories in a modern and diverse format.

Val's Story	
Reason for taking the story and areas covered:	This ladies story highlights her journey through the health care system, whilst suffering from COVID-19.
Brief summary of the story:	Val had a history of underlying health conditions, predominantly asthma for which she had taken steroids and antibiotics in the past. About a month prior to Val becoming really unwell, her General Practitioner (GP) prescribed a course of antibiotic and steroids, to treat an exacerbation in her asthma. Val had put this flare up down to being at a low ebb, after her father had passed away a few months before, following which she had been very busy dealing with his affairs.

Val first noticed her breathing was changing about a week prior to being admitted to hospital. She was experiencing aches all over, headache, ulcers in her mouth, felt weak and lethargic and |

couldn't eat anything. In addition she noticed her breathing was different, she wasn't breathless as such, it felt more like she was unable to breathe in and out to full capacity. At first she carried on, but her condition didn't improve, so she rang her GP for advice. Val explained to us that she was aware that she was displaying symptoms of COVID-19, and following a telephone consultation with her GP, it was confirmed that it did indeed sound like she was suffering from this. Val was advised by her GP that she must call for an ambulance if her symptoms became any worse. This was very frightening time for Val and her family, as she really didn't want to go into hospital.

The following morning, Val's GP rang to see how she was feeling. Val told her GP that if anything she felt worse, whereby the GP told her to call an ambulance, which Val did. The Paramedic team arrived within the hour, which was very comforting to Val and her husband. They gave her a full examination, and following this, the decision was made not to send Val to hospital, but that she should continue self-isolating. Val was satisfied with this decision.

However, by the following day Val felt even worse, and an ambulance was called out again. Following a thorough examination by the ambulance crew, Val was given nebuliser therapy and not taken to hospital. Val recalled that she started to feel a little better following the nebuliser and check-up, for a few hours at least. However, as the day wore on she started to feel very poorly indeed. For the third time, an ambulance was called, with the paramedics having to now seek advice from a senior in regard to the plan of action. This time it was agreed she needed to be admitted to hospital, this was a relief to both Val and her family as she felt so ill.

On arrival to hospital Val recalls being attended to swiftly, being assessed, having a swab taken, and a chest x-ray taken. Val remembered being swiftly admitted to an upstairs ward, although she is unsure of which one, as by this time she was feeling really unwell, and steadily worsening. Despite being so poorly, she recalls a member of the team speaking to her very kindly, this really made a difference. Val's condition again worsened, and she was moved as a result to the High Dependency Unit. Here she was placed on a CPAP (Continuous positive airway pressure) device as she was unable to tolerate being oxygenated nasally. This was a really scary time for Val, however, despite being so ill, she recalled the positives, saying that the staff were "fabulous". They spoke to her as a person, and she was treated with dignity and respect, especially when it came to her personal care. Val also praised the fact that she felt completely involved

and informed in every aspect of what was going on. She wasn't pressurised into doing anything, and said the staff were there in a heartbeat if she needed anything. Val went on to say that nothing was too much trouble for the staff, an example being a night when she did not feel well enough to take her prescribed medication. In response, a member of staff supported Val by crushing her tablets to take in water, and others were put into ice cream to help her swallow them, Val thought this was really thoughtful. Additionally, her grandchildren had sent a printed cushion with their faces on it, this was delivered to Val by the ward staff where she took great comfort from it in this, feeling safe and secure in their hands. Val praised every member of staff, including the domestic team, who she said kept the ward spotless, and whose cheery attitude kept the mood positive, to the nurses and doctors, and clinical support staff. She also wanted to convey her thanks to her GP and the Ambulance staff who attended to her.

Val genuinely thought she would not be coming home. She believes that the high level, compassionate care shown in HDU, is attributable to her coming home.

As Val's condition improved, she was stepped down to a general ward with COVID-19 patients, here her experiences were different to those she had experienced in HDU. An example given by Val was that she felt the staff lacked an understanding of why she still required oxygen. When the tubing to her oxygen supply was too short, this was not rectified, this made Val feel unsafe. This led Val to question whether the breakdown in communication was perhaps due to a language barrier, as she is a Welsh speaker, and not all staff were. Another issue that worried Val was the fact that the ward held many people with dementia, although Val was quick to stress that this was not the issue. Val was worried that these individuals were not being supervised adequately, particularly at night time, Val felt a responsibility towards these people. At this she expressed frustration as she had been very ill, and was still very much in the recovery stage. She wanted to go home and at this point Val was tempted to discharge herself. However, still feeling poorly, Val realised it wouldn't be fair on her family if she did go home, so she stayed. After a while, her Dr came to see her, and felt at this point in her recovery, she would be now better off at home and Val was discharged. She was advised if she needed anything or felt unwell to ring the ward, this was positive and reassuring. Whilst Val did see a physio prior to being discharged, the room with the equipment in, such as steps to test a person's ability to move safely, was locked.

	Val is now at home with her husband recovering, who himself was diagnosed with COVID-19, and admitted to hospital. However, his illness was less severe than Val's and he did not intensivist care, but none the less was still quite ill. At home they support each other the best they can. They are both truly thankful to the NHS for their treatment and recovery.

Andrew's Story	
Reason for taking the story and areas covered:	Whilst witnessing the transfer of a deceased ladies property take place, the PALS officer were able to communicate with her son Andrew. Andrew entered into conversation about all the care and compassion his mother received whilst in hospital during the stressful COVID-19 period. Andrew conveyed the positive difference that effective communication had made during his mother hospitalisation. At this point Andrew was asked if he would like to share his story, in particular how it had felt having a close relative with COVID-19, and not being able to visit her, or be with her at the end of her life (visiting has since changed). He was more than happy to oblige.
Brief summary of the story:	Andrew started by drawing a picture of his mother, Ruth, as a "young" seventy eight year old, who had struggled with lockdown as her husband, his father, had Alzheimer's and was in a care home. Ruth he said, had a heart condition, which was thought to have been brought on by stress of her husband's illness. Ruth loved flowers, and took comfort from tending to her garden, it helped a little to fill the gap, and relive stress. Sadly, Ruth fell in her garden, injuring herself, and ended up as an inpatient, where she appeared to make a good recovery. Indeed, Ruth recovered, and was discharged home following a negative COVID-19 test. Ruth's discharge plan was described by Andrew as "good", with her care being taken up in the community by the District Nursing Team. Initially Ruth looked really well, but after a few days her health declined rapidly, and she collapsed. Andrew relayed that "the paramedics were wonderful, they arrived within ten minutes". Ruth was readmitted to hospital and, after six days, arrangements were made for Andrew and his sister to come in at the request of the ward sister Alison. Andrew said:

"Alison arranged everything for me and my sister to see Mam, albeit one at a time. Everyone was so lovely, really kind. We were so lucky that she had such fantastic nursing care. Whilst we waited to go in to see her, everyone said "hello" and were incredibly compassionate. A doctor and a nurse explained everything to us. I truly cannot fault the communication throughout the whole time, it was excellent."

Andrew went on to say how hard it was for his sister and himself to go in alone to say our goodbyes.

"Obviously, we would have liked to have seen her together but, of course, we both understood that this couldn't happen. We were just grateful that we were allowed to see her one last time."

Andrew was exceptionally grateful to "Dr Ben" who phoned him every 2 - 3 hours towards the end of his mother's life to give him an update. He was touched when Dr Ben asked him how he was feeling.

It was the little things that made the difference, according to Andrew, such as when the nurse took the phone to his mother so his teenage children were able to have a few words with their grandmother. The call he received to tell him his mother had died was filled with detail and compassion, which was much appreciated by Andrew and his sister.

When asked if there was anything that could have been improved Andrew said he felt that everything possible had been done to keep him and his sister informed throughout his mother's stay.

Andrew was exceptionally grateful for the care his mother had been given and couldn't thank the staff enough. He said he found solace that she was so well-cared for by kind, friendly and hard-working staff. He thanked everybody working to keep the NHS going during these difficult times.

Feedback on the new PALS Bereavement Support Service

Some positive feedback has been received with regards to the bereavement support service that has been set up, to support and augment the Bereavement Services at the hospitals during the current pandemic. An example of this was from a lady who wanted to understand more about the final hours of her mother's life, and the care she received during the period before she was in YGC; she still had questions that she needed addressing. Following an exchange with a member of the PALS team on the bereavement line, she expressed her relief and satisfaction with the professionalism and speed of response and now feels confident that she will have her questions answered.

"As you know, a close friend suffered a bereavement lately – my friend's elderly mother passed away and although not unexpected, it was heart-breaking. [She] had Alzheimer's disease but her daughter and two grown-up grandchildren were allowed to spend her final day with her in hospital. My friend was extremely complimentary about the quality of care they received as a family. As my friend felt that she still had questions that needed addressing, I recommended that she phone the new Bereavement help-line. She agreed and phoned. My friend was delighted with the professionalism and speed of response and will now get some answers from the clinical team. I just want to record this as feedback – we rarely have occasion to heed our own advice or offer it to those closest to us but on this occasion, I was able to help. Please pass this message on as appropriate – it was excellent and honest feedback".

Feedback on the new PALS Letter to Loved Ones Service

The Letters to Loved Ones was implemented by the Patient and Carer Experience Team in response to COVID-19 and the challenges friends and families faced as they were not able to visit those who were patients. Due to the popularity and positivity, PALS will continue to offer this service long term. One example of the positive feedback was received for the Letters to Loved Ones Service:

"I just want to say a massive thank you to all of you super star heroes working in these frightening times. I have sent a message to my uncle via this service, thank you for offering this, it is so appreciated. Our message to you is: Bless you all and thank you for the amazing commitment you are showing to your calling".

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

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 28th August 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Quality & Performance Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mr Mark Wilkinson, Executive Director of Planning & Performance
Awdur yr Adroddiad **Report Author:**	Dr Jill Newman, Director of Performance
Craffu blaenorol: **Prior Scrutiny:**	This paper has been scrutinised and approved by the Executive Director of Planning and Performance.
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:
The Quality, Safety & Experience Committee is asked to scrutinise the report and to consider whether any area needs further escalation to be considered by the Board.

Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	

Sefyllfa / Situation:
It is important to note that performance reporting of many of the national indicators has been stood down to enable the health board to focus on the mobilisation phase of the pandemic. Staff time has been released to manage the pandemic and therefore the data included in this report has not been subject to the full level of validation and quality control as would normally be included in performance reports. This report includes available indicators from the National Delivery Framework, together with a section on Covid-19 and Essential Services Delivery.

Cefndir / Background:
Our report outlines the key performance and quality issues that are delegated to the Quality, Safety & Experience Committee.   The summary of the report is now included within the Executive Summary pages of the QAP and demonstrates the work related to Covid-19, essential service delivery as well as the key measures contained within the 2020-21 National Delivery Framework. This framework has been revised to provide performance measures under the Quadruple Aims set out in A Healthier Wales.

Asesiad / Assessment and Analysis

Strategy Implications

The performance measures within the report are aligned with the National Delivery Framework.

Options considered

Not Applicable

Financial Implications

The delivery of the performance indicators contained within our annual plan will have direct and indirect impact on the financial recovery plan of the Board.

Risk Analysis

The present pandemic has produced a number of risks to the delivery of care across the healthcare system. The paper highlights the risks arising directly from covid-19 and the need to maintain essential non-covid services. The impact of covid-19 on non-covid planned care is reported together with the interdependencies between ensuring safe re-start of elective care and balancing the risk of covid-19 for patients, staff and system capacity.

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

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

Covid-19 Pandemic

It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in April and July 2020 is not compared as 'like-for-like' to previous months/ years performance. It is also important to note that national reporting and performance management arrangements have been suspended at this time. In order to release staff time to manage the mobilisation of the pandemic response normal validation and sign off processes have been reduced, so caution needs to be applied to data quality presented in the report.

The content of this month's report has been impacted by the Covid-19 Pandemic.

The format of the report reflects the published National Delivery Framework for 2020-21. This aligns to the Quadruple aims contained within the statutory framework of A Healthier Wales.

Additional sections are added to reflect Covid-19 key performance indicators and the work on maintaining essential services.

Local indicators have been included this month for compliance with national patient safety notices and alerts.

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

The operational planning for 2020-21 has been impacted by the pandemic with planning cycles re-defined into quarterly plans. The Quarter 2 operational plan has been approved by the Board and submitted to Welsh Government. The likelihood of delivery of the actions contained within this plan are reported in the accompanying Q2 Operational Plan monitoring report. Work is underway on the development of a combined Q3/4 operational plan which will also include the winter and surge plans.

As a consequence of the changes in the planning cycle for 2020-21 and the uncertainty around the future levels of Covid-19 the ability to produce month on month profiles to monitor performance against is severely limited. Therefore the report contains factual information on performance indicators without consideration of the delivered performance against plan or a forward trajectory of future performance.

The direction of travel of performance is indicated through trend arrows (*shown below*)

⬆ Performance has improved since last reported

⬇ Performance as got worse since last reported

➡ Performance remains the same as last reported

For July 2020, the performance has not been RAG (Red, Amber, Green) rated as national performance management arrangements have been stood down.

The information provided is management information only.

The intention for future reports is to continue to align the reporting of covid-19 related pandemic indicators with the essential services service status and the National Delivery Framework while developing the reporting against the actions in the quarterly operational plans. As patient and staff safety permit, we will recommence the development of profiles for delivery for activity taking place in short-term cycles, reporting on referrals, new ways of working, emergency and elective activity and waiting lists.

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

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Key Points

Improvement in CAMHS performance

Social Distancing and Safe IPC measures remain priority

Planned Care is being clinically prioritised to reduce risk of Harm

Key Messages

Covid-19 continues to circulate and bed occupancy is starting to increase

Unscheduled Care demands are increasing resulting in high levels of bed occupancy on Acute Sites

Essential services largely maintained, however activity significantly reduced

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The committee are asked to note the following:

Covid-19 .
The levels of Covid-19 have reduced compared to those seen during Quarter1 of 2020-21.North Wales is currently in a transition period between phases in the pandemic response and management. The number of cases and deaths has reduced since the peak in North Wales, although recently there has been an upturn in Wrexham following a local outbreak.
Containing Covid-19 and keeping the number of cases low requires a sustained focus on ensuring all possible measures are taken to prevent the spread of infection.
In North Wales this has included martialling a partnership response to three localised (and largely isolated) outbreaks – the 2 Sisters Plant on Anglesey, Rowan Foods in Wrexham, and more recently Wrexham Maelor Hospital. Outbreak Control Teams were established for all three in line with all Wales Outbreak Plan procedures, as updated in the Communicable Disease Outbreak Plan for Wales (July 2020.)

The Health Board and Local Authority partners have worked together on has developed a local Covid-19 dashboard and this, together on the Local Covid-19 prevention and response plan . This has been submitted to Welsh Government and contains detail of the key actions for primary , secondary and tertiary prevention together with confirmation of the provision for antigen and antibody testing.
The covid-19 intelligence indicates the need to work with a high degree of uncertainty and plan in are relatively short cycles.
We recognise the need for agility and flexibility to ensure we can respond to continuously changing situations appropriately.
We need to ensure we minimise the risk of harm both from the direct impact of Covid-19 and the indirect consequences for our population by maintaining responsive services to meet the needs arising from Unscheduled Care, Essential Planned Care services across primary, community, secondary, tertiary and mental health. At the same time we are taking opportunities to use our reduced capacity to re-commence non-essential services, where it is deemed safe to do

so, using a clinically risk stratified approach to prioritise care

Essential Services.
The Health Board have reviewed compliance with the Essential Service Framework on a monthly basis. The data for the July review is included in this report .The August review is underway. The latest report demonstrates the majority of essential services are being maintained and actions have been implemented to address shortfalls. The Committee is reminded that Essential Services are those services that need to continue throughout Covid-19 to avoid the risk of harm arising from life-threatening and life-changing treatments. The framework applies to services across the whole of the healthcare system.

Planned Care Re-starts
As Essential Services are being sustained and the level of Covid-19 within our hospitals and communities has passed the initial peak work is progressing to recommence planned care services. This entails risk stratifying our existing waiting lists, risk assessing our facilities, and pathways to support safe restart of services with capacity

used for patients with greatest clinical need. This work is complex requiring new ways of working and considerable agility and effective communication to build patient confidence.
We are using the risk stratification for surgery issued by the Royal College of surgeons which provides priority levels for surgery across surgical specialties and identifies the type of condition that fits into each of these priorities levels:
Priority level1a Emergency-operation needed within24hours
Priority level1b Urgent operation needed with 72hours
Priority level2 Surgery that can be deferred for up to 4weeks
Prioritylevel3 Surgery that can be delayed for up to 3months
Priority level4 Surgery that can be delayed for more than 3months
This approach is being adopted across Wales and the present patient administration systems are being re-designed to capture this information. While this is progressing we have developed an internal process to capture the P value of clinical assessments. This carries a risk and is not sufficient to fully address the new ways of working and so has been added to the risk register.

Unscheduled Care:
During the peak of Covid-19 unscheduled care performance improved considerably on all national reported measures. This was primarily due to the reduction in non-covid-19 emergency demand. Some of this demand reduction was expected as fewer activities were taking place, however there was a concern that some patients were not presenting due to the fear of covid-19.

Attendances at ED have steadily increased returning towards pre-Covid-19 levels of attendance. Bed occupancy is high across acute and community sites and flow restricted. Therefore performance although generally better than in July 2019 is deteriorating and delays for patients re-emerging.

The USC improvement group has re-convened and work has been agreed with WAST to address conveyance and hand over. The ED quality and effectiveness framework actions are being refreshed and a deep-dive is underway at YGC to support improvement ahead of the winter period.

Winter planning and Surge planning has commenced and will be completed during September for inclusion in the Q3/4 operational plan. This is taking a whole system view to ensure we are prepared to respond to covid-19, seasonal unscheduled care, essential services and planned care requirements and understand the potential requirements for surge capacity during this period.

Primary Care:
GP practices across North Wales are reporting their escalation status into a new national reporting system. This is continuing to show the majority of practices are not under significant increased pressure at this time with 100 of the 103 practices at level 1 (green –no or steady pressure) and 3 practices amber (moderate pressure) as of 17th August.

Optometry practices have moved from red to amber phase of the pandemic and the majority have re-opened their practices and managing patients on basis of clinical need within socially distanced environments. The 15 emergency eye care hubs have therefore been stood down. The Welsh Eye Care Service is providing a safety net for patients where practices have not been able to re-open. The active recall of patients is being encouraged from the beginning of August.

Quadruple Aim 1:Prevention
National screening programmes recommenced during July. We are working with the services and are starting to see increased demand on hospital services as a consequence. Plans are in place to address this demand with additional sessions needed in services such as endoscopy to address the current backlog and future predicted demand of 18 additional patients per week.

Plans are being completed for implementation of the seasonal flu plan and a potential covid-19 vaccination programme.

Patient self-management is being supported at outpatients through the introduction of See on Symptoms and Patient Initiated Follow Up .

Quadruple Aim 2: Digitally Accessible HealthCare
Primary Care has become fully digitally enabled for consultations during the pandemic, Consultant Connect has been implemented to provide advice and guidance between primary and secondary care. Virtual consultations have increased in secondary care and AttendAnywhere video consultations are being rolled out to the 72 clinicians who expressed an interest in video consultations with patients. However while there has been an increase in virtual consultations above the pre-Covid-19 low levels, they are not suitable for all patients or all conditions and the level of activity does not compensate for the loss of normal outpatient capacity.

The Welsh Government has approved the All Wales Digital Eye Care programme. Demonstration of the software procured will take place during August 2020.

Quadruple Aim 3: Staff motivated and sustained.
Recruitment to substantive vacancies has improved reducing the need for agency staff and providing increased sustainability in the workforce. There are still vacancies in the service and some hard to recruit to areas, however sickness rates are now the best in Wales and our covid-19 absences have reduced.

Quadruple Aim 4:
The Covid-19 prevention and response plan has been produced through close partnership working.

The Test Treat and Protect programme is a multi-agency programme .

Covid-19

Key Messages

Initial Peak of Covid-19 has past, however risk is still present

Good social distancing and infection prevention is essential to sustain lower levels of Covid-19

Prevention and Response Plan for North Wales produced

Continuing social distancing is important in prevention of future peaks

Test Treat and Protect important programme to reduce transmission

Intelligence indicates potential for future spikes and localised areas of risk

Measures

Measure	at 17th August 2020
Total number of tests for Covid-19	76,559
Number of results: Positive	4,760
Number of results: Negative	71,799
% Prevelance of Positive Tests	6.2%
Number of Deaths - Confirmed Covid-19	415

Source: Public Health Wales coronavirus Dashboard, accessed 18th August 2020

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Covid-19 Test Information
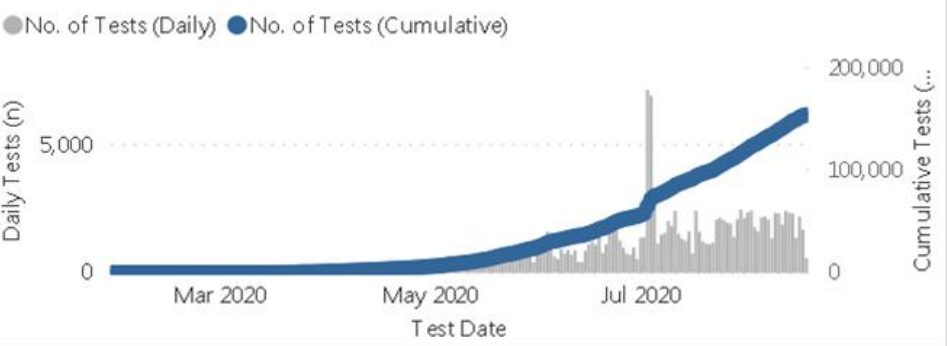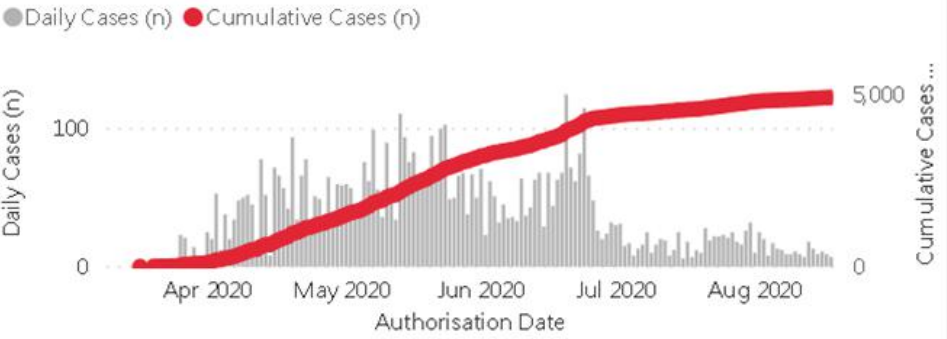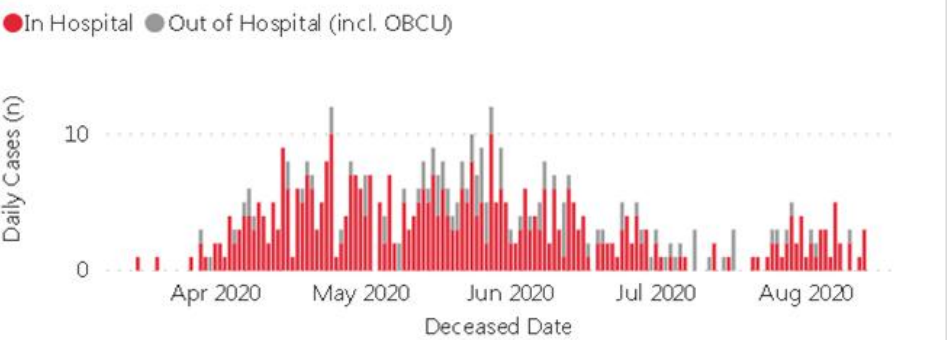
Averager rate of Covid-19 Tests turned around with 24 Hours in the last 7 days

Source: BCU Coronavirus Dashboard, accessed 18th August 2020

51%

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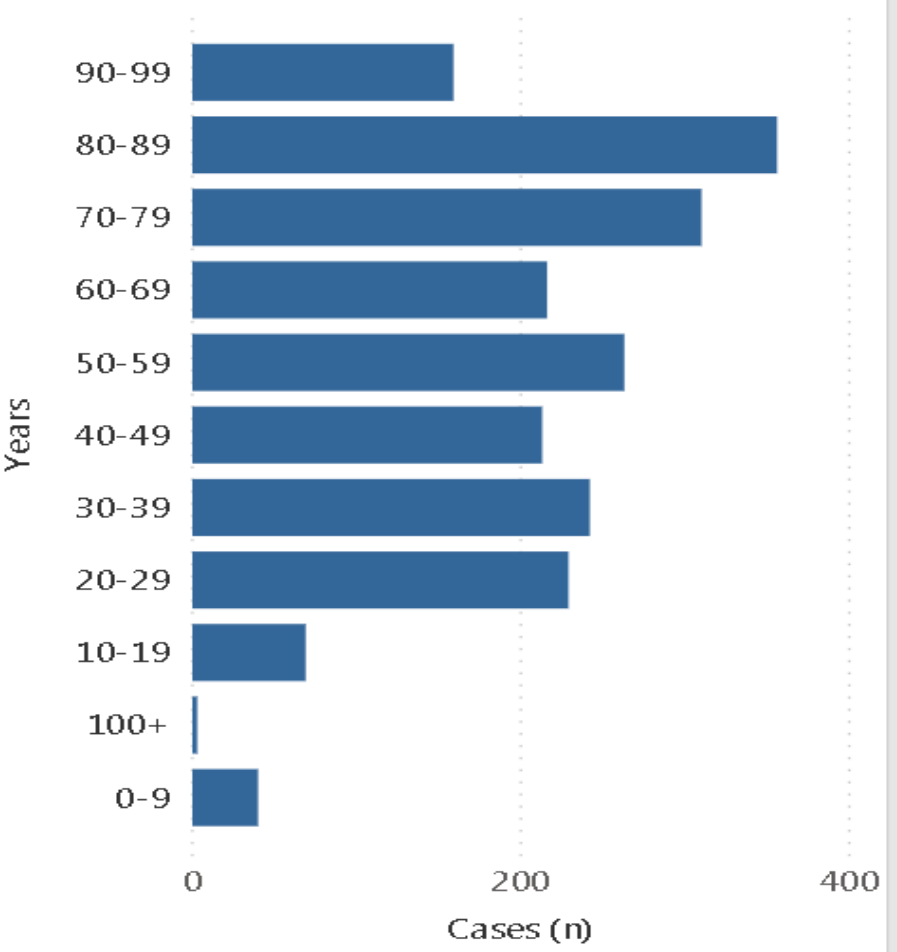
Essential Services

Maintaining essential service activity is key for patients with life-threatening conditions

Essential services form a small proportion of specialties normal business

BCU monitors compliance with Essential Services Framework monthly

Key Messages

Essential Services are those which need to continue throughout the pandemic to reduce risk of harm

Essential services covers a wide range of Primary, Community and Secondary and Tertiary care Pathways

Majority of Essential Services Maintained

Measures

Heat Map of Current Service Status 3.7.20.
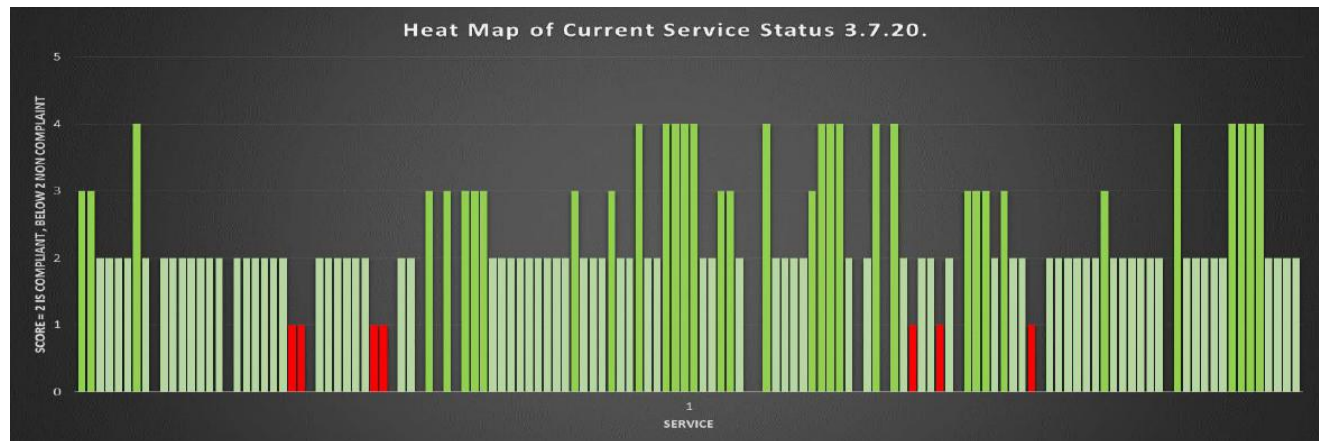
The July assessment demonstrated phlebotomy remains a challenge to deliver. 10 additional phlebotomists have been recruited. CT Angiography was also not functioning, this has been addressed and is taking referrals which have now been clinically re-prioritised. CT Colography is part of the overall lower GI diagnostic service plan. Paediatric surgery via the visiting consultant has relocated to Alder Hey temporarily and urgent pain interventions have been undertaken at Spire Yale. All other services reported meeting the level for compliance. August review is currently taking place with early indications suggesting the majority of services remain compliant.

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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 lies, 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.

Key Messages

Screening services restarted in July 2020

Plans developed for seasonal flu vaccination and preparing for potential Covid-19 vaccinations

See on Symptoms and Patient Initiated Follow Up implemented

Measures

Period	Measure	Target	Actual	Trend
Q4 19/20	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	>= 95%	96.70%	↑
Q4 19/20	Percentage of children who received 2 doses of the MMR vaccine by age 5	>= 95%	94.80%	↑
June 2020	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%	95.77%	↓
June 2020	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%	88.43%	↑

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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.

Consultant Connect advice service implemented

Attend-Anywhere rolled out to 72 users

Welsh Government Approved Digital Eye Care programme for Wales

Key Messages

Primary Care digital access and virtual consultations established

Non –Mental Health Delayed Transfers of Care in single figures

Mental Health Assessment and Intervention times improved

Top 5 Measures (based on movement up or down)

Period	Measure	Target	Actual	Trend
July 20	Percentage of children and young people waiting less than 26 weeks for neurodevelopment assessment	>= 80%	26.49%	⬇
July 20	Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy	>= 80%	30.95%	⬆
July 20	Total Number of health board delayed transfer of care	Reduction	23	⬇
July 20	Total Number of health board delayed transfer of care bed days	Reduction	1,046	⬆

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Quadruple Aim 2: Infection Control Measures

Period	Measure	Target	Actual
July 20	Cumulative rate of laboratory confirmed E-Coli cases per 100,000 population	<= 67	63.83
July 20	Cumulative number of laboratory confirmed E-Coli cases	N/A	149
July 20	Cumulative rate of laboratory confirmed S.Aureus cases per 100,000 population	<= 20	16.28
July 20	Cumulative number of laboratory confirmed S.Aureus cases	N/A	38

Period	Measure	Target	Actual
July 20	Cumulative rate of laboratory confirmed MRSA cases per 100,000 population	N/A	0.43
July 20	Cumulative number of laboratory confirmed MRSA cases	0	1
July 20	Cumulative number of laboratory confirmed MSSA cases	<= 40	37
July 20	Cumulative number of laboratory confirmed Klebsiela cases	<= 38	31
July 20	Cumulative number of laboratory confirmed Aeruginsoa cases	<= 10	15

Quadruple Aim 2: Narrative – Infection Prevention

Covid-19 Pandemic
It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in July 2020 is not compared as 'like-for-like' to previous months/ years performance.

- Normal fluctuations in Infection numbers are to be expected month on month. The year to date figures in terms of performance to trajectory are important in relation to improvement. All Welsh Health Boards have seen increases in both Pseudomonas and Clostridium Difficle Infections (CDI).

- Meticillin Resistant Staphylococcus Aureus (MRSA) remains again at zero across the Health Board for July. This is the same as last month. BCU have had 1 MRSA Blood Stream Infection (BSI) year to date 2020/21. In comparison to last year to date (July 2020) BCU has 80% fewer infections. BCU are in 3rd position out of the 7 Health Boards including Powys and Velindre.

- Meticillin Resistant Staphylococcus Aureus (MSSA) BSIs are less than June. BCU are less than all Wales and are in 3rd position with 42% fewer than last year. Most are Community Onset (CO).

- Clostridium Difficile Infections remain under mean, however we have 1 more case than June (CO) with more infections CO overall. BCU is less than all Wales per 100K population and is in 3rd position. There are currently audits being completed in relation to an increase in CDI potentially due to treatment for Covid 19.

- E.coli BSIs have seen an increase in July. This is potentially due to the increase in Urinary Tract Infections which we see nationally following hot weather spells and risk of dehydration. The majority are CO, rather than inpatient related respectively. BCU are in 5th position. Overall BCU have seen 25% fewer cases year to date.

- Klebsiella BSIs have decreased since June, 30% fewer cases year to date. BCU are less than all wales numbers per 100k population. More are CO again.

- Pseudomonas Aeruginosa BSIs are also less than June 2020. 2 cases were confirmed in July, both CO. BCU is in 6th position overall. However there is an all Wales increase in Pseudomonas infections possibly related to secondary infections related to Covid-19.

Quadruple Aim 2: Mental Health Measures

Frequency	Measure	Target	Actual	Trend
June 20	Percentage of mental health (Adult) assessments undertaken within 28 days of referral	>= 80%	90.50%	⬆
June 20	Percentage of therapeutic interventions (Adult) within 28 days of assessment	>= 80%	90.50%	⬆
June 20	Percentage of mental health (CAMHS) assessments undertaken within 28 days of referral	>= 80%	74.40%	⬆
June 20	Percentage of therapeutic interventions (CAMHS) within 28 days of assessment	>= 80%	45.80%	⬇

Frequency	Measure	Target	Actual	Trend
July 20	Percentage of children and young people waiting less than 26 weeks for neurodevelopment assessment	>= 80%	26.49%	⬇
July 20	Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy	>= 80%	30.95%	⬆
July 20	Total Number of health board delayed transfer of care	Reduction	20	⬆
July 20	Total Number of health board delayed transfer of care bed days	Reduction	1,046	⬆

Covid-19 Pandemic
It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in July 2020 is not compared as 'like-for-like' to previous months/ years performance.

CAMHS
•Reset plans for routine appointments for all teams submitted to BCUHB Clinical Advisory Group for consideration
•Plans allow for reconfiguration of services should Covid-19 pandemic re-escalate
•Flexibility in provision of service with the use of telephone appointments and Attend Anywhere where clinically appropriate
•Facilitation of home working for staff where possible to increase capacity in bases
•Increase in referrals in June however remains significantly lower than previous years' trends
•Anticipation of significant increase in referrals in September/October on schools reopening. EIPs services to be reinstated to provide support
•Recruitment of Family Wellbeing Practitioner posts to support clusters well underway in all teams with some commenced in role
•Reduced demand in recent months allowed for focus on assessment waiting list with considerable improvement
•Further Improvement in Part 1a position in June to 74%

Adult Mental Health
Continue to deliver Mental Health Measures of Assessments and therapeutic interventions within 28 days above national target rate. However there has been an increase in Delayed Transfers of Care which is covered in the next section.

Delayed Transfers of Care (DToC)
Overall the volume and bed days affected by patients being delayed on discharge has improved with the changes in process implemented. The discharge to assess pathways are being used and reported on twice weekly.
These predominantly apply to adult non-mental health pathways.
Mental Health DTOC has not seen the same improvement. Current numbers of DToC patients in MHLD is 14 patients, equating to 1,339 bed days.
Dates for discharge have been identified for 2 patients w/c 17.8.20,
Appropriate placements identified for 9 patients, and being progressed and dates for discharge being confirmed.
Awaiting costings for 3 patients, being presented at CHC panel, w/c 17.8.20.
Discrepancies identified between numbers reported within the Division and those on DToC/Iris system.
Action taken - Senior Leads for each area cross referencing to ensure accuracy of information.
DToC Exceptions Forms will be completed for all areas.

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

New models of care will involve a broad multidisciplinary 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.

80% of Incidents closed within allotted timeframes

1 new Never Event reported in July 2020

Final Reply to complaints down to 55.21%

Key Messages

Increase in recruitment to substantive posts

Reduced use of Agency Staff

Additional Well-Being resources provided for staff

Measures

Period	Measure	Target	Actual	Trend
Q1 2020/21	Percentage of complaints that have received a final reply (under Regulation 24) or an interim reply (under Regulation 26) up to and including 30 working days from the date the complaint was first received by the organisation	75%	55.21%	⬇
July 20	Number New Never Events	0	1	➡
July 20	Cumulative Patient Safety Solutions Wales Alerts or Notices that remain open	0	4	N/A

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Covid-19 Pandemic
It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in July 2020 is not compared as 'like-for-like' to previous months/ years performance.

Incidents

2,993 incidents have been reported in total in July; 2,325 relate to patient safety. Since April 2020 there has been a steady increase in the number of incidents reported month on month reflecting a return to more normal reporting levels previously impacted by Covid-19 related activity changes.

Incident closure performance continues to be strong and above plan, with 2,209 of 2,752 (80%) incidents reported in June being closed within timeframe. Although this is down slightly on May (81%) and April (84%) the consistency in maintaining incident closure performance under unprecedented pressures is to be commended.

Serious Incidents (Welsh Government Reportable)

Seven serious incidents were reported to Welsh Government in July, whilst nine were closed. Three incidents were due for closure in July; two remain open and under investigation, the third was submitted after timeframe. Overall closure rate within timeframe for the year is around 64%, the highest ever achieved by the Health Board although remaining behind the national target of 75%. The Health Board has 41 serious incidents open and under investigation of which 29 (71%) are overdue.

Never Events

One new Never Event was reported to Welsh Government in the month of July. The incident has been categorised as wrong site surgery. Following intra-vitreal injection to the eye, the patient complained of loss of vision. Intra-ocular pressure was found to be high. The patient underwent urgent paracentesis. Following this emergency procedure the patient advised that the loss of vision was in other eye. Paracentesis subsequently performed on correct eye which led to restoration of vision. The unintended paracentesis resulted in no harm. Lessons learnt following the Make it Safe rapid review identified a Local Safety Standard for Invasive Procedures (LocSSIPs) pro-forma must be used prior to undertaking any procedures, unless on the rare occasion a delay would negatively impact patient care, in which case this needs to be documented in the patient's notes after the event.

At time of reporting, the above incident is currently the only Never Event open, the investigation is in the final stages of the approval process.

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.

Delivering higher value in health and social care will focus on outcomes that matter to the individual and making our services safe, effective, people centred, timely, efficient and equitable. This will bring individuals to the fore and consider the relative value of different care and treatment options, in line with Prudent Health. Research, innovation and improvement activity will be brought together across regions - working with RPBs, universities, industries and other partners. Alignment of funding streams and integrated performance management and accountability across the whole system will be in place to accelerate transformation through a combination of national support, incentives, regulation, benchmarking and transparency.

TTP metrics developing to report turnaround and contact tracing

Stroke Therapy Mapping feedback to teams

5 new discharge pathways being managed via Home First Hubs

Key Messages

Continued increase in Mortality Rate, up from 0.85% to 1.17% in 12 months

Increased system working to link Health and Social Care Data

North Wales Covid -19 Protection and Response Plan Produced

National Hip Fracture Database - Best Practice Measures

Overview of Wales	BCU			Benchmarks				
	YG	YGC	WMH	NHFD	Wales	England	Northen Ireland	Expectation
Prompt Orthogeriatric review %	40%	56%	46%	88%	60%	90%	82%	75%
Prompt Surgery %	76%	67%	66%	68%	66%	69%	20%	75%
NICE Compliant Surgery %	67%	63%	65%	71%	70%	72%	74%	75%
Prompt Mobilisation %	84%	77%	80%	80%	74%	80%	83%	75%
Not delirious post-op %	34%	52%	29%	63%	51%	64%	35%	75%
Return to original residence %	74%	74%	67%	69%	74%	69%	75%	75%

Source: National Hip Fracture Database, accessed 13th August 2020 (Data 12 monbths to December 2019)

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Quadruple Aim 4: Measures

Period	Measure	Target	Actual	Trend
May 20	Crude hospital mortality rate (74 years of age or less)	Reduction	1.17%	⬇
May 20	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	100%	➡
May 20	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	55.50%	➡
May 20	Percentage of patients (age 60 years and over) who presented with a hip fracture that received an orthogeriatrician assessment within 72 hours	>= 75%	54.00%	⬆
July 20	Percentage of episodes clinically coded within one reporting month post episode discharge end date	>= 95%	94.20%	⬆

Covid-19 Pandemic
It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in July 2020 is not compared as 'like-for-like' to previous months/ years performance.

Mortality

- Medical Examiners will be coming in to post from September 2020 following successful recruitment to the North Wales posts.
- Medical Examiners will be taking over part one of the DATIX Mortality tool which is agreed on all Wales basis
- Stage 2 Mortality reviews using DATIX module have now gone live in YGC
- Events have been held with secondary care to review learning from deaths and moving mortality reviews forward
- Further event with primary care to review learning from deaths and moving mortality reviews forward will be completed before the end of this calendar year in readiness for Medical examiners reviewing deaths
- Update and finalise Learning from deaths policy with robust dissemination plan for launch
- Continue the work in the Emergency Departments on driving improvements in Sepsis management on arrival to support further reductions in Sepsis mortality
- All acute hospital sites are reviewing mortality review processes ahead of medical examiner introduction to ensure all parts of the reviews are streamlined and areas where problems are identified in the process are improved.

Timely Interventions

Sepsis
- A further sepsis collaborative is to take place on October 14th 2020
- Reporting of Sepsis compliance to Welsh Government did cease during Coronavirus but this has now recommenced with all sites from July 2020. Reporting ceased on an All Wales basis
- DRIPS* meetings have been re-established with all Emergency departments following easing of them to allow focus on Coronavirus

*Data, Review the cases, Improvements, Plot the dots, Share and celebrate

### Hip Fracture Orthogeriatrician Review
- Further discussions with acute sites services are in-progress to understand the plans to improve against current performance.
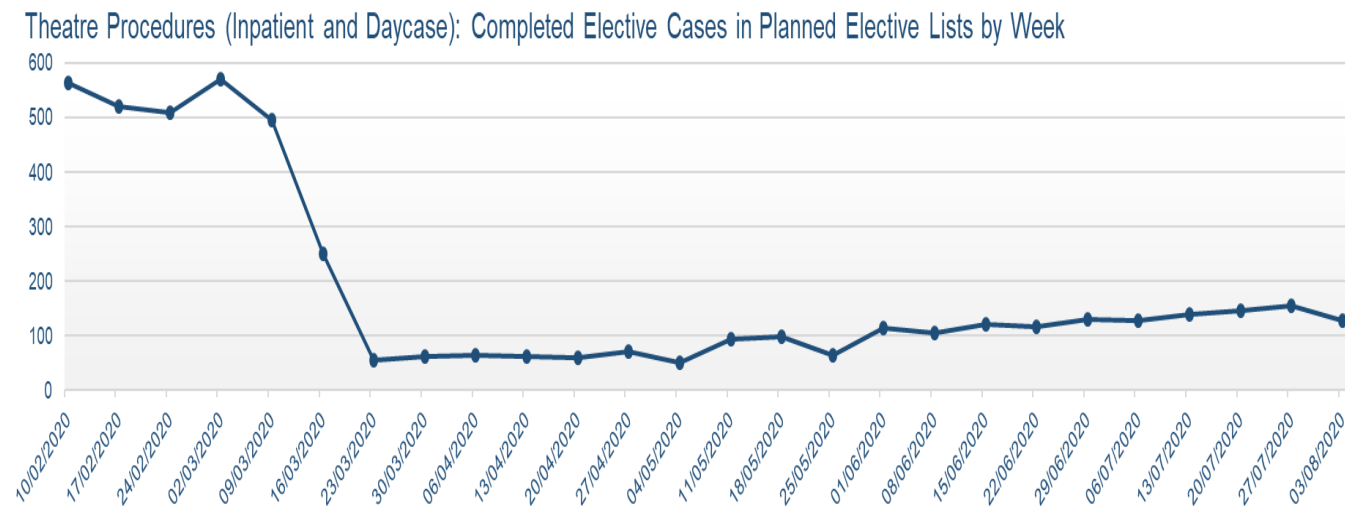
Covid-19: Primary Care Updates

GP Practice Escalation Levels	Date: 03/08/20 BCUHB NWIS REPORT	Date: 16/08/20 BCUHB NWIS REPORT	Date: 16/08/20 All Wales NWIS REPORT
No of GP practices reporting	103	103	403 (ALL)
No. of GP practices reporting Level 5 (CLOSED)	0	0	0
No. of GP practices reporting Level 4 (severe pressure)	0	0	4
No. of GP practices reporting Level 3 (moderate pressure)	2	3	12
No. of GP practices reporting Level 1 & 2 (no/steady pressure)	101	100	387
No./% of GPs absent/self isolating/carers/COVID +ve (excludes locums)	39 8.07%	39 7.99%	140 7.95%
No./% of MDT staff absent/self isolating/carers/COVID +ve	32 6.13%	34 6.54%	129 7.95%
No./% of admin staff absent/self isolating/carers/COVID +ve	92 8.14%	90 7.83%	349 8.77%

17th August 2020

Heat Map of Current Service Status 3.7.20.
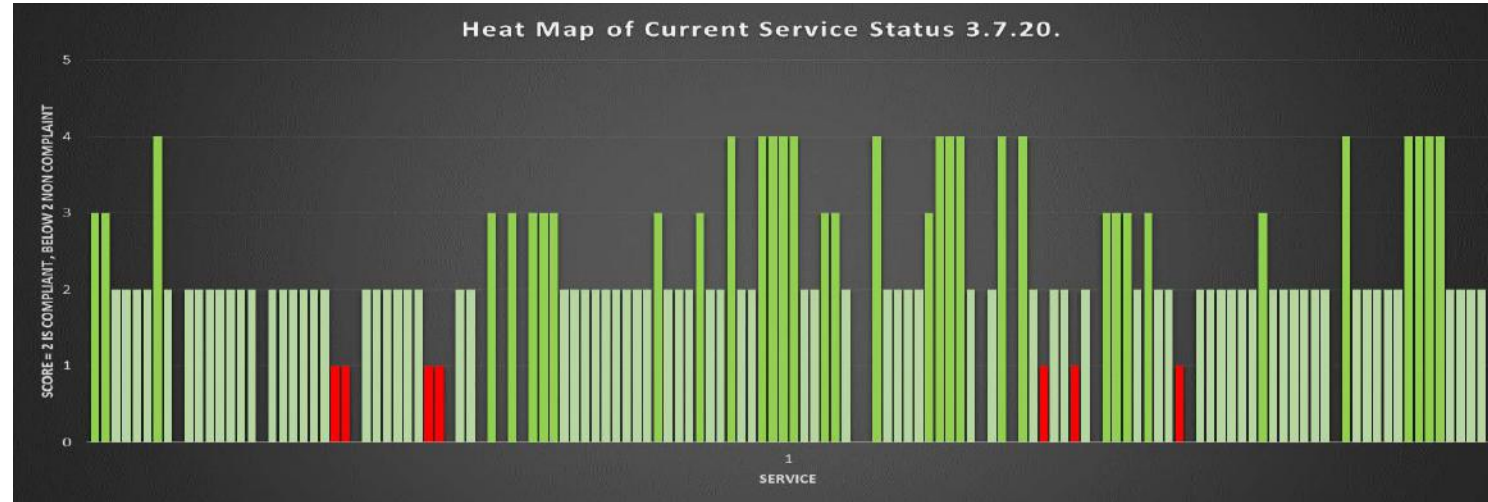
Essential Services have largely been maintained throughout the Covid-19 period. The majority of these pathways are based in primary and community care. However focus is often directed to the Cancer and Surgical elements of Essential Services. The graph below shows the improving position for the Cancer services backlog and the impact of Covid-19 on theatre activity with only essential service procedures being undertaken.

Cancer PTL - Over 62 Day Backlog (BCUHB Total)

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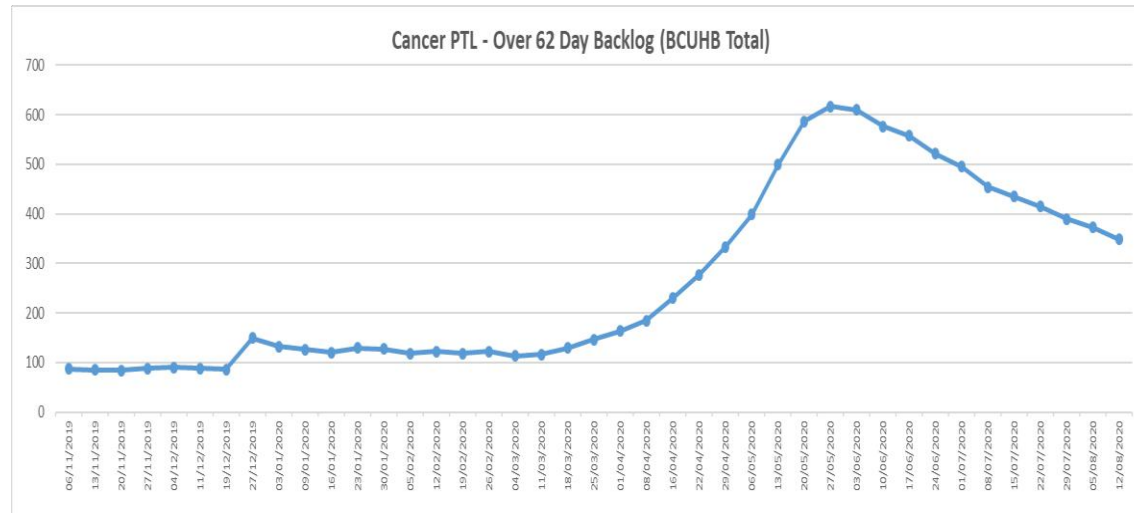
Unscheduled Care: Attendances

ED&MIU Attendances and 4hr Performance

Legend:
- Latest Weekly 4hr Performance
- Latest 30 weeks Attendances
- Corresponding weeks (previous year) Attendances
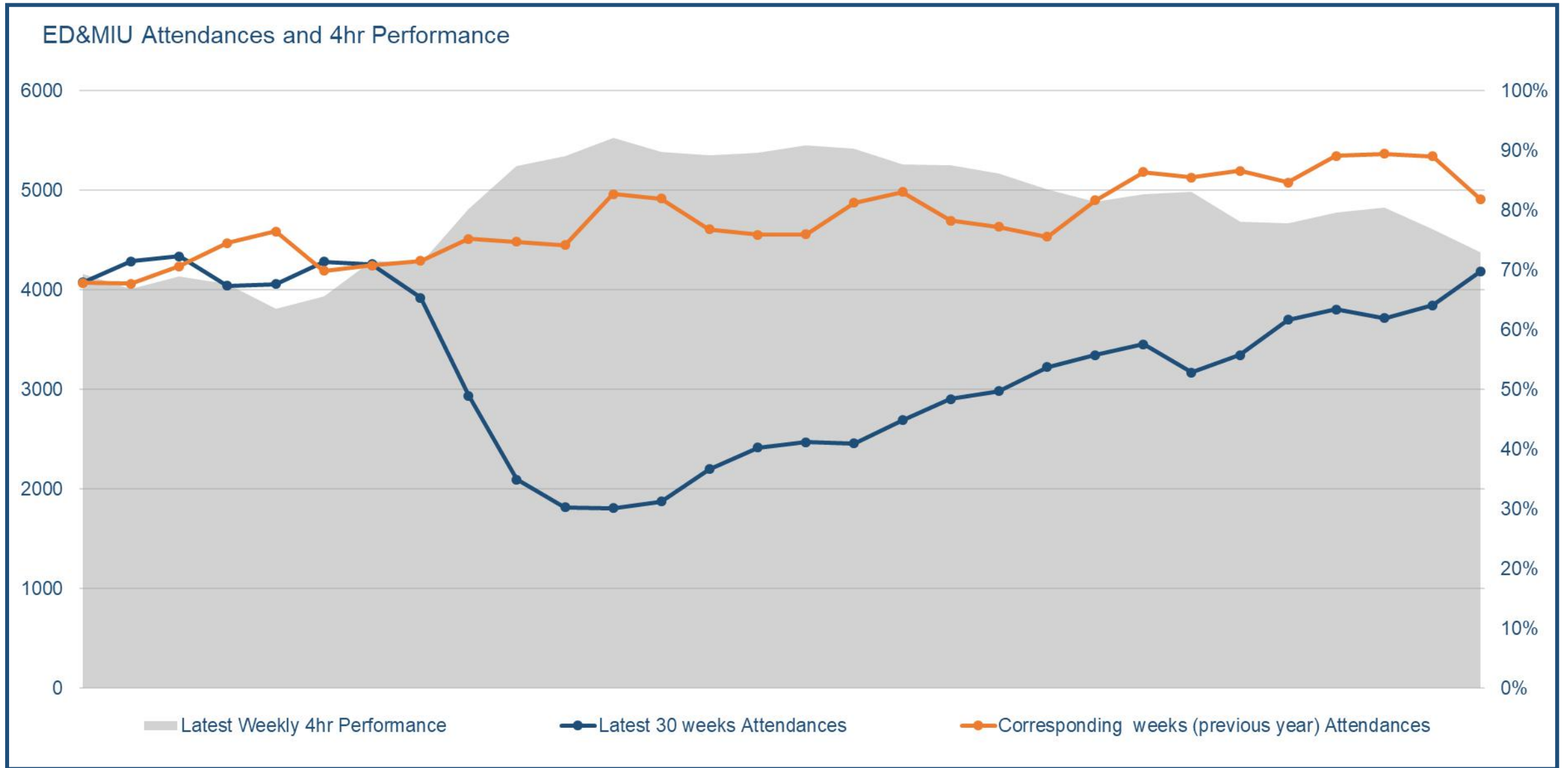
Unscheduled Care: Performance

Position as at end of 16th August 2020	Apr 20	May 20	Jun 20	Jul 19	Jul 20	August 1st - 16th 2019	August 1st - 16th 2020
ED&MIU 4 Hr Performance	87.31%	86.43%	80.47%	73.77%	79.71%	72.11%	**75.04%**
ED 4 Hour Performance	85.13%	84.03%	76.65%	61.93%	75.17%	59.24%	**68.27%**
ED 12 Hour Performance	54	96	466	2044	704	932	**636**
1 Hour Ambulance Handover	32	30	187	811	348	339	**392**
Red 8 Minute	72.44%	69.53%	70.06%	68.16%	65.82%	69.30%	**60.67%**

Covid-19 Impact on Planned Care Referrals and Out Patient Activity
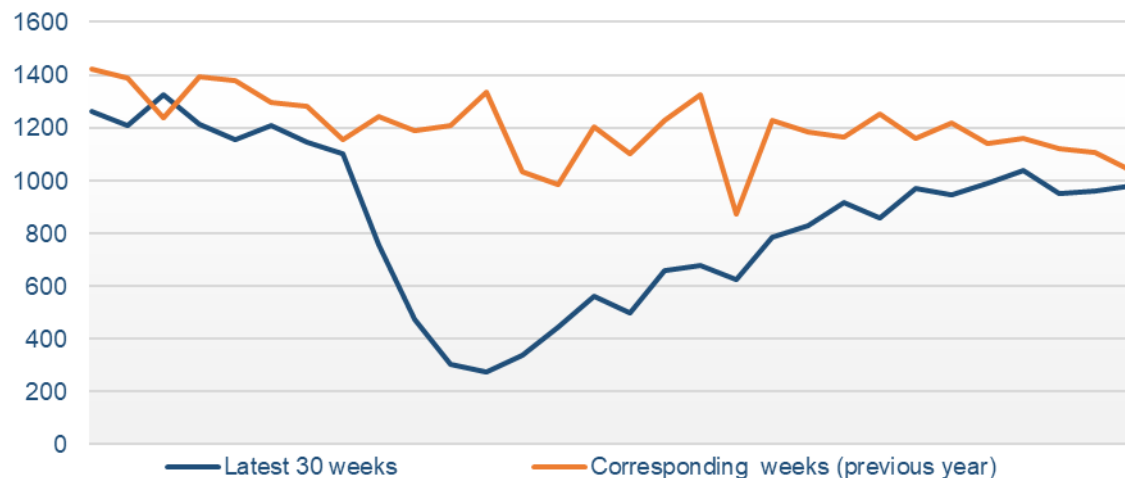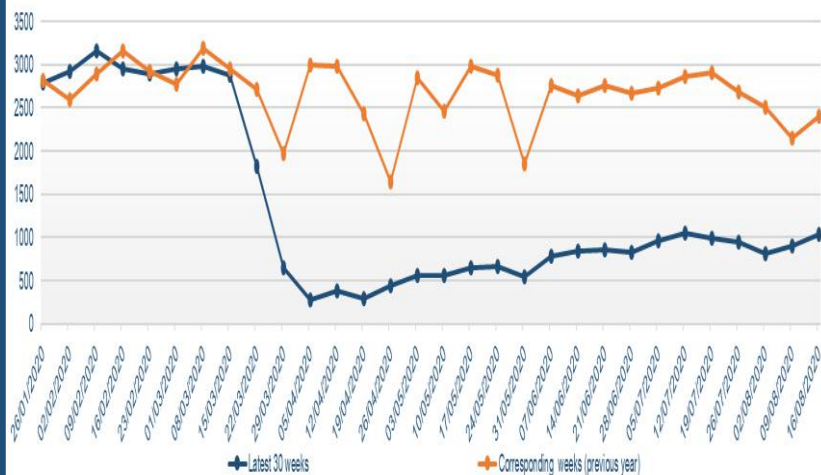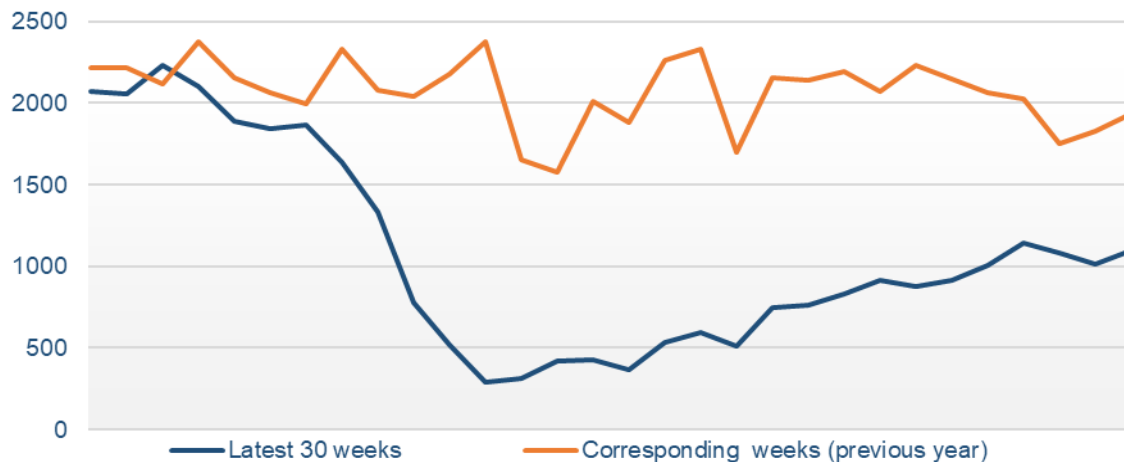
17th August 2020

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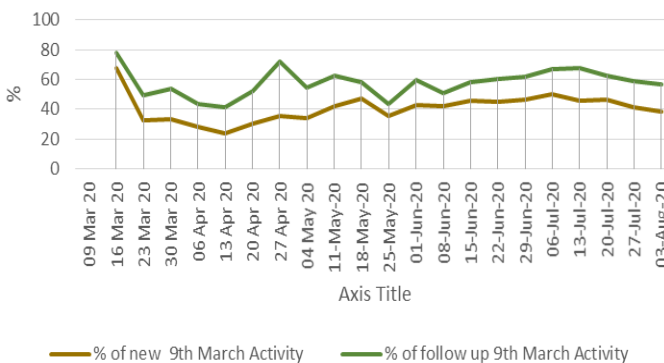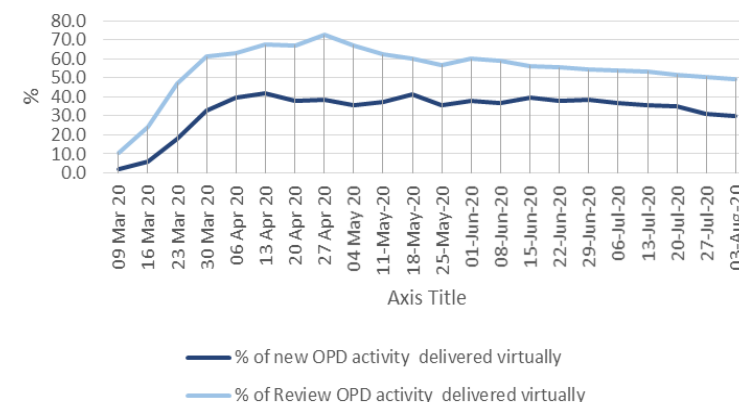
Covid-19 Impact on Planned Activity

Inpatient Day case Activity

Theatre Procedures (Inpatient and Daycase): Completed Elective Cases in Planned Elective Lists by Week
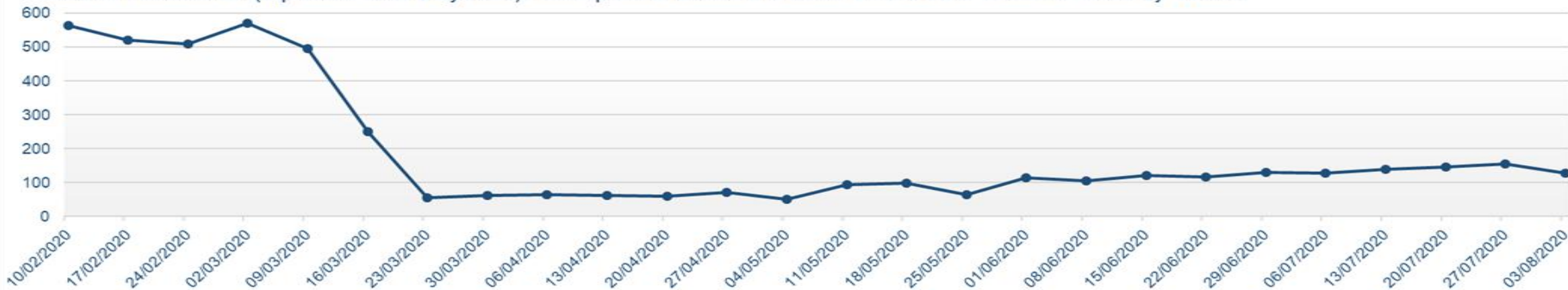
Activity v Plan Comparison																
	2019-20 OUTTURN				Pro-rata Quarterly delivery				Q1 Actual				% of previous activity delivered			
Provider	NEW OPD	FU OPD	other OPD	Elective IPDC	NEW OPD	FU OPD	other OPD	Elective IPDC	NEW OPD	FU OPD	Other OPD	Elective IPDC	NEW OPD	FU OPD	other OPD	Elective IPDC
COCH	6596	13429	9001	4993	1649	3357	2250	1248	685	1876	602	443	42%	56%	27%	35%
RJAH	6717	15361	1854	2638	1679	3840	464	660	305	1776	49	95	18%	46%	11%	14%
BCU	268488	533301	1961	47429	67122	133325	490	11857	31194	71519	117	4421	46%	54%	24%	37%
NB -RJAH activity for IPDC in Q1 includes trauma activity . Actual split is 55 elective IPDC and 40 Trauma pathway IPDC																

17th August 2020   25

Covid-19 Impact on Waiting Lists
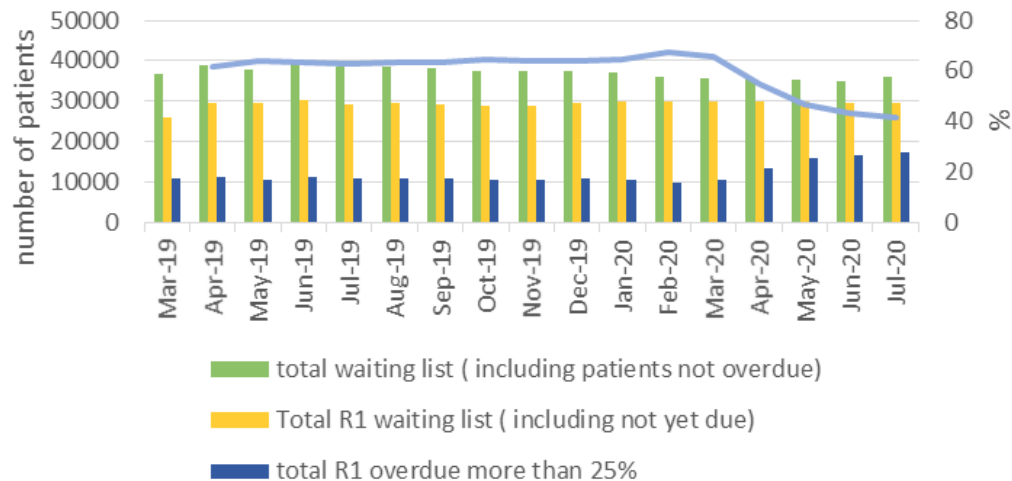
Although Graph Axis shows June, 2020, the data is up to and includes July 2020
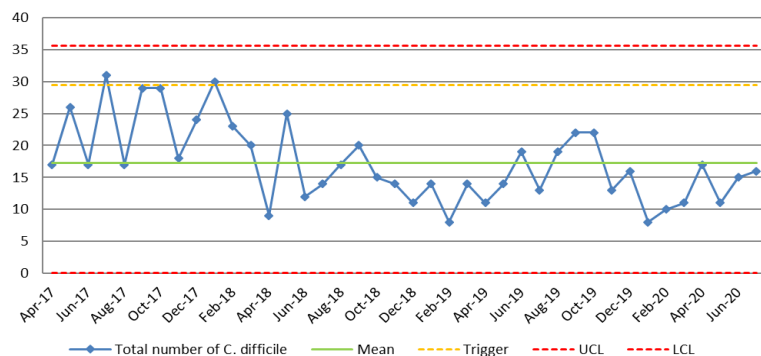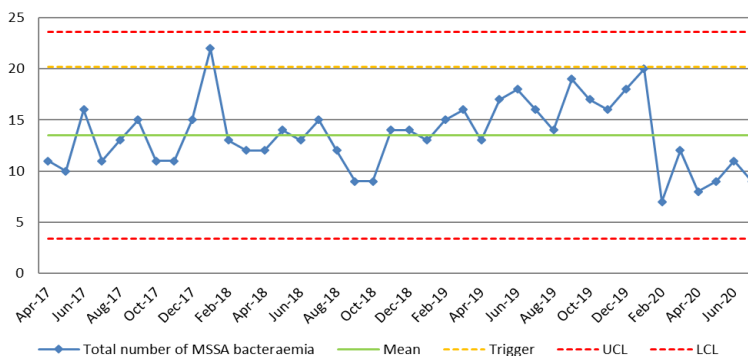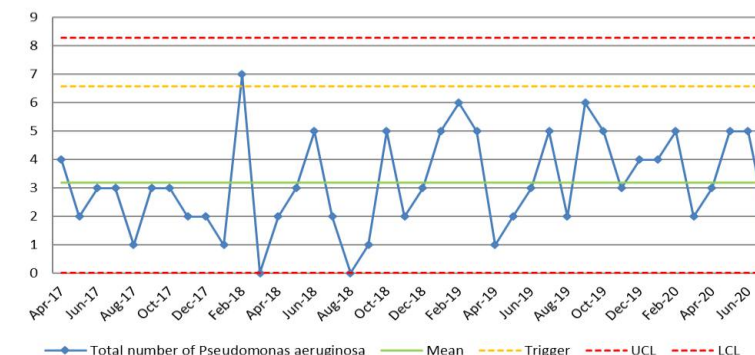
Although Graph Axis shows June, 2020, the data is up to and includes July 2020

Quadruple Aim 2: Charts Mental Health and CAMHS

Quality and Performance Report
Quality, Safety & Experience Committee

July 2020

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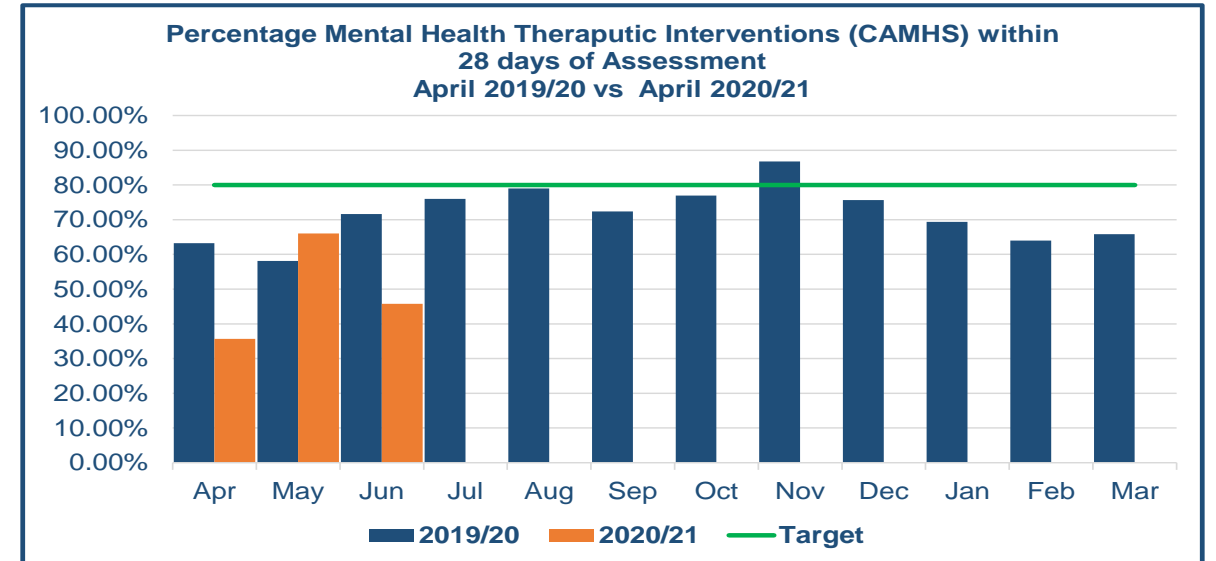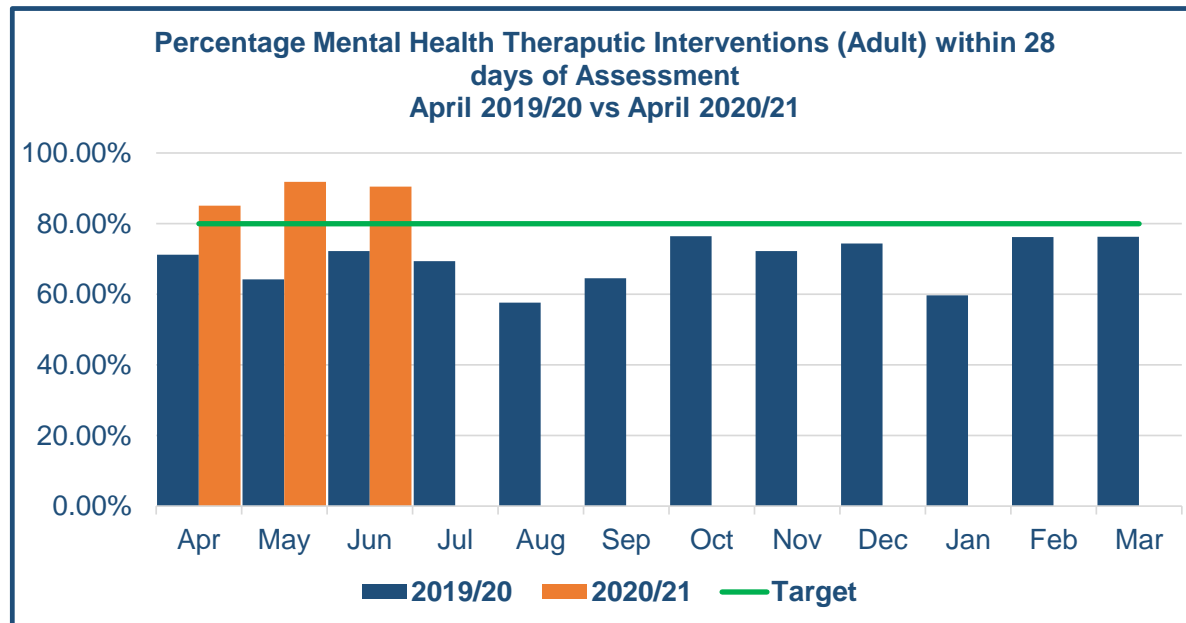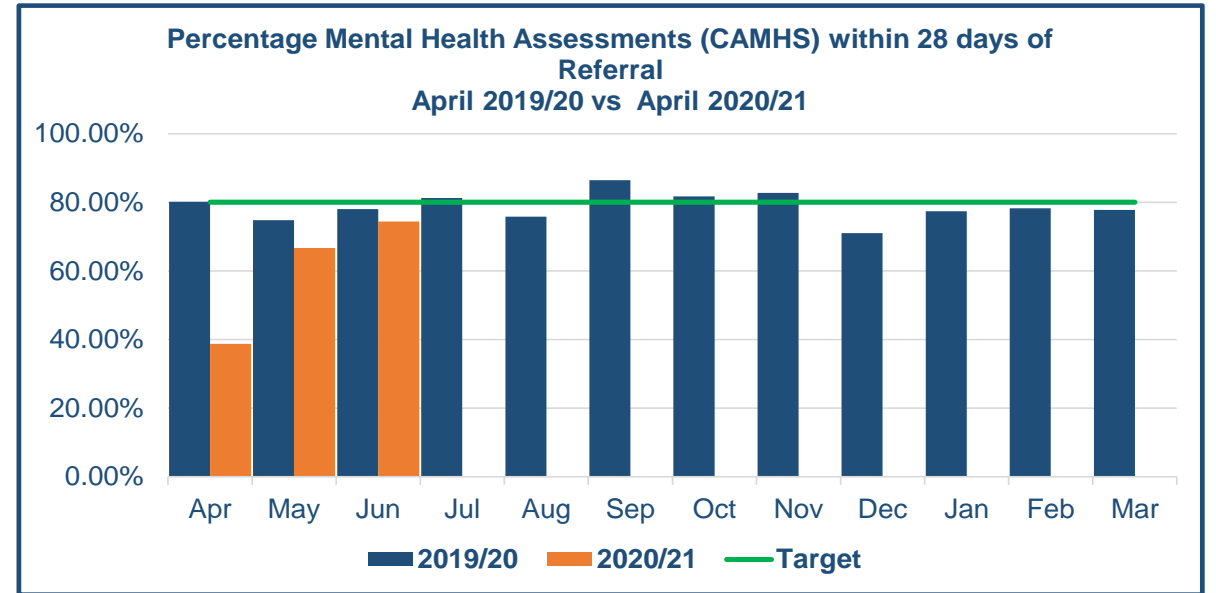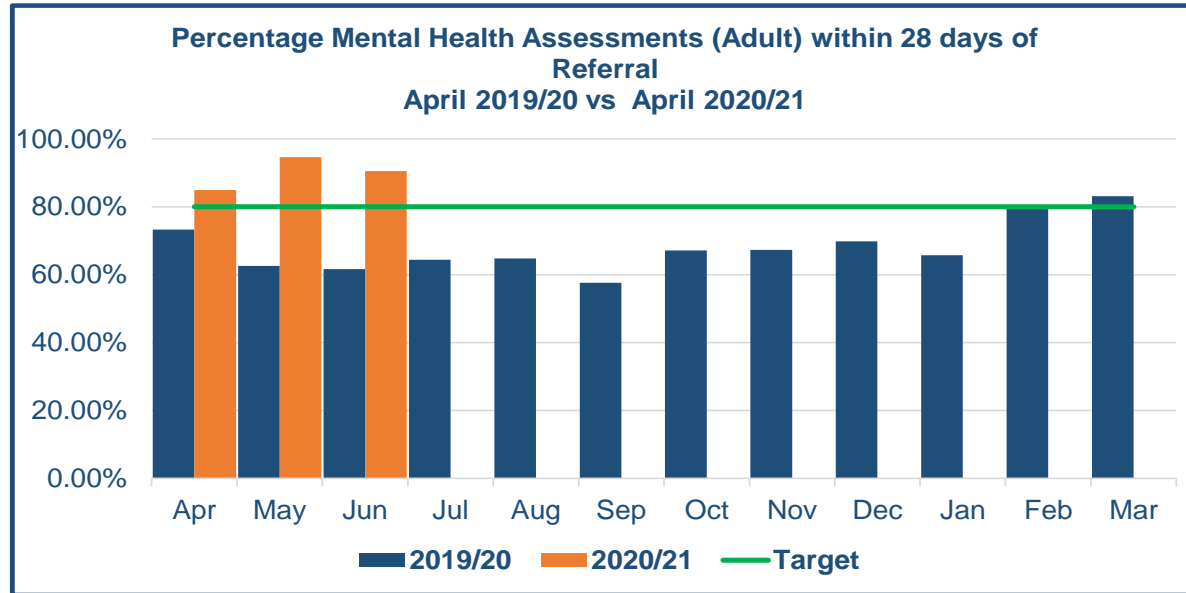
Quadruple Aim 2: Charts Fractured Neck of Femur
page 5

Prompt orthogeriatric review % - Ysbyty Glan Clwyd

Prompt orthogeriatric review % - Ysbyty Gwynedd
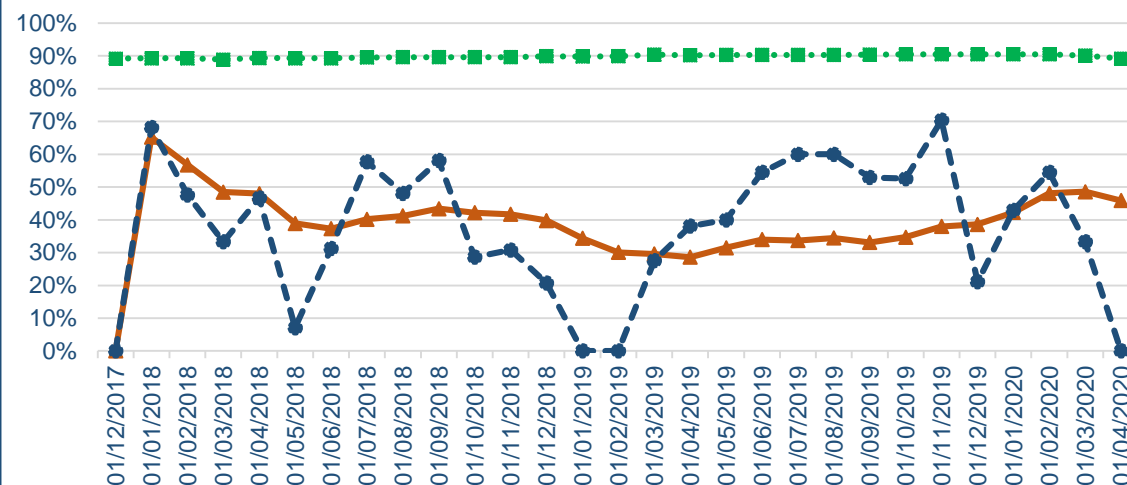
Prompt orthogeriatric review % - Wrexham Maelor Hospital

Graphs will be updated once they have been updated on the National Hip Fracture Database (NHFD) – *accessed 18nd August 2020*
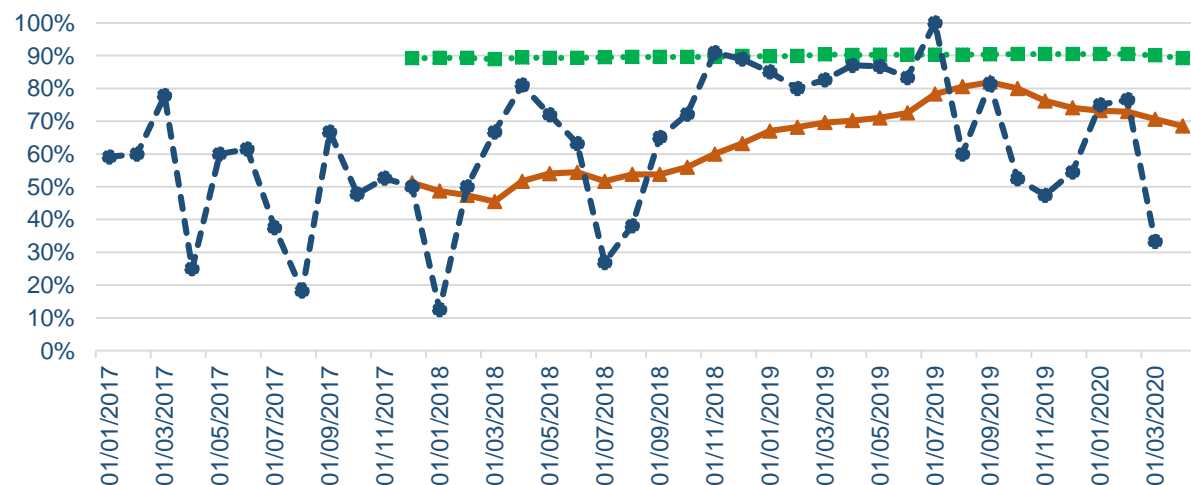
Key:

■ = UK Average (NHFD)

▲ = Annual (12 month) Average

● = Monthly

Source of Graphs and Data – National Hip Fracture Database (NHFD) – accessed 22nd June 2020

Further Information

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

- performance reference tables
- tolerances for red, amber and green
- the Welsh benchmark information which we have presented

Further information on our performance can be found online at:
- Our website   www.pbc.cymru.nhs.uk
                        www.bcu.wales.nhs.uk
- Stats Wales   www.statswales.wales.gov.uk

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 (QSE) Committee 28th August 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Serious Incident Report – June and July 2020
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Acting Associate Director of Quality Assurance & Assistant Director of Patient Safety and Experience
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance & Assistant Director of Patient Safety and Experience and Dr Kath Clarke, Head of Patient Safety
Craffu blaenorol: Prior Scrutiny:	Review by the responsible director and executive director
Atodiadau Appendices:	1. Serious Incident Report – June and July 2020

Argymhelliad / Recommendation:

The Quality, Safety and Experience Committee is asked to note the report.

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

Sefyllfa / Situation:

This report provides the Quality, Safety and Experience Committee with information and analysis on serious incidents and Never Events occurring in the last two months although 14 months of trend data is included to allow for period on period comparison in the last year. Longer-term thematic analysis is included in the quarterly Patient Safety Report.

Cefndir / Background:

A serious incident is defined as an incident (not exclusively a patient safety incident) that occurred in relation to NHS funded services and care resulting in: the unexpected or avoidable death of one or more patients, staff, visitors or members of the public, another serious occurrence from a specified list or one of the specified Never Events.

Asesiad / Assessment & Analysis

Assessment and analysis is included within the report including a breakdown of incidents by division/site, details of the most common type of reported serious incidents and a high-level summary of identified learning.

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

Serious Incident Report
June and July 2020

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

| 1. | **INTRODUCTION** |

1.1 A serious incident is defined as an incident (not exclusively a patient safety incident) that occurred in relation to NHS funded services and care resulting in:

- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- permanent harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy (this includes incidents graded under the NPSA definition of severe harm);
- a scenario that prevents or threatens to prevent an organisation's ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment;
- a person suffering from abuse;
- adverse media coverage or public concern for the organisation or the wider NHS;
- the core set of 'Never Events' as updated on an annual basis.

1.2 With effect from Monday 23rd March 2020, as part of interim COVID-19 contingency measures, only the following incidents need formally reporting to the Welsh Government under the serious incident framework (following a temporary revision to Putting Things Right (PTR) requirements advised by the Deputy Chief Medical Officer):

- never events
- maternal deaths
- neonatal deaths
- in-patient suicides
- mental health homicides
- unexpected deaths where the death is related to healthcare service delivery/failures
- Human Tissue Authority incidents
- IR(ME)R reportable radiation incidents
- other incidents of severe avoidable harm caused by healthcare service delivery/failures

1.3 The Health Board was advised by the Welsh Government on 13 August 2020 that the normal reporting criteria was to be reinstated. At the time of writing, this was being cascaded to across the Health Board.

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

1.5   Since April 2010, all serious incident notifications have been reported electronically to the Improving Patient Safety Team Mailbox at the Welsh Government. This should be done with 24 hours of the incident. The Welsh Government respond within 24 hours and set-out a grade of the incident:

- Grade 0 - Concerns currently and commonly referred to as a 'no surprise' and/or where it is initially unclear whether a serious incident has occurred will be graded 0. Unless further information is received, the Welsh Government will automatically close the incident after 3 days and no further correspondence with the Welsh Government is required.
- Grade 1 - It is expected that a comprehensive investigation will need to be completed by the Health Board organisation within 2 calendar months. In order to close this incident the Welsh Government require confirmation that an appropriate investigation has been undertaken, has been reported to an appropriate committee, an action plan developed and where relevant has identified any actions for wider learning and dissemination. A closure/update report form is completed and submitted for this purpose.
- Grade 2 - This will follow a similar process to the above. A comprehensive investigation is required, and in some cases the incident may be referred for independent external review by Health Inspectorate Wales (HIW) or another regulatory body. Grade 2 incidents will be subject to ongoing monitoring by Welsh Government and final agreement through its Patient Safety Committee that the incident has been investigated appropriately and thoroughly before closure. Examples of such incidents could include mental health homicides, maternal deaths, clusters of similar incidents and never events.

1.6   This report provides the Quality, Safety and Experience Committee with information and analysis on serious incidents and Never Events occurring in the last month and a half (since the Committee's last meeting) although 14 months of trend data is included to allow for period on period comparison in the last year. Longer-term thematic analysis is included in the Patient Safety Report.

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

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

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

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

2. OVERALL SERIOUS INCIDENTS

2.1 During the time period under review, 11 serious incidents were reported compared to 76 in the comparable prior period (please note the change in PTR reporting criteria outlined above).

Reportable Serious Incidents -BCUHB starting 01/06/19
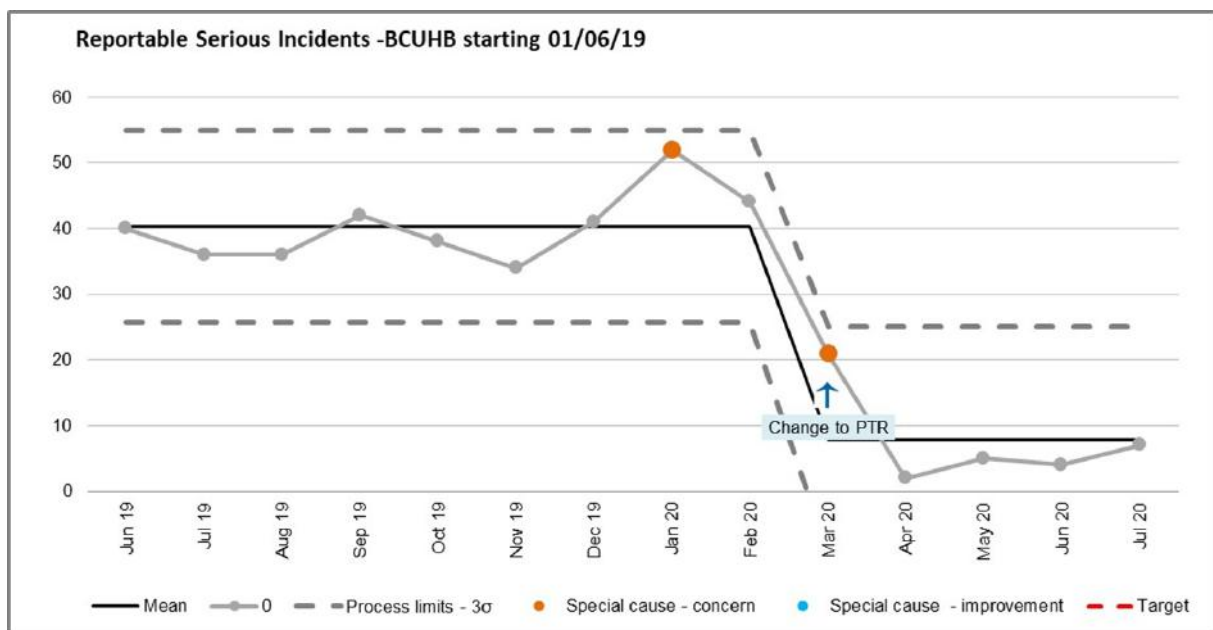
2.2 The following chart shows incidents with Major or Catastrophic outcomes. Although it appears to show a significant increase in May 2020 and June, please note this primarily relates to staff who have tested positive for COVID and have been initially logged as Major outcomes. Many of these will be downgraded as the incidents are investigated and reviewed. The remainder of the increase relates to COVID outbreaks on the wards. When this data is excluded, there does not appear to be an increase in incidents with Major or Catastrophic outcomes

Incidents with Major or Catastrophic Outcomes-BCUHB starting 01/06/19

Legend: Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target
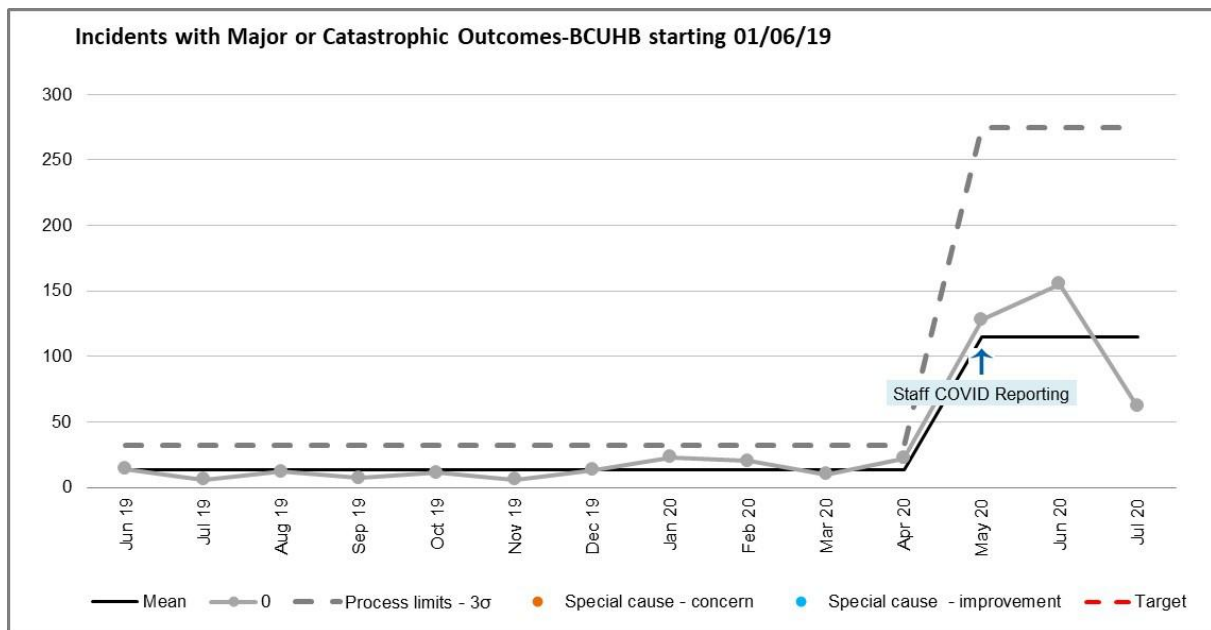
2.3 During the two months under review, form the 11 incidents, there were no themes or hot spots. Since April 2020, COVID related infection control incidents remain the most common category of serious incident.

2.4 At the time of writing, 46 serious incidents remain open with Welsh Government (down from 59 in the last report) of which 36 are overdue (down from 46 in the last report). Of these, the predominance of overdue incidents relate to Central Area (8) and Mental Health and Learning Disability (6). All divisions have seen and continue to see a reduction in overdue incidents. A small number of incidents are overdue by twelve months (4) and these mostly relate to matters subject to police investigation. A number (8) are overdue by 6-12 months and a larger number (10) are overdue by 3-6 months. There has been significant reduction over the last 12 months and divisional governance teams are taking focused action to reduce this further.

2.5 Overall closure rate within timeframe for the year is around 64%, the highest ever achieved by the Health Board although remaining behind the national target of 75%.

2.6 The Patient Safety and Experience Department were planning a comprehensive review of the incident process and this will be conducted in co-production with divisions and other stakeholders. This work was due to commence in March 2020 but due to COVID 19 pandemic has been put on hold for the foreseeable future. A revised plan has now been developed and the intention is to engage and develop a new process for launch on 01 January 2021. This will allow time for engagement (July/August), development (September), approval (October), and implementation including training and system changes (November/December).

3. SPECIFIC SERIOUS INCIDENTS

3.1 The following serious incidents reported during the reporting period are being specifically highlighted for the attention of the Committee:

- Ysbyty Glan Clwyd (YGC) – Delayed diagnosis of cancer arising from process errors.
- YGC – Death of a staff member with possible occupational exposure to COVID-19.
- Mental Health & Learning Disabilities (MHLD) – Three unexpected deaths of patients open to community services (cause unknown).

4. NEVER EVENTS

4.1 During the reporting period, one Never Event was reported:

- Wrexham Maelor Hospital (WMH) - The incident has been categorised as wrong site surgery. Following intra-vitreal injection to the eye, the patient complained of loss of vision. Intra-ocular pressure was found to be high. The patient underwent urgent paracentesis. Following this emergency procedure the patient advised that the loss of vision was in other eye. Paracentesis subsequently performed on correct eye which led to restoration of vision. The unintended paracentesis resulted in no harm. Lessons learnt following the Make it Safe rapid review identified a Local Safety Standard for Invasive Procedures (LocSSIPs) proforma must be used prior to undertaking any procedures, unless on the rare occasion a delay would negatively impact patient care, in which case this needs to be documented in the patient's notes after the event.

4.2 In total, three Never Events have been reported so far in 2020 – all three fall into the "wrong site surgery" bracket and the lack of or failure to use a LocSSIPs is a theme. The Quality and Safety Group has requested a detailed assurance plan from the Secondary Care Division to address these concerns.

4.3 During the reporting period no Never Events were closed.

5. LEARNING FROM SI REVIEWS

5.1 The current serious incident process has been amended in response to Welsh Government changes to PTR and the current COVID 19 pandemic. The rapid review has been replaced with a "Make it Safe" process. A "Make it Safe Review" must be completed by the service within 72 hours for all severe and catastrophic incidents and submitted to the Corporate Patient Safety and Experience Department who will make a decision on whether the incident can be closed or whether a full serious incident review is needed. The decision will be communicated to the service within 24 hours. If the incident can be closed the Corporate Patient Safety and Experience Department will complete the Welsh Government closure form.

5.3 Due to the low numbers of serious incidents occurring in the period under review (11), no new themes or trends have been identified to those previously reported.

5.4 A number of recurring issues have been identified in relation to surgical incidents and Never Events as outlined above.

6. CONCLUSION AND RECOMMENDATIONS

6.1 This report provides the Quality, Safety and Experience Committee with information and analysis on serious incidents and Never Events occurring in the last two months although 14 months of overall trend data is included (section 2.1 and 2.2) to allow for period on period comparison in the last year. Longer-term thematic analysis is included in the quarterly Patient Safety Report.

6.2 The QSE Committee is asked to note the report.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 28th August 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Make it Safe Process (Updated Rapid Review Process)
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Acting Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience and
Craffu blaenorol: Prior Scrutiny:	Review by responsible director and executive director
Atodiadau Appendices:	1. Make it Safe Template

Argymhelliad / Recommendation:

The QSE Committee is asked to note this report.

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**	

Sefyllfa / Situation:

As a result of the COVID-19 pandemic, revised internal incident processes and national changes to the serious incident process were implemented. These changes were designed to increase the level of support, governance and improve the rapid sharing of learning during the pandemic. This paper focuses on the Make it Safe process implemented during COVID-19.

The Make it Safe process replaced the Rapid Review process and consists of the following:

- Where a potential serious incident has occurred, or another significant occurrence, the service governance team facilitate a Make it Safe review within 72 hours led by a senior clinician. This review focus on any immediate learning and actions needed to make safe the current situation.

- The Make it Safe review is submitted to the Corporate Patient Safety Team, and a virtual panel of at least two senior members of the team (normally the Assistant Director of Patient Safety and Experience and Head of Patient Safety) review and scrutinise the review and either:

  - Request additional information or assurance, or sharing of learning;
  - Commission a serious incident review in line with national and Health Board policy;
  - Determine that no further action is needed.

Cefndir / Background:

Prior to the implementation of the Make it Safe process, divisions completed Rapid Reviews. The decision to complete a rapid review, the scrutiny and sign off for the review, and the decision to progress to a serious incident review all rested within the decision. Additionally, custom and practice had developed that rapid reviews routinely took longer than 72 hours and had become seen as a level of serious incident investigation in their own right.

A full re-design of the incident and serious incident process is underway as reported previously. This commenced pre-COVID-19 before being paused due to the pandemic, and has re-commenced in July. A new process is targeted for implementation in January 2021. Early feedback from the review has identified that the Make it Safe process is considered an improved approach and is likely to feature in the new overall process.

A new Datix system is planned for implementation in 2021 and this will include an updated incident module and a new investigation module and serious incident reporting module. This work is part of the national Once for Wales Concerns Management System.

The Welsh Government are currently reviewing the national serious incident framework with a new policy expected by the end of the year.

Additionally, Welsh Government are preparing guidance on the new statutory duty of candour which is expected to come into force in April 2022.

Collectively, these fundamental changes present an opportunity to further improve the incident and serious incident process within the Health Board. This will be facilitated through the incident process re-design.

A new human factors faculty is also being established within the Health Board that will underpin a fundamental shift in methodology for investigations. Work on just culture is proposed to commence later in the year.

Asesiad / Assessment & Analysis

The new Make is Safe process has improved the oversight and scrutiny of incidents and has added an additional layer of governance into the incident process. It has also re-focused the purpose of the rapid review element of the process back to immediate learning and improvements to make safe.

The quality of Make it Safe reviews is generally good. However, a challenge remains in the timeliness of the Make it Safe reviews. Whilst this is better than the previous rapid review, it is not performing as intended. Because the process was instigated as a temporary COVID-19 measure, no changes were made to the Datix system to allow monitoring of overdue and incomplete reviews (i.e. the responsibility for determine when a Make it Safe review is needed and for ensuring this is done on time is entirely within divisions). This will be addressed shortly so improved data and oversight is in place.

Make it Safe Review

Following the reporting of a catastrophic or major category incident

APPENDIX 1

INC Reference		**Incident Grading**	
Area		**Location**	
Who did it affect? (do not include personal details)		**Age of patient (if known)**	
Date and time of Incident		**Date of Review**	
Review team			
Summary of incident (taken from Datix)			
Brief description of what happened			
Review discussion (brief)			

Actions taken and planned to make it safe	**Action**	**Lead**	**Deadline**

Lessons learned	

Has this been reported to WG?		Has this been referred to the coroner?	
Recommendation for any further review		Further information required?	

Notes	

Please send this completed form to the Corporate Patent Safety and Experience Department via: BCU.WelshGovernmentIncidents@wales.nhs.uk.

This form should be completed and submitted within 72 hour of the incident occurring.

The Corporate Patent Safety and Experience Department will determine whether this incident requires a serious incident review, and will submit the closure form to WG (if applicable).

Decision – For Corporate patient Safety & Experience use only:	

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 28th August 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quality Governance Structure Review
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Acting Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience
Awdur yr Adroddiad Report Author:	Anne Hall, Head of Quality Assurance Erika Dennis, Business Manager (Quality Assurance and Regulation)
Craffu blaenorol: Prior Scrutiny:	Review by responsible director and executive director
Atodiadau Appendices:	A) Proposed sub-structure to QSE Committee B) Terms of Reference of proposed Groups reporting into QSE C) Cycles of Business for proposed Groups D) Report front sheet E) Agenda template F) Minutes template G) Standardised Triple AAA Chair's report template H) Action log template

Argymhelliad / Recommendation:

The QSE Committee is asked to:

1. Approve the formal creation of four permanent groups reporting into the Committee, namely the Patient Safety and Quality Group, Clinical Effectiveness Group, Patient and Carer Experience Group and Strategic Occupational Health and Safety Group (as shown on Appendix A).
2. Approve the requirement that any changes to the structure must have approval of either the Committee for changes to its reporting groups, or the new groups for the sub-structure.
3. Approve the terms of reference for the four groups (Appendix B).
4. Approve standard templates (Appendix D-H) for usage across the quality governance structure (initial draft templates are attached with version control to be maintained by the Corporate Quality Assurance Team).
5. Approve the use of a new Chair's Report template (Appendix G) (replacing the Issues of Significance Report) with the principle that every meeting reports into its parent group through a Chair's Report.
6. Note the cycles of business for the four groups (Appendix C) (which will be further refined by each group).
7. Approve commencement of phase 2 of this work looking at the sub-structure beneath these four groups including divisional quality governance structures (this specifically includes the instruction that the term Committee is not to be used outside of a Board Committee).

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**	**X**	**Er gwybodaeth For Information**	

Sefyllfa / Situation:
Currently the Quality, Safety and Experience Committee (QS&E) has delegated powers authorised by the Board that are in respect of its provision of advice and assurance to the Board. The Quality and Safety Group (QSG) reports into QSE as the primary sub-group.

Cefndir / Background:
Phase 1 – work completed so far A review has been completed of the quality governance structure in line with discussions held pre-COVID-19 including specific consideration of QSG. This work is part of the Quality Governance Self-Assessment Acton Plan from January 2020. The remit and purpose of the review is to further develop the assurances required by QSE of working to its delegated function and authority from the Board. This includes rationalising the flow of information and reporting up into QSE. The Committee is asked to approve formally that the QSG meeting is split into 4 groups i.e. Patient Safety and Quality, Patient and Carer Experience, Clinical Effectiveness and Strategic Occupational Health and Safety. These groups will report directly into the Quality, Safety & Experience Committee. A schematic of the proposed structure is at Appendix A. This provides an opportunity to revise and develop Terms of Reference for each Group to further support QSE in fulfilling its duty and responsibilities concerning its delegated powers from the Board. The review undertaken has included; 1. Review of Terms of Reference for groups reporting into QSE 2. Development of cycles of business for each proposed group 3. Further development of standardised meeting templates The review has been completed by engagement with relevant Chairs and meeting members. Enclosed are terms of reference and proposed cycles of business for all four groups: Clinical Effectiveness, Strategic Occupational Health and Safety, Patient Safety and Quality and the Patient and Carer Experience Group for approval. The introduction of a new format Chair's Report (structured around a "Triple AAA" reporting framework – Appendix G) for these meetings will ensure consistency and support a strengthened assurance for groups reporting into QSE. Triple AAA Chair's Report intend to replace the 'Issues of Significance' (IOS) reports. It will prompt discussion of achievements as well as urgent alert issues and assurance.

Templates also play a key role as they provide a consistent approach and have been produced with the intention of a standardised approach to meetings.

As proposed in Phase 2 below, a training package will be offered to the Chairs and Secretariat of the 4 Groups.

It is important that the proposed four groups are working to their Terms of Reference with a cycle of business that supports their delegated duties, including matters for escalation. This will also ensure that assurance and improvement are integral parts of BUCHB quality governance structure.

Phase two – proposed work

Moving forward, the review will widen to ensure the following:

- Review and agreement of standard terminology as set out in the Health Board Standing Orders; Committee, Sub-committee, Group, and Sub-group.
- Review and rationalise reporting sub-groups into the proposed Groups reporting into QSE, commencing with Clinical Effectiveness.
- Review Divisional quality governance meeting structures and functions, currently reporting up to QSG to ensure alignment and standardisation. This will also strengthen the links between corporate and operational governance.
- The creation of a master library for Health Board wide governance meetings
- Divisions adopt the standardised templates contained within this Report that are filed in the master library.
- Ensure that agreed templates are available in both Welsh and English mediums.
- Exploration of moving all governance meeting administration onto Admin Control.
- Development of a procedural document that "locks down" any changes to the quality governance meeting structure without appropriate approval.
- Support and training to be offered to Chairs and Secretariat for reporting groups
- Consider an internal or external audit of the new structure post-implementation.

Implementation Plan:

It is proposed that the new groups come into effect from 01 October with a three month window of targeted support from the Corporate Quality Assurance Team. This date ensures alignment with the new Risk Management Strategy.

Phase 2 will commence in September 2020 with the review of corporate and divisional meetings by 31 December 2020 and implementation of changes by 31 March 2021. This allows for detailed engagement with stakeholders, an implementation period recognising winter pressures and alignment with the Quality Strategy.

Asesiad / Assessment & Analysis

Strategy Implication

The establishment of these four new groups to replace QSG will provide a strengthened, coordinated and comprehensive approach to Board assurance, quality governance and risk management processes.

Financial Implications

Resource to undertake the review has been identified within the Quality Assurance and Patient Safety and Experience Teams. A reduction in meetings has the potential to release efficiencies.

Risk Analysis

Further work will be required to align divisional meetings reporting into the proposed groups and to achieve consistency across the Health Board. The review so far has also identified possible reporting gaps – such as the visibility of primary care, children's services, cancer services, vascular services and North Wales managed clinical services. This will be explored during phase 2.

Legal and Compliance

Standing Orders (SOs) are the regulation for the Health Boards proceedings and business. The work has been be completed in accordance with the Health Board Standing Orders.

Impact Assessment

This report is focussed on the quality governance and assurance function of the Board and there are no associated impacts or specific assessments required.

Proposed sub-structure under QSE Committee

	Patient Safety and Quality Group	Clinical Effectiveness Group	Patient and Carer Experience Group	Strategic Occupational Health and Safety Group
Predecessor	Quality and Safety Group	N/A - established	Listening and Learning Group	N/A - established
Chair	Executive Director of Nursing and Midwifery	Deputy Executive Medical Director	Associate Director of Quality Assurance	Executive Director of Workforce and OD
Vice Chair	Executive Medical Director	Senior Associate Medical Director	Associate Director of Nursing	Associate Director of Health, Safety and Equality
Secretary	PA to AD of Quality Assurance	PA to Deputy Executive Medical Director	PA to AD of Quality Assurance	PA to Executive Director of Workforce and OD
Frequency	Monthly	Bi-monthly	Bi-monthly	Bi-monthly
Membership	Divisional Nurse Directors or agreed representative (6) AD of Quality Assurance AD of Nursing Deputy Executive Medical Director Senior Associate Medical Director Director of Estates and Facilities Director of Performance AD of Safeguarding AD of IPC AD of HS&E Clinical Director of Therapy Services Chief Pharmacist or Medications Safety Officer * chairs of subgroups in attendance	Divisional Medical Directors or agreed representative (6) PHW Consultant AD of Nursing AD of Medical Physics AD of Research and Development Chief Pharmacist Clinical Director of Therapy Services Head of Clinical Effectiveness and Audit Head of Quality Assurance * chairs of subgroups in attendance	Senior Division Representatives (6) Head of Patient and Carer Experience Head of Engagement Head of Equality and Human Rights Head of Organisational Development Head of Welsh Language Head of Transforming Nursing Care *In attendance:* Patient Representative Carer Representative CHC Representative HIW Relationship Manager * chairs of subgroups in attendance	Senior Division Representatives (6) Trade Union Representatives Executive Director of Planning & Performance AD of HSE AD of Quality Assurance Director of Estates and Facilities Fire Safety Lead AD of Workforce and OD AD of IPC Head of Risk Management Head of Health & Safety Head of Occupational Health and Wellbeing Senior Division Representatives * chairs of subgroups in attendance
Reporting Out	Chair's Report to QSE	Chair's Report to QSE	Chair's Report to QSE	Chair's Report to QSE

(to QSE)	Quality Report Patient Safety Report IPC Report Nurse Staffing Report Safeguarding Report Annual Quality Statement Annual PTR Report	Clinical Audit Report Research Report	Patient and Carer Experience Report Accessible Healthcare Report Learning from Experience Assurance Framework	Quarterly Occupational Health and Safety Report
Remit	Quality Strategy Patient Safety Strategy Quality Assurance Quality Regulation Patient Safety Incidents/Serous Incidents Safety Alerts Infection Prevention Control Safeguarding Safe Staffing Inquests/Claims/Redress External reports	Quality Improvement Clinical Effectiveness Clinical Pathways NICE Mortality Clinical Outcomes Prudent Healthcare Clinical Audit Research and Development Medical Engineering Medical Devices Medicines Optimisation	Patient and Carer Experience Strategy Patient and Carer Feedback Patient and Carer Involvement Complaints PSOW CHC Bereavement Accessible Healthcare	Occupational Safety Occupational Health Fire Safety Estates Safety (Asbestos, Legionella, etc) Statutory H&S Consultative Committee (SRSC Regs 1977)
Reporting In (from Divisions)	Chair's Report from Divisional Quality Group (6)	Chair's Report from Divisional Quality Group (6)	Chair's Report from Divisional Quality Group (6)	Chair's Report from Divisional Quality Group (6)
Reporting In (from Sub-groups)	Chair's Report	Chair's Report	Chair's Report	Chair's Report
Sub-groups	Divisional Quality Groups (7) Safeguarding Governance and Performance Group IPC Group Decontamination Group PPE Group Quality Dashboard Group Quality and Concerns Management Systems Group HASCAS/Ockenden Group	Divisional Quality Groups (7) Clinical Improvement & Audit Group North Wales Managed Clinical Services Quality Group Mental Health & Learning Disabilities Clinical Effectiveness Group New Technologies Oversight group Medical Devices Oversight Group Reducing Mortality Group NICE Assurance Group	Divisional Quality Groups (7) Patient Communication and Readers Panels Bereavement Quality Group	Divisional H&S Groups (7) Health and Safety Leads Group Operational Occupational Health and Safety Group Health and Wellbeing Group Asbestos Management Group Security Management Group Fire Safety Group Water Safety Group Electrical Safety Group Medical Device/Gases Group

		Radiation Protection Group		
		Pathology (including Blood Transfusion Group and Point of Care		
		Resuscitation Group		
		Drugs and Therapeutics Group		
		Safer Medicines Steering Group		
		Medication Safety Group		
		Trauma Group		
		Clinical Law and Ethics Group		

Appendix B

Terms of Reference of Proposed Groups reporting into QSE

Strategic Occupational Health and Safety Group (SOHS)

1) INTRODUCTION

1.1 Section 2 (7) of the Health and Safety at Work etc. Act 1974 states that "In such cases as may be prescribed it shall be the duty of every employer, if requested to do so by the safety representatives mentioned in subsections (4) and (5), to establish, in accordance with regulations made by the Secretary of State, a safety committee having the function of keeping under review the measures taken to ensure the Health and Safety at work of his employees and such other functions as may be prescribed. These arrangements are aligned to the Safety Committees Regulation 1977 and the Health and Safety (Consultation with Employees) Regulations 1996 (as amended).

1.2 The Strategic Occupational Health and Safety Group has been established to provide an effective means of facilitating a partnership approach to the management of Health and Safety risk across the Betsi Cadwaladr University Health Board (BCUHB). Thus providing compliance with the requirements of Statutory Legislation, approved codes of practice and guidance documentation.

1.3 The Quality, Safety and Experience Committee (QSE) has agreed to establish the Strategic Occupational Health & Safety Group. The detailed terms of reference and operating arrangements in respect of this Group are set out below.

2) PURPOSE

2.1 The purpose of the SOHSG is to provide the means by which the management and staff representatives can work in partnership, to develop and maintain health and safety management arrangements across the Health Board.

2.2 The SOHSG will ensure that an integrated approach to the identification and management of workplace health and safety risk is maintained throughout the organisation.

2.3 The SOHSG will support the development of a positive safety culture and safety management system that enhances the organisations ability to identify and manage risks to those affected by their work activity.

3) DELEGATED POWERS AND AUTHORITY

3.1 The Executive Director of Workforce and Organisational Development has lead responsibility for the Management of Occupational Health and Safety within the Health Board. The specific powers, duties and responsibilities delegated to the Executive Director of Workforce and Organisational Development from the Chief Executive are:-

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3.1.1   To chair the Strategic Occupational Health and Safety Group.

3.1.2   To make recommendations for risk based improvements to the management of occupational health and safety risk across the Health Board.

3.1.3   To ensure the implementation of relevant policies, procedures and other written control documents that enable the Health Board to meet the requirements of Statutory Health and Safety Legislation.

3.1.4   Ensure competent health and safety advice and guidance is available.

3.1.5   Submit regular assurance reports to the Health Board through the Quality, Safety, and Experience Committee for consideration as part of the Integrated Governance through to the Health Board.

3.2   The SOHSG in respect of its provision of advice and assurance will and is authorised by the QSE to:-

3.2.1   Provide assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects impacting on patient care, quality, safety and experience;

3.2.2   Provide assurance on the robustness and appropriateness of Health and Safety arrangements for Occupational Safety, Occupational Health, Fire Safety, Estates Safety (Asbestos, Legionella, etc.) and Statutory H&S Consultative Committee (SRSC Regs 1977

3.2.3   Monitor the effectiveness of the Health and Safety arrangements in Divisions and on hospital sites, ensuring consistency with BCU corporate governance arrangements;

3.2.4   Escalate Health and Safety proposals with financial implications as necessary
to QSE;

3.2.5   Review and monitor clinical risks from Divisions and be proactive to ensure that QSE is aware of emerging risks and that appropriate Health and Safety mitigations are in place;

3.2.6   Review Health and Safety Risks on the Risk Register (appropriateness of the scoring and mitigating actions in place);

3.2.7   Report formally, regularly and on a timely basis to the Health Board on the Group's activities. Including the presentation of an Annual Report.

3.2.8   Submit the Group's minutes and issues of significance to the Quality, Safety and Experience Committee for consideration as part of the Integrated Governance Committee through to the Health Board.

3.2.9   Ensure arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees/Groups of any

urgent/critical matters that may affect the safety of staff and others and the operation and/or reputation of the Health Board

3.2.10 Provide assurance to the Risk Management Group by raising risks through the governance structure as necessary and providing quarterly and annual reports to the Group

3.2.11 Provide assurance in terms of the effective management of Occupational Health and Safety risk across all activities and facilities within the Health Board.

3.2.12 Ensure that effective partnership working arrangements are maintained between Management and Staff Health and Safety Representatives.

3.2.13 Provide assurance that occupational health and safety management arrangements within the Health Board meet the requirements of the Health and Safety at Work etc. Act 1974 and supporting legislation.

3.2.14 Receive occupational health and safety management reports from all clinical and corporate Departments.

3.2.15 Monitor the delivery of the Health Board's risk Health & Safety and performance reporting systems.

3.2.16 Monitor actions being taken to address significant occupational health and safety risks within the organisation.

3.2.17 Monitor the delivery of the Health Boards health and safety improvement plan in response to identified areas of improvement within the organisation.

3.2.18 Continued development of the Occupational Health and Safety Policy and supporting documents and management arrangements.

3.2.19 Report on performance in respect of the key health and safety performance indicators within the Health Board.

4) Authority

4.1 The Group may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee - and all employees are directed to cooperate with any legitimate request made by the Group; and
- other Groups to assist in the delivery of its functions

4.2 It may consider and where appropriate, approve on behalf of QSE any procedure within the remit of the Group business

4.3 Review the relevant risks from the Corporate Risk Register that are assigned to the Group by QSE and advise QSE on the appropriateness of the scoring and mitigating actions in place.

5) GROUP

5.1 The Group may, establish Groups or task and finish groups to carry out work on specific aspects of the Groups business. In addition, all Divisional Health and Safety Groups will be accountable to this Strategic Group;

5.2 The current established Groups reporting into the SOHSG include;

Health and Safety Leads Group
Operational Occupational Health and Safety Group
Health and Wellbeing Group
Asbestos Management Group
Security Management Group
Fire Safety Group
Water Safety Group
Electrical Safety Group
Medical Gases Group

6) MEMBERSHIP

6.1 Chair: Executive Director of Workforce and Organisational Development

6.2 Vice Chair: Associate Director of Health, Safety and Equality

6.3 Members:

Trade Union Health and Safety Representatives (in line with the Local Partnership TOR including representatives of employee safety)
Executive Director of Planning & Performance
Associate Director of Health, Safety and Equality
Associate Director of Quality Assurance
Director of Estates and Facilities
Fire Safety Lead
Associate Director of Workforce and OD
Assistant Director of Infection Prevention and Control
Head of Risk Management
Head of Health & Safety
Head of Occupational Health and Wellbeing
Senior Division Representatives

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The Chairs of the sub-groups will be in attendance is not already a member:

Health and Safety Leads Group Chair or Representative
Operational Occupational Health and Safety Group Chair or Representative
Health and Wellbeing Group Chair or Representative
Asbestos Management Group Chair or Representative
Security Management Group Chair or Representative
Fire Safety Group Chair or Representative
Water Safety Group Chair or Representative
Electrical Safety Group Chair or Representative
Medical Gases Group Chair or Representative

6.4 Invites are extended to:

6.4.1 Public Health Wales Representative

6.5 Secretariat

6.5.1   Determined by Executive Director of Workforce and Organisational Development.

6.5.2   Meeting minutes will be maintained, with names attached to allocated actions and collated into an action log. Minutes and the action log will be circulated within10 working days and approved at the next meeting.

6.6 Support to Group Members

6.6.1   All members may submit requests for inclusion of items on the agenda.

6.6.2   If unable to attend the meeting, members are required to arrange a representative to attend on their behalf, who is able to actively contribute to the meeting discussions.

7) GROUP MEETINGS

7.1   Quorum

7.1.1 At least ½ of members (one of which must be the Chair or Vice Chair) must be present to ensure the quorum of the Group.

7.2   Frequency of Meetings

7.2.1 Meetings shall be held bi-monthly and otherwise, as the Chair of the Group deems necessary.

7.3   Withdrawal of individuals in attendance

7.3.1 The Group may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular

matters.

8) RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES /GROUPS

8.1 The Group is directly accountable to QSE for its performance in exercising the functions set out in these Terms of Reference.

8.2 The Group, through its Chair and members, shall work closely with the other Groups to provide advice and assurance by contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the overall risk and assurance arrangements.

9) REPORTING AND ASSURANCE ARRANGEMENTS

9.1 Meeting minutes will be maintained, with names attached to allocated actions and collated into an action tracker. Minutes and action log (reviewed by the Chair) will be circulated within 10 working days and approved at the next meeting.

9.2 The Chair will report formally, to QSE. This includes verbal updates, the submission of regular Chair's written reports.

9.3 The Chair will also ensure appropriate escalation arrangements are in place to alert QSE of any urgent/critical matters that may affect patient and carer experience.

9.4 A Group meeting effectiveness review will be completed annually.

10) REVIEW

10.1 These Terms of Reference and operating arrangements will be reviewed annually as part of the meeting annual cycle of business.

11) CHAIR'S ACTION ON URGENT MATTERS

11.1 There may, occasionally, be circumstances where decisions, which would normally be made by the Group, need to be taken between scheduled meetings. In these circumstances, the Chair, supported by the Secretariat as appropriate, may deal with the matter on behalf of the Group. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting for consideration and ratification.

11.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

11.3 To assist the Health Board in the conduct of its business, the function of this

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Group is to provide advice and assurance to QSE in relation to its responsibilities for Strategic Occupational Health and Safety.

Appendix B

Clinical Effectiveness Group (CE)

1) INTRODUCTION

1.1 The Quality, Safety and Experience Committee (QSE) has agreed to establish the Clinical Effectiveness Group. The detailed terms of reference and operating arrangements in respect of this Group are set out below.

2) PURPOSE

2.1 The purpose of the Group is to provide advice and assurance to QSE in discharging its functions and meeting its responsibilities with regard to the Clinical Effectiveness of health services.

3) DELEGATED POWERS AND AUTHORITY

3.1 The CE Group, in respect of its provision of advice and assurance will and is authorised by the QSE to:-

3.1.2 Provide a strategic oversight and leadership in relation to the clinical effectiveness agenda within BCUHB in line with the following Principles of Prudent Healthcare;

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production;
- Care for those with the greatest health need first, making the most effective use of all skills and resources;
- Do only what is needed, no more;
- Do no harm;
- Reduce inappropriate variation using evidence-based practices consistently and transparently.

3.1.3 Achieving prudent healthcare in NHS Wales (2014)

- Drive improvements in the quality and safety of healthcare it is important that decisions, including clinical decisions are based on the best available evidence and information.

3.1.4 Health & Care Standards for Wales (2015)

- Patients achieve health benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes

3.1.5 NHS Wales Care Principles for the Improvement of Care (2014)

- The extent to which specific clinical interventions when deployed in the field for a particular patient or population do what they are intended to do i.e. maintain and improve the greatest possible health gain from the available

resources

3.1.6 A framework for action in and through the NHS (1996)

- Value-based healthcare is the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences for every person. Defining Value-based Healthcare in the NHS): Centre for Evidence-Based Medicine Report (2019)

3.1.7 Ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals; stated priorities within the Quality Strategy and the principle of continuous quality improvement including organisational learning are in place;

3.1.8 Develop a Clinical Effectiveness Strategy and priority setting to include national themes, 'Prudent Healthcare' and 'Value Based Healthcare'

3.1.9 Provide assurance that systems are in place to review and monitor the ongoing development and implementation of the Clinical Effectiveness Strategy including a system for urgent escalation and resolution of issues;

3.1.11 Provide assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) and scrutinize the quality dimensions contained within the IQPR;

3.1.12 Receive periodic updates in respect of the flu vaccination programme including workforce

3.1.13 Receive assurance and relevant reports from HMT's/Areas that National Confidential Enquiries are implemented and monitored as required;

3.1.14 Provide an Annual Report to QSE providing assurance that the Group has met its terms of reference and key duties;

3.1.15 Enable the Health Board to demonstrate improvements through metrics and monitoring tools;

3.1.16 Review and monitor Divisional clinical effectiveness risks and be proactive to ensure that QSE is aware of emerging risks and that appropriate scoring and mitigating actions ae in place;

3.1.17 Review clinical effectiveness risks on the Risk Register including appropriate scoring and mitigating actions are in place

4) AUTHORITY

4.1 The Group may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee - and all employees are directed to cooperate with any legitimate request made by the Group; and
- other Groups to assist in the delivery of its functions.

4.2 It may consider and where appropriate, approve on behalf of QSE any procedure within the remit of the group business concerning clinical effectiveness.

4.3 It will review the relevant risks from the Corporate Risk Register that are assigned to the Group by QSE and advise QSE on the appropriateness of the scoring and mitigating actions in place.

5) GROUPS

5.1 The Group may, establish groups or task and finish groups to carry out work on specific aspects of the Groups business. The current established groups reporting into the CE Group include:

Clinical Improvement & Audit Group

North Wales Managed Clinical Services Quality Committee

Mental Health & Learning Disabilities Clinical Effectiveness Group

New Technologies Oversight Committee

Medical Devices Oversight Group

Reducing Mortality Group

NICE Assurance Group

Radiation Protection Committee

Pathology (including Blood Transfusion Committee and Point of Care

Resuscitation Committee

Drugs and Therapeutics Group

Safer Medicines Steering Group

Trauma Group

Clinical Law and Ethics Group Clinical Law and Ethics Group

6) MEMBERSHIP

6.1 Chair: Deputy Medical Director

6.2 Vice Chair: Senior Associate Medical Director

6.3 Members: Deputy Executive Medical Director

- Public Health Wales Consultant
- Associate Director of Nursing
- Associate Director of Medical Physics
- Associate Director of Research and Development

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- Chief Pharmacist
- Clinical Director of Therapy Services
- Head of Clinical Effectiveness and Audit
- Head of Quality Assurance
- Divisional Medical Directors or agreed representative

The Chairs of the sub-groups will be in attendance is not already a member:

- Clinical Improvement & Audit Group Chair or Representative
- North Wales Managed Clinical Services Quality Committee Chair or Representative
- Mental Health & Learning Disabilities Clinical Effectiveness Group Chair or Representative
- New Technologies Oversight Committee Chair or Representative
- Medical Devices Oversight Group Chair or Representative
- Reducing Mortality Group Chair or Representative
- NICE Assurance Group Chair or Representative
- Radiation Protection Committee Chair or Representative
- Pathology (including Blood Transfusion Committee and Point of Care Chair or Representative
- Resuscitation Committee Chair or Representative
- Drugs and Therapeutics Group Chair or Representative
- Safer Medicines Steering Group Chair or Representative
- Trauma Group Chair or Representative
- Value Based Healthcare Group Chair or Representative
- Clinical Law and Ethics Group Clinical Law and Ethics Group Chair or Representative

6.4 Invites are extended to:

6.4.1. Primary Care Representation
6.4.3 Women's Services

6.5 Secretariat

6.5.1 PA to Deputy Medical Director
6.5.2 Meeting minutes will be maintained, with names attached to allocated actions and collated into an action log. Minutes will be circulated within 10 working days and approved at the next meeting.

6.6 Support to Group Members

6.6.1 All members may submit requests for inclusion of items on the agenda.

6.6.2 If unable to attend the meeting, members are required to arrange a representative to attend on their behalf, who is able to actively contribute to the meeting discussions.

7) GROUP MEETINGS

7.1 Quorum

7.1.1 At the least ½ of members plus one including the chair or vice chair who must be present to ensure the quorum of the Group.

7.2 Frequency of Meetings

7.2.1 Meetings shall be held no less than bi-monthly and otherwise, as the Chair of the Group deems necessary.

7.3 Withdrawal of individuals in attendance

7.3.1 The Group may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

8) RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES /GROUPS

8.1 The Group is directly accountable to QSE for its performance in exercising the functions set out in these Terms of Reference.

8.2 The Group, through its Chair and members, shall work closely with the other Groups to provide advice and assurance by contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the overall risk and assurance arrangements.

9) REPORTING AND ASSURANCE ARRANGEMENTS

9.1 Meeting minutes will be maintained, with names attached to allocated actions and collated into an action tracker. Minutes and actions (reviewed by the Chair) will be circulated within 1 week and approved at the next meeting.

9.2 The Chair will report formally, to QSE. This includes verbal updates, the submission of regular Chair's written reports.

9.3 The Chair will also ensure appropriate escalation arrangements are in place to alert QSE of any urgent/critical matters that may affect patient and carer experience.

9.4 A Group meeting effectiveness review will be completed annually.

10) REVIEW

10.1   These terms of reference and operating arrangements will be reviewed annually. As part of the meeting annual cycle of business.

11) CHAIR'S ACTION ON URGENT MATTERS

11.1   There may, occasionally, be circumstances where decisions, which would normally be made by the Group, need to be taken between scheduled meetings. In these circumstances, the Chair, supported by the Secretariat as appropriate, may deal with the matter on behalf of the Group. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting for consideration and ratification.

11.2   Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

11.3   To assist the Health Board in the conduct of its business, the function of this Group is to provide advice and assurance to QSE in relation to its responsibilities for Clinical Effectiveness.

Patient and Carer Experience Group (PCE)

1) INTRODUCTION

1.2   The Quality, Safety and Experience Committee (QSE) has agreed to establish the Patient and Carer Experience Group. The detailed terms of reference and operating arrangements in respect of this Group are set out below.

2) PURPOSE

2.1   The purpose of the Group is to provide advice and assurance to QSE in discharging its functions and meeting its responsibilities with regard to patient, carer and service user experience of health services.

3) DELEGATED POWERS AND AUTHORITY

3.1   The PCE Group, in respect of its provision of advice and assurance will and is authorised by the QSE to:

3.1.1   Provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations' or as part of a partnership arrangement;

3.1.2   Provide assurance that listening to the experiences of patients, service users and carers is a fundamental part of learning. BCUHB has a mandatory responsibility to listen, learn and act from patients, service users and carers experience and feedback fostering a culture of continuous, positive improvement;

3.1.3   Provide assurance of the development, implementation and embed a Patient and Carer Experience Strategy and operational work plan that reflects the NHS Wales' framework to deliver against four mutually supportive goals, 'the Quadruple Aim';

- Better population health and wellbeing through prevention.
- Better experience and quality of care
- Better engagement of the workforce
- Better value from the funding

3.1.4   Review the sustainability of service provision across the Health Board in terms of patient and carer experience;

3.1.5   Provide assurance of achievement of the Accessible Health Care Standards;

3.1.6   Produce an Annual Report on the key objectives;

3.1.7 Oversee implementation of the Welsh Government's National Framework for Assuring Service User Experience (2015) across the Health Board;

3.1.8 Receive a bi-monthly review against progress of the Patient and Carer Experience Department Delivery Plan;

3.1.9 Review and analyse trends emerging from patient, service users and carers feedback and identify improvement actions (any reference to service user feedback, includes all methods of feedback, including formal and on the spot complaints):

3.1.10 Provide assurance that early resolution, informal and formal complaints are investigated, discussed and actioned at the appropriate level in the organisation as they arise;

3.1.11 Receive bi-monthly reports from all service clinical teams Senior Staff to demonstrate that patient and service user experience is an integral part of their service agenda, and improvements and outcomes are achieved and sustained;

3.1.12 Receive and act on feedback from relevant stakeholder groups (e.g. Community Health Council (CHC));

3.1.13 Take account of national reports or external reviews in relation to patient and carer experience and develop action plans/adjust work plan accordingly

3.1.14 Provide a quarterly report and annual report to QSE Committee on patient and carer experience with assurance that the Group has met its terms of reference and key duties.

3.1.15 Review and monitor Division patient and carer experience risks and be proactive to ensure that QSE is aware of emerging risks and that appropriate scoring and mitigating actions ae in place;

3.1.16 Review patient and carer experience risks on the Risk Register including appropriate scoring and mitigating actions are in place;

3.1.17 Ensure that the Public Sector Equality duty is integral to and influences decision making; ensuring any differences in patient, service user and carer experience between the protected groups is monitored and acted on where appropriate;

3.1.18 The group will seek to embed the Equality Act 2010 and operate from an equality and rights context to better understand and respond to diverse and changing community needs.

Appendix B

4) AUTHORITY

4.1 The Group may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee - and all employees are directed to cooperate with any legitimate request made by the Group; and
- other Groups to assist in the delivery of its functions.

4.2 It may consider and where appropriate, approve on behalf of QSE any procedure within the remit of the groups business concerning patient and carer experience.

4.3 It will review the relevant risks from the Corporate Risk Register that are assigned to the Group by QSE and advise QSE on the appropriateness of the scoring and mitigating actions in place.

5) GROUPS

5.1 The Group may, establish groups or task and finish groups to carry out work on specific aspects of the Groups business. The current established group reporting into the PCE Group include;

- Bereavement Quality Group
- Patient Communication & Readers Panels

6) MEMBERSHIP

6.1 Chair: Associate Director of Quality Assurance

6.2 Vice Chair: Associate Director of Nursing

6.3 Members:

- Head of Patient and Carer Experience
- Head of Engagement
- Head of Equality and Human Rights
- Head of Organisational Development
- Head of Welsh Language
- Head of Transforming Nursing Care
- Senior Division Representatives

The Chairs of the sub-groups will be in attendance is not already a member:

Bereavement Quality Group Chair or Representative

6.4 Invites are extended to:

6.4.1.Patient Representative
6.4.2 Carer Representative
6.4.3 North Wales Community Health Council (CHC)
6.4.4 Healthcare Inspectorate Wales (HIW) Inspector/Relationship Manager

6.5 Secretariat

6.5.1 PA to Associate Director of Quality Assurance
6.5.2 Minutes will be circulated within 10 working days and approved at the next meeting.

6.6 Support to Group Members

6.6.1   All members may submit requests for inclusion of items on the agenda.

6.6.2   If unable to attend the meeting, members are required to arrange a representative to attend on their behalf, who is able to actively contribute to the meeting discussions.

7) GROUP MEETINGS

7.1 Quorum

7.1.1   At least 10 individuals (one of which must be the Chair or Vice Chair) must be present to ensure the quorum of the Group.

7.2   Frequency of Meetings

7.2.1   Meetings shall be held no less than bi-monthly and otherwise, as the Chair of the Group deems necessary.

7.3   Withdrawal of individuals in attendance

7.3.1   The Group may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

8) RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES /GROUPS

8.1   The Group is directly accountable to QSE for its performance in exercising the functions set out in these Terms of Reference.

8.2   The Group, through its Chair and members, shall work closely with the other Groups to provide advice and assurance by contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the overall risk and assurance arrangements.

9) REPORTING AND ASSURANCE ARRANGEMENTS

9.1   Meeting minutes will be maintained, with names attached to allocated actions and collated into an action tracker. Minutes and actions (reviewed by the Chair) will be circulated within 1 week and approved at the next meeting.

9.2   The Chair will report formally, to QSE. This includes verbal updates, the submission of regular Chair's written reports, as well as the presentation of a quarterly Patient and Carer Experience Report.

9.3   The Chair will also ensure appropriate escalation arrangements are in place to alert QSE of any urgent/critical matters that may affect patient and carer experience.

9.4   A Group meeting effectiveness review will be completed annually.

10) REVIEW

10.1   These terms of reference and operating arrangements will be reviewed annually. As part of the meeting annual cycle of business.

11) CHAIR'S ACTION ON URGENT MATTERS

11.1   There may, occasionally, be circumstances where decisions, which would normally be made by the Group, need to be taken between scheduled meetings. In these circumstances, the Chair, supported by the Secretariat as appropriate, may deal with the matter on behalf of the Group. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting for consideration and ratification.

11.2   Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

11.3   To assist the Health Board in the conduct of its business, the Patient and Carer Experience Group (PCE) (formerly known as the Listening and Learning from Experience (LLE) Group) has been revised. The function of this Group is to provide advice and assurance to QSE in relation to its responsibilities for learning from patients, carer and service user experience and feedback.

Appendix B

Patient Safety & Quality Group (PSQ)

1) INTRODUCTION

1.3   The Quality, Safety and Experience Committee (QSE) has agreed to establish the Patient Safety & Quality Group. The detailed terms of reference and operating arrangements in respect of this Group are set out below.

2) PURPOSE

2.1   The purpose of the Group is to provide advice and assurance to QSE in discharging its functions and meeting its responsibilities with regard to Patient Safety & Quality.

3) DELEGATED POWERS AND AUTHORITY

3.1   The PSQ Group, in respect of its provision of advice and assurance will and is authorised by the QSE to:

3.1.1. Provide assurance that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Strategy and the principle of continuous quality improvement including organisational learning;

3.1.2   Provide assurance that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that;

- Sources of internal assurance (including clinical audit) are reliable;
- Recommendations made by internal and external reviewers are considered and acted upon on a timely basis;
- Appropriate review is carried out and corrective action is taken arising from Concerns as defined within the Putting Things Right Regulations.

3.1.3   Provide assurance that patient safety and quality issues and themes are identified and managed;

3.1.4   Provide assurance that incident reviews identify and embed learning opportunities;

3.1.5   Provide assurance that the Health Board's responses to the above is sufficient and direct action is taken where necessary;

3.1.6   Provide assurances from the Quality Strategy and Legislation Assurance Framework to allow the Group to review achievement of accessible health care to inform the Annual Report and Annual Quality Statement.

3.1.7 Review and monitor progress in relation to compliance with HIW reports and performance against Health and Care Standards and performance and manage any outstanding action plans;

3.1.8 Provide assurance on the adequacy of safeguarding and infection, prevention and control arrangements;

3.1.9 Provide assurance of compliance with patient safety solutions (previously known as alerts);

3.1.10 Review and monitor Divisional patient safety & quality risks and be proactive to ensure that QSE is aware of emerging risks and that appropriate scoring and mitigating actions are in place;

3.1.11 Review patient safety & quality risks including appropriate scoring and mitigating actions are in place;

3.1.12 Provide an Annual Report to QSE providing assurance that the Group has met its terms of reference and key duties;

3.1.13 Provide assurance of the engagement, development, implementation and embedding of a Quality Strategy.

4) Authority

4.1 The Group may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee and all employees are directed to cooperate with any legitimate request made by the Group; and
- other Group to assist in the delivery of its functions.

4.2 It may consider and where appropriate, approve on behalf of QSE any procedure within the remit of the Group business concerning patient safety & quality.

4.3 It will review the relevant risks from the Corporate Risk Register that are assigned to the group by QSE and advise QSE on the appropriateness of the scoring and mitigating actions in place.

5) GROUPS

5.1 The Group may, establish Sub-groups or task and finish groups to carry out work on specific aspects of the Groups business. The current established groups reporting into the PSQ Group include;

Divisional Quality Groups (7)
Safeguarding Governance and Performance Group

Appendix B

IPC Group
PPE Group
Quality and Concerns Management Systems Group
HASCAS/Ockenden Group

6) MEMBERSHIP

6.1 Chair: Executive Director of Nursing and Midwifery Deputy Chief Executive

6.2 Vice Chair: Executive Medical Director

6.3 Members:

Associate Director of Quality Assurance
Associate Director of Nursing
Deputy Executive Medical Director
Senior Associate Medical Director
Director of Estates and Facilities
Director of Performance
Associate Director of Safeguarding
Associate Director of IPC
Associate Director of HS&E
Clinical Director of Therapy Services
Chief Pharmacist or Medications Safety Officer
Divisional Nurse/Midwifery Directors or agreed representative

The Chairs of the sub-groups will be in attendance is not already a member:

Safeguarding Governance and Performance Group Chair or Representative
IPC Group Chair or Representative
Decontamination Group Chair or Representative
PPE Group Chair or Representative
Quality Dashboard Group Chair or Representative
Quality and Concerns Management Systems Group Chair or Representative
HASCAS/Ockenden Group Chair or Representative

6.4 Secretariat

6.5.1 PA to Associate Director of Quality Assurance
6.5.2 Meeting minutes will be maintained, with names attached to allocated actions and collated into an action log. Minutes and the action log will be circulated within 5 working days and approved at the next meeting.

6.6 Support to Group Members

6.6.1   All members may submit requests for inclusion of items on the agenda.

6.6.2 If unable to attend the meeting, members are required to arrange a

representative to attend on their behalf, who is able to actively contribute to the meeting discussions.

7) GROUP MEETINGS

7.1 Quorum

7.1.1 At least ½ of members (one of which must be the Chair or Vice Chair) must be present to ensure quorum.

7.2   Frequency of Meetings

7.2.1 Meetings shall be held monthly and otherwise, as the Chair of the Group deems necessary.

7.3   Withdrawal of individuals in attendance

7.3.1 The Group may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

8) RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES /GROUPS

8.1   The Group is directly accountable to QSE for its performance in exercising the functions set out in these Terms of Reference.

8.2   The Group, through its Chair and members, shall work closely with the other Groups to provide advice and assurance by contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the overall risk and assurance arrangements.

9) REPORTING AND ASSURANCE ARRANGEMENTS

9.1   Meeting minutes will be maintained, with names attached to allocated actions and collated into an action tracker. Minutes and actions (reviewed by the Chair) will be circulated within 5 working days and approved at the next meeting.

9.2   The Chair will report formally, to QSE. This includes verbal updates, the submission of regular Chair's written reports.

9.3   The Chair will also ensure appropriate escalation arrangements are in place to alert QSE of any urgent/critical matters that may affect patient and carer experience.

9.4   A Group meeting effectiveness review will be completed annually.

10) REVIEW

10.1 These terms of reference and operating arrangements will be reviewed annually. As part of the meeting annual cycle of business.

11) CHAIR'S ACTION ON URGENT MATTERS

11.1 There may, occasionally, be circumstances where decisions, which would normally be made by the Group, need to be taken between scheduled meetings. In these circumstances, the Chair, supported by the Secretariat as appropriate, may deal with the matter on behalf of the Group. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting for consideration and ratification.

11.2 Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

11.3 To assist the Health Board in the conduct of its business, the function of this Group is to provide advice and assurance to QSE in relation to its responsibilities for Patient Safety & Quality.

Clinical Effectiveness Group cycle of business 2020/21

	Item	Lead	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
	Welcome and members present	Chair			✓		✓		✓		✓		✓	
	Apologies	Chair												
	Quorum	Chair												
	Declarations of Interest	Chair			✓		✓		✓		✓		✓	
	Review cycle of business	Chair			✓		✓		✓		✓		✓	
	Review and agree minutes from previous meeting	Chair/All			✓		✓		✓		✓		✓	
	Review and update action log	Chair/All												
	Agree Terms of Reference	All							✓					
	Receive Chair or representative report (AAA) from below:													
	HMT (West)	Mandy Jones							✓		✓			
	HMT (Central)	Tania Bugelli					✓							
	Clinical Improvement and Audit Group (Central)	Tania Bugelli					✓							
	HMT (East)	Geeta Kumar			✓				✓					
	NICE Assurance Group	Geeta Kumar			✓				✓					
	Clinical Improvement and Audit Groups (East)	Geeta Kumar			✓				✓					
	Area (West)	Mary Cottrill									✓			
	Area (Central)	Mandy Casey									✓			
	Area (East)	Richard Waterson									✓			
	Radiation Protection Committee	Helen Hughes			✓									
	North Wales Managed Clinical Services Quality Committee	Helen Hughes					✓							
Assurance	Women's Services	Gudrun Rieck					✓							
	New Technologies Oversight Committee (NTOC)	Vacant Post												
	Pathology (including Blood Transfusion Committee and Point of Care)	Bernie Astbury					✓							
	Medical Devices Oversight Group	Patrick Hill					✓				✓			
	Quarterly Reporting process	Clinical Audit					✓							
	BCUHB Trauma Board	Rob Perry									✓			
	Clinical Law and Ethics Group	Ben Thomas							✓					
	Resuscitation Committee	Sarah Bellis							✓					
	Mental Health and Learning Disability Clinical Effectiveness Group	Alberto Salmoiraghi												
	Safer Medicines Steering Group / Trauma Group	Louise Howard-Baker									✓			
	Drug and Therapeutics Group	Louise Howard-Baker									✓			
	Chair's report to QSE Committee (Triple A)	All					✓							
	Review Clinical Effectiveness Risks on Risk Register (appropriateness of scoring and mitigating actions in place)	Chair			✓		✓		✓		✓		✓	
	Meeting effectiveness review	Administrator											✓	
	Any other urgent Business (AOUB): *Matters for referral to other groups *Matters impacting on policy and/or practice * Matters to be brought forward to review next meeting	All			✓		✓		✓		✓		✓	
Improvement	Patient Story	Head of Quality Assurance			✓		✓		✓		✓		✓	
	Quality Improvement Strategy	Chair			✓		✓		✓		✓		✓	
	Clinical Effectiveness Strategy	Chair			✓		✓		✓		✓		✓	
	Clinical Audit Report	Chair												
	Integrated Quality and Performance Report (IQPR)	TBC												
	Receive update of Workforce Flu Vaccine Programme	TBC												
	Contracting Quality Report	TBC												

Note: The Apr-20 and May-20 columns are marked "Cancelled Due to Covid-19".

QSE

Strategic Occupational Health & Safety Group | Clinical Effectiveness Group | Patient and Carer Experience Group | Patient Safety and Quality Group

Patient Carer Experience Group cycle of business 2020/21

	Item	Lead	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Assurance	Welcome and members present	Chair	Cancelled Due To Covid-19		✓		✓		✓		✓		✓	
	Apologies	Chair												
	Quorum	Chair												
	Declarations of Interest	Chair			✓		✓		✓		✓		✓	
	Review cycle of business	Chair			✓		✓		✓		✓		✓	
	Review and agree minutes of previous meeting	Chair/All			✓		✓		✓		✓		✓	
	Review and update action log	Chair/All												
	Receive Chair's Report from reporting groups (Triple A)	All			✓		✓		✓		✓		✓	
	Agree Terms of Reference	All					✓							
	Patient Carer Experience Strategy 2021-2024 - Update Report	All												
	Review Patient Carer Experience Risks on Risk Register (appropriateness of scoring and mitigating actions in place)	All			✓		✓		✓		✓		✓	
	Chair's report to QSE Committee (Triple A)	Chair/All			✓		✓		✓		✓		✓	
	Meeting effectiveness review	Administrator											✓	
	Any other urgent Business (AOUB): Matters for referral to other groups Matters impacting on policy and/or practice	All			✓		✓		✓		✓		✓	
Improvement	Patient Story	Head of Patient Experience			✓		✓		✓		✓		✓	
	NHS Delivery Framework - Reporting of Measures - Responding to Service User Experience to Improve Services	Head of Patient Experience			✓				✓				✓	
	Receive a written progress report of implementation of the Patient and Carer Experience Department Delivery Plan.	Head of Patient Experience			✓		✓		✓		✓		✓	
	Patient Carer Experience Feedback from Services	Acute, Area, and Services			✓		✓		✓		✓		✓	
	Accessible Health Care Standards Report (six monthly)	Head of Patient Experience							✓				✓	
	Community Health Council update	CHC			✓		✓		✓		✓		✓	
	Quarterly Patient Carer Experience Report: Engagement, patient and service user feedback, improvement work and celebrate best practice care to share, CHC update, once for Wales, PALS activity, 360 degree report to include Ward Accreditation, KPIs, staff experience	Head of Patient Experience			✓		✓		✓		✓		✓	
	Patient Carer Experience Annual Report	Head of Patient Experience												
	Ombudsman Lessons Learned Report	Denise Williams			✓		✓		✓		✓		✓	

QSE

Clinical Effectiveness Group

Strategic Occupational Health & Safety Group

Patient and Carer Experience Group

Patient Safety and Quality Group
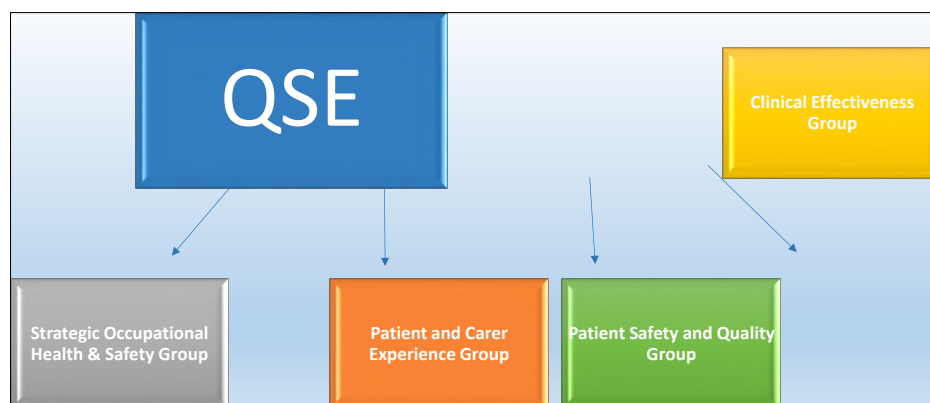
Patient Safety & Quality Group cycle of business 2020/21

	Item	Lead	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Assurance	Welcome and members present	Chair												
	Apologies	Chair												
	Quorum	Chair							✓	✓	✓	✓	✓	✓
	Declarations of Interest	Chair							✓	✓	✓	✓	✓	✓
	Review cycle of business	Chair							✓	✓	✓	✓	✓	✓
	Review and agree minutes from previous meeting	Chair/All							✓	✓	✓	✓	✓	✓
	Review and update action log	Chair/All												
	Receive Chair's Report from reporting groups (Triple A)	All							✓	✓	✓	✓	✓	✓
	Receive Divisions Report relevant to their areas of responsibility (Triple A)	Directors							✓	✓	✓	✓	✓	✓
	Receive Quality Assurance Report Bi monthly to include External reports (HIW, HASCAS etc. Quality Dashboard and significant risks)	Associate Director of Quality Assurance								✓		✓		✓
	Agree Terms of Reference	All												
	Chair's Report to QSE	All							✓	✓	✓	✓	✓	✓
	Review Patient Safety and Quality Risks on Risk Register (appropriateness of scoring and mitigating actions in place)	All							✓	✓	✓	✓	✓	✓
	Meeting effectiveness review	Administrator												
	Any other urgent Business (AOUB): Matters for referral to other groups Matters impacting on policy and/or practice	All							✓	✓	✓	✓	✓	✓
Improvement	Patient Story	Associate Director of Quality Assurance							✓	✓	✓	✓	✓	✓
	Receive Corporate Patient Safety Report	Associate Director of Quality Assurance							✓	✓	✓	✓	✓	✓
	Receive Safeguarding Report	Associate Director of Safeguarding							✓					
	Receive Infection Prevention Control Report	Associate Director of IPC							✓					
	Receive Safe Staffing Report	Secondary Care Nurse Director							✓					
	Receive PTR Annual Report	Associate Director of Quality Assurance												
	Receive Annual Quality Statement	Associate Director of Quality Assurance												

Apr-20 to Sep-20: Cancelled due to Covid-19

QSE

- Strategic Occupational Health & Safety Group
- Clinical Effectiveness Group
- Patient and Carer Experience Group
- Patient Safety and Quality Group

Strategic Occupational Health and Safety Group cycle of business 2020/21

	Item	Lead	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Assurance	Welcome and members present	Chair		√	√		√			√		√		
	Apologies	Chair		√	√		√			√		√		
	Quorum	Chair		√	√		√			√		√		
	Declarations of Interest	Chair		√	√		√			√		√		
	Review cycle of business	Chair		√	√		√			√		√		
	Review and agree minutes from previous meeting	Chair/All		√	√		√			√		√		
	Review and update action log	Chair/All		√	√		√			√		√		
	Receive Chair's Report from reporting groups (Triple A)			√	√		√			√		√		
	Health and Safety Leads Group	Chair or representative		√	√		√			√		√		
	Operational Occupational Health and Safety Group	Chair or representative		√	√		√			√		√		
	Health and Wellbeing Group	Chair or representative		√	√		√			√		√		
	Union Representatives feedback	Representatives		√	√		√			√		√		
	Security Management Group	Chair or representative		√	√		√			√		√		
	Asbestos Management Group	Chair or representative		√	√		√			√		√		
	Fire Safety Group	Chair or representative		√	√		√			√		√		
	Water Safety Group	Chair or representative		√	√		√			√		√		
	Electrical Safety Group	Chair or representative		√	√		√			√		√		
	Medical Gasses Group	Chair or representative		√	√		√			√		√		
	Agree Terms of Reference	All								√				
	Review Health and Safety Risks on Risk Register (appropriateness of the scoring and mitigating actions in place)	All		√	√		√			√		√		
	Chair's report to QSE Committee (AAA)	All		√	√		√			√		√		
	Meeting effectiveness review	Administrator										√		
	Any other urgent Business (AOUB): Matters for referral to other groups Matters impacting on policy and/or practice	All		√	√		√			√		√		
Improvement	Patient or Staff Story	Associate Director of Quality Assurance		√	√		√			√		√		
	Progress update of Health and Safety Improvement Plan implementation			√	√		√			√		√		
	Quarterly Health and Safety Report			√	√		√			√		√		
	Occupational Health and Safety Management Reports			√	√		√			√		√		
	Health & Safety Annual Report													

(Note: "Cancelled due to Covid-19" appears in the Apr-20 column)

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

Report front sheet

Report Details	
Report Title	
Agenda reference number	
Report to what meeting	
Date of meeting	
Presented by	
Who has approved this report	
Contributing authors	
Version number	
Appendices number of (A,B, C etc)	

Report Briefing

1. Situation – a concise statement of the purpose of this report

2. Background – contextual and background information relevant to the situation/purpose of the report

3. Assessment – analyses and considerations of the options and risks

4. Recommendations – what action/recommendation is required

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

Agenda Template

Ref	Title of item	Format	Presented by	Time	Attachment
	PART 1: ASSURANCE				
	Standing items				
19/20/	Welcome and members present			00:00	
19/20/	Apologies				
19/20/	Quorum			00:00	
19/20/	Declarations of Interest			00:00	
19/20/	Review 2019/20 cycle of business			00:00	
19/20/	Review and agree minutes of previous meeting			00:00	
19/20/	Review and update action schedule				
19/20/	Review minutes received from reporting groups			00:00	
	Internal reporting and matters of governance and assurance				
19/20/	Chairs Report: AAA			00:00	
19/20/	Review Risks on Risk Register			00:00	
19/20/				00:00	
19/20/				00:00	
	Strategy / Strategic Development				
19/20/				00:00	
19/20/				00:00	
19/20/				00:00	
19/20/				00:00	
19/20/				00:00	

		Break (00:00 to 00:00)			
Ref	Title of item	Format	Presented by	Time	Attachment
		PART 2: IMPROVEMENT			
19/20/				00:00	
19/20/				00:00	
19/20/				00:00	
19/20/				00:00	
19/20/				00:00	
19/20/				00:00	
19/20/				00:00	
19/20/				00:00	
	Any other urgent business (AOUB)				
19/20/	Matters for referral to other groups			00:00	
19/20/	Matters impacting on policy and/or practice			00:00	
				00:00	
				00:00	
		Close (00:00)			

Date, time and venue of the next meeting:

_____

**Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board**

Minutes

<<NAME OF MEETING>>		
Date / Time	<<Date>>	<<Time>>
Location	<<Location>>	

1.	**WELCOME AND MEMBERS PRESENT**	
	• <<Role>> • <<Role>> • <<Role>> • <<Role>> • <<Role>> • <<Role>> • <<Role>> • <<Role>> • <<Role>>	• <<Name (initials)>> • <<Name (initials)>> • <<Name (initials)>> • <<Name (initials)>> • <<Name (initials)>> • <<Name (initials)>> • <<Name (initials)>> • <<Name (initials)>> • <<Name (initials)>>
2.	**APOLOGIES**	
	• <<Role>> • <<Role>> • <<Role>>	• <<Name (initials)>> • <<Name (initials)>> • <<Name (initials)>>
3.	**QUORUM (at least ½ of members, one of which must be the Chair or Vice Chair**	
4.	**DECLARATIONS OF INTEREST (**declare interests that members may have that could conflict with the work of the Group)	
5.	**CYCLE OF BUSINESS (confirm all papers are on agenda and if not when will be received)**	
6.	**REVIEW AND AGREE MINUTES FROM PREVIOUS MEETING**	
	The minutes of the meeting on (date) reviewed and confirmed as an accurate record of that meeting.	Signed by: XXX

7.	REVIEW AND UPDATE ACTION LOG	Owner	Status (open/closed)
Item	Action update		
8.	AAA REPORT Receive minutes from reporting groups Tripe A report (Alert Assurance Achievement)		
	8.1 8.2 8.3 8.4		
9.	DIVISIONAL AAA REPORT Receive Divisions Triple A report relevant to their areas of responsibility		
	9.1 9.2 9.3 9.4		
10.	STANDARD AGENDA ITEMS		
	10.1 10.2 10.3 10.4 10.5 10.6 10.7 10.8 10.9		
11.	REVIEW RELEVANT RISKS ON REGISTER (appropriateness of the scoring and mitigating actions in place)		
12.	CHAIRS REPORT TO QSE (AAA)		
13.	ANY OTHER URGENT BUSINESS Any other urgent Business (AOUB): Matters for referral to other groups. Matters impacting on policy and/or practice		

14.	SUMMARY OF ACTIONS		
Item	Action	Owner	Status
15.	NEXT MEETING		
	Date: Time:		
16.	MINUTES CONFIRMED		
	Chairs signature: Date:		

Standardised Chair's Triple A Report

Alert Assurance Achievement (AAA)

Chair's Report	
Name of meeting	
Chair of meeting	
Date of meeting	

Alert

Assurance

Achievement

Action Schedule: Patient and Carer Experience Group							Appendix H
Date	Agenda Item	Action Description	Lead Responsible	Date Due	Update	Date completed	Comments

Quality, Safety & Experience Committee 28th August 2020	To improve health and provide excellent care

Advisory Group Chair's Report

Name of Advisory Group:	**Quality and Safety Group**

Meeting date:	**10th July 2020**

Name of Chair:	**Gill Harris - Executive Director of Nursing and Midwifery**

Responsible Director:	**Gill Harris - Executive Director of Nursing and Midwifery**

Summary of key items discussed:	**Health Inspectorate Wales (HIW)** No inspections have taken place since the start of COVID, but an unannounced visit took place yesterday on the Heddfan unit, for which we are awaiting the report. Continuing to work through the 2018 actions, which is now reduced to 2 outstanding, started working on the 2019 open actions. Concerns from HIW will be included in future reports, group were informed that we have received one regarding Heddfan unit. Explained that at present the tracking is done through a spreadsheet and is person dependant. It was proposed to move into using a database and Datix, discussion with colleagues is also taking place. It will enable all services the ability to amend the master copy and update evidence for actions. **Therapy services waiting list update** Group were presented with the outcome of investigation and lessons learnt. Conclusion was that there was no directive issued by the organisation to discharge patents but in the absence of guidance a few heads of service incorrectly undertook this action following the meeting on the 19th March. Which resulted in an inconsistent approach across the services. The context of the COVID situation was also highlighted as a factor.

	Lessons learnt
	It has been agreed to amend the governance structure to limit who can make the changes on the PAS system. And the need to be closer to organisational groups whose core function relates to outpatient and waiting list management – will review and introduce links. **An update on actions will be presented to QSG in August.**
Key advice / feedback for the QSE:	**Risks to highlight:** <u>Never event</u> Wrong site block administered in the anaesthetic room for an emergency patient undergoing surgery for a fractured neck of femur. A 'make it safe' review has been undertaken. A number of factors were identified which included failure to follow the process of 'stop before you block'. NatSsips and LocSsips audits will be presented via the Site Governance meetings following their development and implementation, to provide assurance of their usage and demonstration of their effectiveness. This is the fourth incident of this type to date, although about of work that has taking place. Looking at the use of checklists **A plan will be requested to address the themes** <u>Delivery of Planned Care</u> There is currently a delay in Gastroenterology OPD and a capacity gap in Endoscopy. With patient appointment delays and cancellations in both Outpatients and Endoscopy. There is a risk that patients will be harmed due to incurring a delayed diagnosis and/or treatment through the length of wait incurred by Surveillance, Cancer and RTT patients. The waiting time is driven by the increased demand on the service outstripping the current capacity. **A position statement will be provided to the next QSG meeting** <u>Estates and Facilities</u> Recruitment challenges has now been moved to a fully populated structure, resulting in being closed and removed from the risk register
Special Measures Improvement Framework Theme/Expectation addressed	

Planned business for the next meeting:	To be determined from cycle of business
Date of next meeting:	14th August 2020

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Advisory Group Chair's Assurance Report Template V4.0 June 2016

Quality, Safety & Experience Committee 28th August 2020	GIG CYMRU NHS WALES / Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
	To improve health and provide excellent care

Advisory Group Chair's Report

Name of Advisory Group:	**Quality and Safety Group**

Meeting date:	**14th August 2020**

Name of Chair:	**Gill Harris**

Responsible Director:	**Gill Harris - Executive Director of Nursing and Midwifery**

Summary of key items discussed:	QSG received: • Summary of the PPE Steering Group work to date highlighting key achievements and reflections regarding ongoing issues noting all risks continue to be aligned to the corporate risk register. • Verbal report following the HSE engagement with the Health Board following the Wrexham Maelor Outbreak and the fit testing competencies of staff. • The Organ and Tissue Donation Annual Report and noted the key achievements including positive engagement with local schools • A proposal for the Management of Policies including standing operational procedures • Endorsement of the flu plan • Secondary care working on an improvement plan and assurance report on themes arising from recent never events • New interim DoN for MHLD seeking greater assurance in regards to Heddfan Unit • Discussed the recent HIW unannounced visit to the Heddfan Unit and action plan and HIW inspections restarting using a tiered model (with visits planned to the three acute sites)
Key advice / feedback for the QSE:	**Risks to highlight:** • Group were advised that a mass fire and evacuation took place on 6 August in Rainbow Deeside and the report was received this week; a response had been developed in light of the a concern raised regarding Palliative Care so a leaflet was available for across North Wales.

	• In Central work was ongoing to support staff in returning to community dental services and was working with E&F to explore the ventilation system and fit testing was being undertaken for urgent dental services. They are working to bring back therapy services however issues remained regarding inadequate dietetic and podiatry cover on vascular wards. • Secondary care advised that the first significant item was around COVID and the transmission on sites during the pandemic; cluster outbreaks had been seen on all 3 sites with Wrexham ongoing for 5 weeks. The learning from the initial outbreak has been shared and noted that we were still learning about the virus. There has been a number of HCAI's in which some had resulted in mortality
Special Measures Improvement Framework Theme/Expectation addressed	
Planned business for the next meeting:	To be determined from cycle of business
Date of next meeting:	11th September 2020

Advisory Group Chair's Assurance Report Template V4.0 June 2016

Cyfarfod a dyddiad: Meeting and date:	Quality Safety & Experience (QSE) Committee 28th August 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Mental Health & Learning Disabilities (MHLD) Division update report
Cyfarwyddwr Cyfrifol: Responsible Director:	David Fearnley, Executive Medical Director
Awdur yr Adroddiad Report Author:	Mike Smith, Interim Director of Nursing
Craffu blaenorol: Prior Scrutiny:	None
Atodiadau Appendices:	None
Argymhelliad / Recommendation:	

The Committee is asked to note the report and seek any further assurances.

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	
Sefyllfa / Situation:							

This is a personal update on the key risks and the urgent priorities within the MHLD division to highlight key issues of significance to the QSE Committee from the Interim Director of Nursing casting "fresh eyes" upon the division.

The MHLD division has undergone significant instability over recent times and acutely since early 2020. Two of the four directors in post are interims from outside of both the organisation and Wales - both are new in post (2 and 9 weeks). The Director of Strategy and Partnerships is interim in the Director of Mental Health role. Only the divisional Medical Director is substantive in their role and their experience at BCUHB.

On top of this instability there has been the Covid 19 outbreak and the necessary system response. This has affected the whole organisation and further destabilised the division due to staff absence, shielding, working from home (as per Public Health Wales guidance), but with an acute lack of presence and visibility in service.

Cefndir / Background:

1.0 Purpose of the paper

The purpose of this paper is to share with the QSE Committee key issues and risks in the MHLD division as I have seen them "with fresh eyes into the division" and have been informed by my peers in my induction. I would also like to share my priorities and actions to remedy this in the role of Director of Nursing.

2.0   The key issues in the division for the information of the Committee are

i.   The lack of stability in senior leadership within the division.
ii.   There is a palpable sense of a lack of assurance in the operational delivery of mental health and learning disability services both within and without of the Health Board. This is most likely due in part to senior people being out of substantive position, sickness or vacancy.
iii.   There have been issues in the East of the division April to May, consequent to the Covid response that have led to a series of whistleblowing to Healthcare Inspectorate Wales (HIW) and a need for assurance to the board, that is not necessarily confidently deliverable given these other key issues herein.
iv.   The lack of senior and broader clinician contribution to and ownership of the divisional strategy. Some groups of clinicians with great depth of experience, are of the opinion that their experiences and contribution have not been utilised and whose importance has been underestimated to enable the delivery of the strategy. Clinical Psychology, therapy, mental health peer organisations and other allied professions are but a few to be named.
v.   The lack of consultation with and involvement of key stakeholders outside of the division in the development of the strategy.
vi.   There is a great deal of clinical competence not necessarily utilised.
vii.   The Phase 2 strategy is seen as vague and complex, widely treated with cynicism and disowned internally despite having some very good elements.
viii.   I have seen nothing which unduly worries me in terms of patient safety or indeed quality in my travels around the Board's services. There is an apparent competence of managers and clinical leaders however there are similar issues with managers and clinical leaders below the Senior Leadership Team (SLT) within the division, who are absent, out of place or not in substantive roles/ covering long term sickness.
ix.   The acute response to the Covid situation, given all of the above has exacerbated most issues.
x.   I have reviewed the Heddfan action plan (HIW) and the Heddfan improvement plan and am assured that the key issues are being resolved, but there needs to be better communication with local partners and interested parties in both the Covid response and the provision of support in the eastern patch.
xi.   I have 40 years' experience of mental health service delivery as a clinician and as a director of mental health service provision in the NHS and the third sector and believe the issues above are able to be remedied with the following key actions by myself and of course the wider SLT.

3.0 Key priorities and actions to remedy or mitigate the key issues

xii.   Stabilise the senior leadership team and develop capacity, internal communication and working together. Issues of absence and vacancy need to be progressed and resolved

xiii.	Provide robust assurance to the Board and the wider health and political community.
xiv.	Involve senior clinicians and wider professional groups in the strategy of the division in a way that assures them that they have a contribution to make, are heard and can influence the strategy.
xv.	Develop external consultation and communication, be available and be present/known as director of Nursing within the division. My feedback so far from partner and stakeholder organisations has been that communication, consultation and coproduction is not robust. I will explore, recover & remedy this, applying the same approach with other health partners, the CHC, local authorities, local elected members and other parties who could also feel this way.
xvi.	To develop the plan for "return to new normal services" post the acute response.
xvii.	To review the phase 2 plan with my SLT peers to simplify, clearly state and consult on the immediate strategy. The concept of integrated care pathways that are evidence based, describe the patient journey and the level of support are implicit. The explicit reference to pathways has distracted people from the intentions in phase 2 to provide whole divisional leadership for a specific need i.e. adult, older adult, learning disability, forensic across the area - this will of course always be locally expressed and in my experience increases local presence and ownership. In mental health services internationally this is being expressed as a "whole system, whole person, whole life approach" to implementing the national strategy.
xviii.	Phase 2 must be owned by and subscribed to by clinicians and the wider health community
xix.	Further develop with my peers within the divisional SLT, in the form of an action plan, my personal actions, interdependencies and timescales to resolve these issues and priorities expressed here.

4.0 Conclusions

At this time I cannot provide full assurance to the Committee but feel that by working toward (but not exclusively) the actions and priorities in section 3 I can go some way to recover and remedy the issues that have been apparent in section 2. I aim to be able to report back to the next meeting a more robust assurance statement

Asesiad / Assessment & Analysis
Strategy Implications These reflections comment upon the MHLD Division's ability at this time to deliver the all Wales strategy Together for Mental health. **Options considered** None relevant **Financial Implications** Non **Risk Analysis** There are no new risks for the MHLD Division consequent to this paper **Legal and Compliance** None appropriate **Impact Assessment** *N/A*

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 28th August 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Holden Report – Update
Cyfarwyddwr Cyfrifol: Responsible Director:	David Fearnley, Executive Medical Director Gill Harris, Executive Director of Nursing and Midwifery / Deputy Chief Executive
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience
Craffu blaenorol: Prior Scrutiny:	Review by responsible directors
Atodiadau Appendices:	None

Argymhelliad / Recommendation:
The Quality, Safety and Experience (QSE) Committee is asked to note the report.

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

Sefyllfa / Situation:

The Information Commissioner's Office (ICO) recently upheld an appeal by a member of the public that the Holden Report (2013) should be published under the Freedom of Information Act, following the Health Board's earlier decision not to disclose the report on the basis that doing so would identify individuals who had expected a right to privacy (i.e. those staff specifically named in the report and those staff who raised concerns through the whistleblowing process who can be identified). The Health Board has appealed this decision and a tribunal hearing is expected in early 2021.

This recent activity has generated significant attention and continued concern from those families who feel their loved ones have been affected by care at the Hergest Unit (the unit involved in the Holden Report) and the Ablett Unit, where some families and local representatives have drawn parallels between concerns at the two units around the same time.

To ensure that a coordinated approach is taken across the Health Board to ongoing queries leading up the tribunal, the Interim Chief Executive has appointed the Executive Director of Workforce and Organisational Development (OD) to case manage the issue.

It is vital the Health Board is able to give confidence to its community and stakeholders that the recommendations from the Holden Report (2013) have been implemented and sustained. The Executive Medical Director and Executive Director of Nursing and Midwifery/Deputy CEO have commissioned work to validate that the recommendations have been implemented and remain in place at this current time. The Acting Associate Director of Quality Assurance is leading this work ensuring both a corporate objectivity to the work and a degree of independence given they have no prior involvement in the unit, division or report and only joined the Health Board within the last year. The work is supported by the Acting Divisional Director of Nursing for Mental Health and Learning Disabilities, who similarly has a degree of independence given they also have no prior involvement in the unit, division or report, and recently started working for the Health Board, whilst bringing extensive experience as a former executive nurse.

This work, due to the need to robustly validate the evidence, is aiming to be completed by the end of September for executive scrutiny and reporting to the QSE Committee at its next meeting in October 2020.

Cefndir / Background:

On 20 July 2013 the then Executive Director of Nursing and Patient Services visited the Hergest Unit in Bangor and spoke to a number of staff who raised concerns. In a letter, dated 26 July 2013, the members of staff concerned confirmed the exact nature of the allegations and confirmed the names of staff who had signed a petition stating that the signatories had "No confidence in the Management of the Mental Health CPG [Clinical Programme Group] in their dealings with the Hergest Unit."

Robin Holden was commissioned to investigate these concerns. A report was finalised and submitted on 08 December 2013. The Holden Report found:

- "With the exception of Taliesin Ward, the Hergest Unit is in serious trouble. Relationships between Staff and Management at Matron level and above have broken down to a degree where Patient care is in undoubtedly being compromised."
- "The lines of communication are critically weak and although regular management returns are received from the Wards one has to question whether these adequately reflect the worrying standards of the care being provided and the inherent level of clinical risk. These systemic communication weaknesses have been brought about, to a large degree, by a lack of presence on the Wards by Senior Managers."
- "The HIP [Hergest Improvement Plan] is a useful document which harvests the recommendations of both HIW and the DSU. However the execution, appears to be process driven."
- "There has been a critical underestimation of the training and personal development required by qualified and unqualified Ward Staff in order to prepare them for the journey ahead."
- "There is no trust in the Managers above Ward level. Consequently any Management interventions, even if well intentioned, are open to misinterpretation, further reinforcing the belief system that has become established."

The report did note:

- "During interviews with Managers there is acknowledgement that their approach to change could have been handled better and a willingness to attempt to engage more effectively with Staff. There is already some evidence of this in some of the later interviews, where staff advise that Ward rosters are being arranged in such a way that more Staff are able to attend HIP events."

The Holden Report made 19 recommendations:

1. "The current arrangements for the Management of the CPG are unwieldly. Responsibilities and lines of management are unclear. Relationships between significant numbers of Staff and Unit/Senior Managers have broken down. There appears to be a high number of temporary and interim posts. The BCUHB needs to review management arrangements of the CPG with a view to strengthening local management of the whole system. The temporary and interim posts need to filled with substantive post holders as soon as possible.

2. The issues surrounding the key relationship between the Modern Matrons and the Ward Managers needs to be addressed urgently. This critical breakdown in communication has created a worrying poverty of leadership in the Unit.

3. Attention needs to be paid to the status and impact of Mental Health Nursing in the Unit. The recently vacated Programme Manager post, could potentially be redesigned as an Advanced Nurse Practitioner or Nurse Consultant role developing and promulgating excellence in Acute Mental Health Nursing in the Hergest Unit and across the Health Board.

4. Special attention needs to be paid to repairing the relationship between the Modern Matrons and the Ward Managers. The commencement of this work may not be possible until after the grievance procedures that are currently ongoing have been resolved. Very skilled mediation will be necessary and HR advice will need to be sought on how best to facilitate this. This is such a critical area that it may be that expertise will need to be brought in if not available within the Health Board.

5. A structured programme of safety walk arounds and Ward visits should be implemented by the Senior Management Team in order to improve their presence on the wards.

6. Arrangements for regular briefing of Staff need to be implemented.

7. Steps need to be taken to better engage Staff in the change process. The current implementation plan is clearly in difficulty.

8. The Communication Strategy needs to be rethought. It needs to reflect the need for staff to be fully engaged on a personal level.

9. Change champions need to be identified throughout the unit, including the more junior and unqualified Staff. Arrangements should be put in place to ensure their time is protected to to enable their full participation. This approach would, in part, mirror the successful inclusive approach to change adopted by the current Interim Modern Matron when Ward Manager on Taliesin.

10. The concurrent implementation of the eight HIP work streams needs to be reconsidered. A glance at the plethora of implementation documents on the HIP notice board is a manifestation of the difficulties being experienced by the current implementation process. A better approach may be to consider the relative urgency of the work streams and prioritise them into smaller steps, in which the staff are engaged.

11. Arrangements need to be made for the Ward Staff to have opportunity engage with external networks of similar organisations. This is particularly important considering the relative isolation, geographically, of the Unit. Otherwise the opportunities for sharing and learning from best practice will be extremely limited.

12. A training and development programme, including arrangements for Appraisal, Management Supervision and Clinical Supervision, needs to be implemented for all Staff in the Unit. The weekly minuted Ward Managers meetings need to be reinstated without delay.

13. A system of recognition would be helpful where the contribution of individual Staff is celebrated.

14. Urgent attention needs to be paid to the how the Wards are staffed. The results of the benchmarking exercise recently undertaken, wherein the Unit's staffing establishment is seen as comparable with peers, are in stark contrast to the reported experience of those interviewed. This discrepancy is deserving of detailed scrutiny.

15. Staffing should be planned in such a way that it would be exceptional for Staff working a twelve hour shift to be unable to take a break.
16. The issues surrounding the Junior Doctors Rota need to resolved urgently.
17. The issue of the conflicting models of clinical care that have been adopted by Consultants on the Unit needs to be urgently addressed. The Ward Staff find the current arrangements difficult and it is likely that the current situation will have a deleterious effect on recruitment and retention of Senior Medical Staff.
18. The current arrangements for the care of frail elderly Patients needs to be urgently reconsidered. It is clearly unacceptable for the needs of frail vulnerable people to be neglected in the way that has been reported.
19. The current arrangements for Ward Rounds need to be addressed as the current arrangements are disruptive to the Nursing care that can be afforded to patients."

There had been external scrutiny of the services provided at the Hergest Unit around the same time period by Healthcare Inspectorate Wales (HIW), the Royal College of Psychiatry (Accreditation for Inpatient Mental Health Services, AIMS) and the NHS Wales Delivery Unit, as well as a consultation exercise undertaken by an external person which was terminated prior to completion. The recommendations made by these reviews were integrated into a single improvement plan known as the Hergest Improvement Plan (HIP).

Asesiad / Assessment & Analysis

As outlined above, the work to robustly collect and validate assurances that the Holden Report (2013) recommendations remain sustained in practice is underway and aiming for completion by the end of September for executive scrutiny, and reporting to the QSE Committee at its next meeting in October 2020.

Separately, the QSE Committee is asked to be assured that the Executive Director of Nursing and Midwifery/Deputy CEO and the Acting Associate Director of Quality Assurance are developing a corporate system to track significant quality related reports (including external reports) so that future monitoring, scrutiny and evidence collection is more robust and transparent. This system will be modelled on that currently in place to track and scrutinise HIW inspections and actions.

Strategy Implications

There are no direct strategy implications from the work summarised in this report, however the work will support the Health Board's commitment to be open and transparent.

Options considered

This report does not present any options for consideration.

Financial Implications

There are no direct financial implications from the work summarised in this report.

Risk Analysis

The completion of this work will support the Health Board's commitment to be open and transparent and is aimed to provide confidence to the Board and our community that actions identified in the Holden Report (2013) were implemented and remain sustained at the current time.

Legal and Compliance

There are no direct legal and compliance implications from the work summarised in this report. However, the Committee is asked to be mindful of the ongoing Information Tribunal process.

Impact Assessment

There are no direct equality, Welsh Language, data or quality impact assessment implications from the work summarised in this report. When complete, the work outlined in this report may make recommendations on future quality assurance arrangements.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 28th August 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Improvement Group (HASCAS & Ockenden) Chair's Assurance Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mrs Gill Harris, Deputy Chief Executive / Executive Director of Nursing & Midwifery
Awdur yr Adroddiad **Report Author:**	Claire Brennan, Head of Office, Executive Director of Nursing
Craffu blaenorol: **Prior Scrutiny:**	HASCAS & Ockenden Improvement Group
Atodiadau **Appendices:**	Appendix 1: Progress update of recommendations

Argymhelliad / Recommendation:

The Committee is asked to note the progress against the recommendations to date.

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**	**X**	**Er gwybodaeth For Information**	**X**

Sefyllfa / Situation:

The paper provides the progress update against the recommendations arising from both the HASCAS independent investigation and the Ockenden governance review.

Cefndir / Background:

The Quality, Safety & Experience Committee meeting held 28th January received a report on the progress against the HASCAS & Ockenden recommendations. The HASCAS & Ockenden Improvement Group was stood down during the pandemic and unfortunately the meeting due to be held in February was cancelled due to sickness. The HASCAS & Ockenden Improvement Group held its first meeting since the pandemic on 28th July, chaired by the Deputy Chief Executive / Executive Director of Nursing & Midwifery and was attended by senior representatives from the NW Community Health Council. The meeting reviewed the current position of each recommendation and reported on progress to date, acknowledging some disruption to the programme of work as a result of the pandemic.

The current status of the total 35 recommendations for both HASCAS & Ockenden is detailed below;

- 15 are reporting green, as on track to achieve delivery;

- 1 is reporting amber, where work is progressing but some additional focus or support is required to address some challenges that is impacting on timely progress;

- 19 recommendations have now been completed; these are relation to;
  – HASCAS 3: Care Homes & Service Integration
  – HASCAS 4: Safeguarding training
  – HASCAS 5: Safeguarding Informatics & Documentation
  – HASCAS 6: Safeguarding Policies & Procedures
  – HASCAS 7: Tracking of Adults at Risk across NW
  – HASCAS 13: Restrictive Practice Guidance.
  – Ockenden 2d: Recruitment of the second Consultant Nurse for Dementia
  – Ockenden 4b & 4c: Staff Surveys
  – Ockenden 10: Reviewing External Reviews
  – Ockenden 14: Board Development and prescribed disengagement.
  – Ockenden recommendation 2a – Quality Impact Assessment
  – Ockenden recommendation 2b – Integrated Reporting
  – Ockenden recommendation 3 – Policy Review
  – HASCAS recommendation 11 – Evidence Based Practice
  – Ockenden recommendation 2c – Workforce Development
  – Ockenden recommendation 4a – Staff Engagement
  – Ockenden recommendations 4d – Clinical Engagement
  – Ockenden recommendation 13 – Culture Change

The following graph shows the overall progress status of the 35 recommendations.
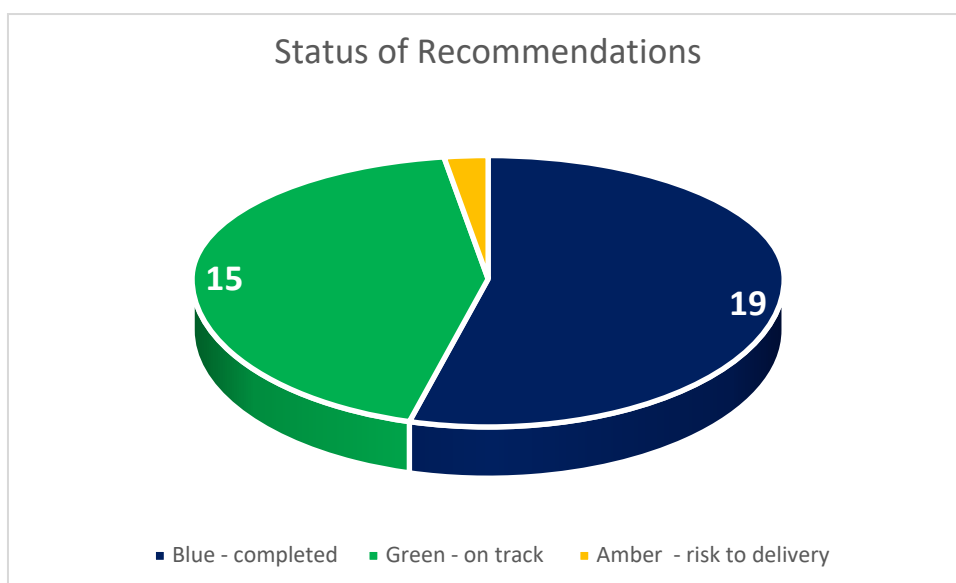
Improvement Group

The Improvement Group continues to monitor progress and scrutinise any risks to delivery and mitigating actions. The last meeting was held on Tuesday 28th July 2020 at which operational leads presented highlight reports on the current position and progress.

For recommendations that have previously been signed off as fully implemented, operational leads confirmed that work in response to the recommendations has been embedded into business as usual and continues to be monitored through local governance and reporting arrangements.

The Chief Officer and Deputy Chief Officer of the NW Community Health Council (CHC) were invited to attend for their review and comment on the delivery of actions to date in relation to the recommendations. Subsequent feedback from the CHC advised that they do not support sign off at this stage and proposed to take a broader and more comprehensive view of Mental Health services.

Stakeholder Group

The Stakeholder Group has met 7 times since its inception in October 2018 and is routinely scheduled to meet quarterly. The most recent meeting was held on 18th February 2020.

A number of stakeholders have provided support to the operational leads for the recommendations they expressed an interest in being involved with. The following are examples of some of the activities that stakeholder members have actively engaged in, relating to the work of recommendations as follows;

- In relation to safeguarding activity, stakeholder members were invited to engage with a Level 3 Mental Health & Learning Disabilities (MHLD) training event and asked to engage with the process, attend, and provide constructive comments and feedback in relation to the event and package content. Stakeholder member Mr J Gallanders provided a report detailing feedback from the training, which set out some key issues with regards to safeguarding training for both BCUHB staff and agency / bank staff. This report was received by the Stakeholder Group meeting and presented by Mr Gallanders and the Associate Director of Safeguarding Michelle Denwood.
- Stakeholder member were invited to engage with the revision of the Deprivation of Liberty Safeguards (DoLS) structure, consultation and review.
- Stakeholder members have participated as interview panel members.
- Some stakeholder Group members have undertaken visits to establishments, including Mental Health units and also end of life care facilities on Bryn Hesketh and Cefni. A second visit to Bryn Hesketh by two stakeholder members commended the photo wall within the end of life suite on the unit, which was donated by a staff member with an interest in photography, and printed onto washable vinyl with the support of third sector organisation. Stakeholders described the artwork as 'better than they could have imagined' and that it has transformed the unit.
- A member attended the first day of the 5 day aggression training course with the Positive Intervention and Clinical Support Services team.
- Another member has agreed to be actively involved in the Ablett Redevelopment group.

Operational leads have formally acknowledged the valuable contribution from the engagement and involvement that stakeholders have made in supporting the progress of actions.

To date, the Stakeholder Group has received presentations to highlight the work being undertaken to progress actions in the following areas;

- End of Life Care;
- Dementia Care in Emergency Departments;
- Restrictive Practice Guidance
- Neurological conditions (pathways)
- Estates OPMH including anti-ligature and the Ablett Redevelopment

- Draft Integrated pathway supporting access to health care for patients with a diagnosis of dementia, from referral to discharge
- Update on Dementia Services

The Stakeholder Group meetings were disrupted due to the pandemic and plans are in place to reconvene and also refresh the work of this group so we can continue to engage with and involve those members who have been actively engaged in the improvement work. The CHC have agreed to support this and wider engagement as appropriate.

Asesiad / Assessment & Analysis

Strategy Implications
The report is for administrative purposes in response to the findings of both the HASCAS Independent Investigation and the Ockenden Governance Review. In terms of impact the recommendations align to the overall improvement work that the Health Board is driving.

Financial Implications
The Executive Team have agreed the funding for the required additional posts to support progress of the relevant recommendations where this need was identified.

Risk Analysis
Additional resources required have been identified to support 3 of recommendations in order to progress the work further to deliver improvements and fully address the recommendations

Legal and Compliance
There are no legal implications

Impact Assessment
Operational leads will undertake any necessary equality / quality impact assessments where applicable within the remit of the work for their respective recommendations

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Recommendation	Operational lead	Timescale																			Progress Update
		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	
HASCAS 1 Integrated Care Pathways An integrated service review is required to map the needs of the older adult and those with dementia across north Wales. This review needs to involve all stakeholders (from the statutory, independent and voluntary sectors) and those with performance responsibilities. The review should include all care and treatment settings (not just those) confined to mental health and older adult services in order to ensure that all interventions are integrated and that patients, service users and their families do not encounter service barriers that prevent them from receiving access to the care, treatment and support that they need **Ockenden 1 Integrated service model for Older People & dementia** The patient pathway for service users of older people's mental health was fragmented from the 'birth' of BCUHB in 2009 and remains fragmented today from the perspective of many service users, service user representatives and carers (as of the end of 2017). As of the end of 2017 there has been insufficient evidence seen by the Ockenden review team that the patient pathway and the systems, structures and processes of governance underpinning service provision for vulnerable older people at BCUHB is improving. The current service model remains fragmented with multiple service providers across health, social care, the voluntary sector and other independent sectors. There will be the need for extensive multi-agency working between BCUHB and a range of partners with continuing oversight by the BCUHB Board and Welsh Government as this work progresses **Ockenden 12 Older Persons strategy** Develop a clear plan for the clinical services of older people to improve training across the workforce, set clinical standards and uniformity with a solid foundation of evidenced based policies and procedures	Associate Director of Nursing																					Three logic models have been developed to demonstrate the outcomes, measurable outputs and a list of activities required to achieve the overall objectives of the (HASCAS 1, Ockenden 1 and Ockenden 12 recommendations). Former implementation plans have been translated into the logic models, and are now used as our baseline for delivery. There are eight specific actions identified to be achieved in this combined programme of work for the older person, 6 of which are completed. Work continues to progress the 2 remaining actions, which are now two thirds complete, in relation to an integrated service gap analysis which is acknowledged as a longer term action and care pathways for older persons and dementia that are under development.

■ Fully Implemented   ■ on track for delivery   ■ risk to delivery requires attention

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HASCAS 2 & Ockenden 8 Dementia Strategy BCUHB is required to develop a detailed and costed action plan to support the implementation of its Dementia Strategy; the plan should be developed in partnership with the Regional Partnership Board response to the Welsh Government's new Dementia Plan. This work should be undertaken in conjunction with (HASCAS) Recommendation 1. The action plan should incorporate the consequent implications and requirements for all clinical services (not just the mental health directorate) in all care and treatment settings (community, primary and secondary care). The dementia strategy should be developed to work across all relevant clinical services across BCUHB not just within the MH&LD division. The dementia strategy should incorporate care across home, primary care and secondary care.	Area Nurse Director (West)	🟩 on track																				The logic model for HASCAS 2 has been refined with clearer outcomes, measurable outputs and a list of activities required to achieve the overall desired impact. The former implementation plan has therefore been translated into this logic model, and is now used as our baseline. There are 6 main outputs to be achieved within the programme of work, which have now been completed. The RPB integrated NW Dementia Strategy has now been completed following extensive consultation across all 6 counties and with a variety of stakeholders. No meetings have been held to progress this during COVID-19 phase 1 period. The BCUHB contribution is the development of the Dementia Clinical Strategy. The governance group had been established and started meeting to draft this but was stood down during lockdown.
HASCAS 3 Care Homes & Service Integration The current Care Home work streams need to be incorporated into a single action plan, which in turn should dovetail into the pre-existing BCUHB mental health and dementia strategies.	Associate Director of Nursing	🟩 on track (Jan-19 to Jun-19), 🟦 Fully Implemented (Jul-19)																				The logic model for HASCAS recommendation 3 has been refined with clearer outcomes, measurable outputs and a list of activities required to achieve the overall desired impact. The former implementation plan has therefore been translated into this logic model, and is now used as our baseline. The three main outputs to be achieved within the programme of work have been completed.
Ockenden 2d Consultant Nurse in Dementia There is currently only one Consultant Nurse in Dementia for the whole of BCUHB. With the currently extensive work plan this single post-holder is already likely to be stretched very thinly. Going forward there will not be sufficient Consultant Nurse resource to even begin to get to grips with the recommendations arising from this review and the HASCAS investigation. BCUHB should take active steps to appoint a second Consultant Nurse in Dementia.	Area Nurse Director (West)	🟦 Fully Implemented (Jan-19)																				The second Consultant Nurse for Dementia was successfully recruited to in July 2019. Recruitment process now in place due to impending retirement of the existing 2 consultants in post currently.

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HASCAS 4 Safeguarding Training BCUHB will revise its safeguarding training programme to ensure it is up to date and fit for purpose. The updated training programme will incorporate all relevant legislation and national guidance BCUHB will engage with all prior safeguarding course attendees to ensure that they are in receipt of the correct and updated guidance. The responsibility for this will be overseen by the relevant BCUHB Executive Director with responsibility placed on all clinical service managers from all of the clinical divisions within the organisation BCUHB has not been able to ensure staff attend safeguarding training sessions in the numbers required. There are multiple factors involved which will require a detailed and timed action plan with external oversight.	Associate Director of Safeguarding	🟩	🟩	🟩	🟩	🟦																All existing safeguarding training packages have been refreshed and updated to ensure that packages are in line with current legislation. A learning environment has been created, led and embedded by Corporate Safeguarding. This is promoted online and through the Safeguarding Bulletin, which targets education, learning and updates relating to legislation, policy and procedures. Robust analysis of training compliance occurs through the refreshed Safeguarding Reporting Framework and into Area/Secondary Care /Divisional governance Training Reports are undertaken and areas of low compliance within Safeguarding Training are identified and scrutinised. Underperforming areas are reported via the Safeguarding Reporting Framework and into Area / Secondary Care / Divisional governance forums. And actions taken to remediate. Activity continues to embed safeguarding practice and is monitored via the Safeguarding reporting framework.
HASCAS 5 Safeguarding Informatics and Documentation BCUHB has conducted an audit on the compliance of safe filing safeguarding information in patients' case notes. BCUHB will ensure that the consequent recommendations it set in relation to informatics in its BCUHB Corporate Safeguarding Team Safeguarding and Protections of People at Risk of Harm Annual Report 2017-18 are implemented namely;• The use of the dividers to be re-iterated in safeguarding training, briefings, and other communication activities and a key annual audit activity;• Process of secure storage of strategy minutes of strategy meetings and outcomes of referrals to be revisited at safeguarding forums with legislative guidance from Information Governance;• Team and ward managers to continue to include safeguarding documentation in team meetings and safety briefs.BCUHB will reconsider how clinical teams should record safeguarding information and the quality of the information provided.	Associate Director of Safeguarding	🟩	🟩	🟩	🟩	🟦																The Health Records department and the Associate Director of Safeguarding have worked collaboratively to support the review and amendment of the safe storage of safeguarding information in clinical records in line with the Social Services & Well-Being Wales Act and GDPR. Good Record Keeping (GRK) training has been delivered, which incorporates a sign off element for safeguarding to ensure that records are correct. Initial scoping work has been completed to review the approach for the transition to a digitalisation system from paper records by the Health Records Department.Good Record Keeping Training now explicitly includes a section on filing safeguarding information.Communications cascaded on Things You Need To Know (TYNTK) to remind staff of the importance of appropriately filing 'safeguarding' informationSupplier of the safeguarding divider (for the case note folders) include updated Safeguarding terminology and also include the harm agenda. A list of documents which are to be included behind the divider has been set out.The GRK Training and communications from the action above are being used to strengthen the HR1 Policy for appropriate filing of safeguarding information. Level 3 Record Management training is included within the Safeguarding Training portfolio. This package incorporates the safe storage of safeguarding information.

🟦 Fully Implemented   🟩 on track for delivery   🟧 risk to delivery requires attention

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HASCAS 6 Safeguarding Policies & Procedures The BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017-2018 identified that there were priority actions required in relation to safeguarding policies and procedures. This investigation recommends that these priority actions are incorporated into the action plan consequent to the publication of this report. The actions are; • To identify those policies, procedures and SOPs that firmly sit within the Safeguarding remit and those that should be the responsibility with internal and external partners • Agree a priority list and activity timeframe to review documents within the parameters of corporate safeguarding • Provide safeguarding expert advice to internal and external partners in order that those documents are reviewed appropriately and in line with local and national policy band legislative safeguarding frameworks; • Agree a governance structure and reporting framework for all safeguarding policies, procedures and SOPs; • Update and maintain the Safeguarding Policy webpage; • Continue to actively participate in the Policy and Procedure sub group of the Regional Safeguarding Boards	Associate Director of Safeguarding	🟩	🟩	🟩	🟩	🟦																All policies and procedures within Corporate Safeguarding have been identified and a register has been implemented which manages version control and the publishing of policies in a timely and accurate way. The Safeguarding team are linking in with the Board Secretary and the Policy on Policies (PoP) and the work to develop a central repository as part of this process. A priority list of policies was identified with a full review of Phase 1 completed of which the priority procedures and guidance were approved at QSG. In addition, other key processes have been signed off. The work for this recommendation continues to be monitored via the Safeguarding Governance & Performance Group.
HASCAS 7 Tracking of Adults at Risk across NW BCUHB will work with multi-agency partners through the North Wales Adult Safeguarding Board, to determine and make recommendations regarding the development of local safeguarding systems to track an individual's safeguarding history as they move through health and social care services across North Wales in order to ensure ongoing continuity of protection for that individual.	Associate Director of Safeguarding	🟩	🟩	🟩	🟩	🟦																BCUHB worked in collaboration with North Wales Safeguarding Adult Board to coordinate a Task and Finish Group for shared learning with regard to documentation and communication. The Lead Practitioner programme has been developed in collaboration with the North Wales Safeguarding Adults Board (NWSAB). Over 70 key BCUHB staff were identified to participate in the pilot and undertake the Lead Practitioner training, which was implemented by July 2019. This programme represents a major change in how Adults at Risk are coordinated and managed across the Health Board and will result in a more individualised and improved experience for the patient. The programme will continue to be rolled out, implementation is a priority for 2020-21 and progress is monitored via the NW Adult Safeguarding Board.

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HASCAS 8 Evaluation of Revised Safeguarding Structures / Ockenden 6 Safeguarding Structures BCUHB will evaluate the effectiveness of its new safeguarding structure in the fourth quarter of 2018/2019. This will be overseen by Welsh Government	Associate Director of Safeguarding	🟨	🟨	🟨	🟨	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	An evaluation of the existing 2017 Organisational Change Policy safeguarding structure was presented to Quality & Safety Group on 10th January 2020. A safeguarding and DoLS business case will be prepared for approval and implementation of a revised and enhanced service model. This will incorporate 7 day on-call / flexible working to support access to Safeguarding service delivery outside of service hours. The vacant Business Manager job description has been reviewed and is awaiting banding review prior to commencing employment and recruitment process. As part of the organisational update the third and final phase of the current Safeguarding JDs are in the process of being reviewed to ensure that they are fit for purpose. The Named Doctor Adults at Risk Job Description, implementation and engagement requires further action to progress. The Executive Medical Director is progressing this, which will need reorganisation of the senior medical roles in 20/21 to enable the development of this new part, the delay for this has been included on the risk register. Corporate safeguarding have provided information to support an internal audit relating to governance and organisational accountability which confirmed substantial assurance as the outcome from this audit.
HASCAS 9 Clinical Records BCUHB needs to undertake a detailed check of clinical records in the investigation cohort to evaluate and reorder all co-mingled case notes. BCUHB needs to ensure that none of the commingling involving living patients could have led to any inappropriate acts or omissions on the part of clinical treatment teams during any episode of care (past and present) BCUHB needs to restructure and redesign its hard copy clinical records archiving and retrieval systems. This redesign needs to provide assurance in relation to the tracking of individual case notes across North Wales together with a set of service level agreements pinpointing the timeframes required for clinical record retrieval and access.	Chief Information Officer	🟥	🟥	🟥	🟥	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟨	🟩	🟩	Actions progressed to ensure correction of the co-mingling of the cohort records. Good Record Keeping Training includes a section on filing safeguarding information. Communications cascade undertaken on the Health Boards internal corporate bulletin to remind staff of the importance of appropriately filing safeguarding information. Safeguarding divider for the case note folders are updated to include full list of documents provided by Safeguarding lead. Health records policy (HR1) redesigned to take account of transition to digital records and scheduled for sign off in September. Clinical Audit lead has also included checks for co-mingling within the annual clinical audit of case notes, this will be resource matched by support from within the Health Records service. Action to strengthen the checks made by the Access To Health Records (ATHR) teams prior to release - Service is now live in Central and East with new

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Recommendation	Operational lead	Timescale (Jan-19 – Aug-20)	Progress Update
(continued from previous recommendation)		**Jan-19–Apr-19: red; May-19–Jun-20: yellow (risk to delivery requires attention); Jul-20: green (on track)**	processes and a digitised approach to collating and providing responses via secure web services, including comprehensive co-mingling checks being carried out. The need for additional resource required in the ATHR service to roll out to the West and maintain QA standards that ensure compliance, however, this has been declined this financial year. The service will therefore undertake a 'pause and review' of the new ATHR service to inform the resources required to i) complete the roll out of the service to the West and ii) to reduce breaches to more tolerable levels. Recruitment process was unsuccessful for a Band 7 Project Manager required to undertake baseline work of the storage, processes, management arrangements & standards compliance, for all types of patient records and present the business case for pan-BCUHB compliance with legislation and standards for in patient records management. This approach has subsequently been reviewed post COVID to ensure compliance with new restrictions in the undertaking of the review (within Health Records resource) with a focus on how to progress this at pace. Work is expected to commence in Q2 with the aim to make up as much time as possible within the constraints and conclude as planned for Q4.
HASCAS 10 Prescribing & monitoring of anti psychotic medication The updated BCUHB 2017 antipsychotic prescribing guidance will be kept under review and be subject to a full audit within a 12 month period of the publication of this report. BCUHB will continue to work with care homes across North Wales to provide practical clinical advice, guidance and training so that residents with behaviours that challenge can be supported and kept safe with the minimal amount of anti-psychotic medication possible. The effectiveness of this should be built into the antipsychotic prescribing guidance audit.	Chief Pharmacist	**Jan-19–Jul-19: yellow (risk to delivery requires attention); Aug-19–Aug-20: green (on track)**	Anti-psychotic prescribing audits have been completed within primary care and secondary care. Results are being collated and will be presented to OPMH and other clinicians initially, prior to wider presentation to other divisions / specialities and primary care. Anti-psychotics also features within the single care home action plan developed for Recommendation 3. CAIR (checklist for antipsychotic initiation and review form) has been developed and distributed to all OPMH and Community Mental Health Teams (CMHT) across MH&LD division which has reported limited uptake to date. Actions identified to issue posters and reminders to wards to raise staff awareness with further audits undertaken to monitor completion of the forms. CAIR forms will also be sent out to care homes and discussions around education and training are in progress. Training plan to be developed for staff following a recognised need for training and awareness of the purpose and side effects of anti-psychotics and the need for a benchmark assessment before starting anti-psychotics.

Legend:
- ■ Fully Implemented
- ■ on track for delivery
- ■ risk to delivery requires attention

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HASCAS 11 Evidence Based Practice BCUHB will conduct a review of all clinical policies to determine the ratification processes that were conducted together with an assessment of the appropriateness of content and currency; this will include all hard copy policy documentation still retained in clinical areas, and all electronic documentation held currently on the BCUHB intranet.	Acting Board Secretary											■										The new external BCUHB website is now live and work continues to upload revised policies. This work is now considered business as usual. A policy working group has been established to review policies and subsequently reduce the significant focus within QSE committee meetings to sign off the significant number of revised policies.
HASCAS 12 Deprivation of Liberties BCUHB will conduct a formal audit and provide a progress report in relation to the 2017-2018 action plan. This will include a review of any barriers to implementation (such as office accommodation) together with a timed and resourced action plan to ensure full implementation can be taken forward in 2018-2019 **Ockenden 9 Deprivation of Liberties** BCUHB will complete and report to the BCUHB Board a review of the 2017-18 DoLS work plan as set out in the 2017-18 Annual Report. Any remaining actions are required to be SMART.	Associate Director of Safeguarding																					Internal Audit has been provided with evidence to support the scope of the internal Safeguarding DoLS audit, the outcome of the audit was confirmed as limited assurance against DoLs activity and identified 5 key recommendations. These have all now been implemented with the exception of the appointment of the remaining BIA post, progress has been made and the employment and recruitment process is being followed. DoLS activity during the period of 2017-18 has been reviewed. Based upon the outcome of this activity and the evaluation of 2018-19 Safeguarding annual report action log. A paper was presented to QSG 10th January 2020 relating to the proposed revised structure of the DoLS team. On agreement, this will enable full implementation of the actions, reduce risk and increase activity. The paper will be presented to F&P Committee. The role and responsibility of the DoLs signatory has previously been held by the Office of the Medical Director. Since the transfer of this responsibility to the Office of the Nurse Director and Corporate Safeguarding Team, the number of signatories has risen to approximately 40 and an evaluation of the activity is taking place. An evaluation of new working practices has taken place including the Mental Capacity Documentation Pilot and the Signatories training package and was reported to Safeguarding Governance & Performance Group on 22nd January 2020. The impact of the training to signatories has increased awareness & understanding for clinical professional staff in their workplace and contributed to the largest number of applications in 2019-20 (1014, an increase of 37% compared to the previous year).

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HASCAS 13 Restrictive Practice Guidance BCUHB will provide assurance that all older adults and those with dementia are in receipt of lawful and safe interventions in relation to restrictive practice management across all care and treatment settings within the BCUHB provision	Director of Nursing (Mental Health)	🟩	🟩	🟩	🟩	🟦																The 2 policies relating to the positive reduction of challenging behaviours and physical restraint, have both been subject to governance scrutiny and review and are fully ratified and operational. A full schedule of training dates in proactive approaches was established for all clinical areas where a training need was identified. Following an initial pilot training by the PICSS team this was then handed over to the corporate training team. Uptake has been low and this is being addressed by the Head of Health & Safety and Violence & Aggression Manager to discuss a revised approach for 2020-21. Training in the use of Datix to report incidents of restrictive physical intervention is included. PICSS team continue to monitor any corporate RPI incidents and are able to effectively monitor for compliance and best practice and where necessary escalate to relevant governance structures. Responsibility to monitor incidents outside of the MHLD division remains requires additional support from relevant medical clinician. Year on year comparisons of incidents of RPI being used within clinical environments throughout the organisation shows a marked reduction in key areas. Within the MHLD division, BCUHB Psychiatric Intensive Care Unit staff (Tryweryn) together with Caniad showcased a number of initiatives being introduced to the wards to the Leaders Collaborative conference. This included new ideas and approaches in reducing restrictive practices, improved co-production and a revised all Wales training syllabus in the prevention and management of behaviours which challenge.
HASCAS 14 Care Advance Directives BCUHB will conduct an audit to establish how many patients and their families have advance directive documentation within their clinical records together with care plans in relation to choice and preference about end of life care	Senior Associate Medical Director	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	The monitoring process which commenced in November 2018 is ongoing and continues to capture data on End of Life paperwork for inpatient deaths, this includes 'What Matters', future care plans, Advance Care Plans (ACP), treatment escalation plans (TEP), care decisions, DNACPR etc. This will provide baseline data for improvement work and also enable the identification of patients for more in-depth review. End of life case note reviews for inpatient notes were held in April and May with clinical staff from palliative care and mental health teams, based on the 5 priorities of care for the dying person, which showed that in general, patients were receiving the 5 priorities of care, although not in as timely a manner as required and that end of life conversations needed to

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																						take place earlier. Results have been analysed and an audit report finalised. Out of date guidance was found in critical care and national updated guidance is awaited.
HASCAS 15 End of Life Care Environments Improve end of life environment on OPMH wards and associated guidance training	Senior Associate Medical Director																					First round of bespoke EoLC training programme with Consultant Psychiatrists and ward managers has concluded. Evaluation of training very positive, 68% registered OPMH nurses attended. Interest expressed from other groups e.g. Adult psychiatry. A meeting was held with stakeholders recently to provide assurance of progress. Positive feedback had also been received regarding the improvements to the bereavement rooms. National Audit for Care at End of Life has been received and is being considered within the services. This provides a baseline for ongoing care improvements. Strategic Group for Palliative and End of Life Care chaired by Dr Chris Stockport established with agreement that these recommendations now form part of the work of this group. During COVID-19 period the OPMH wards have worked in partnership with palliative and end of life team members to ensure all had high quality care to the end. There has been mortality reviews with specialists from outside MH&LD to quality assure this.
Ockenden 2a Quality Impact Assessment QIAs (where the clinical implication of financial savings plans are assessed by Executive members of the BCUHB board) were 'still in the process of refinement' (as of Spring 2017). Evidence is required of focussed Board attention going forward	Acting Board Secretary											(Fully Implemented)										An internal audit brief to review whether the Health Board has an adequate system for developing, monitoring and managing quality impact assessments, concluded. The draft report issued on 19th March and a further revised report following management comment issued on16th June. The Executive approved management response remains outstanding. Once approved the progress against recommendations will be logged in the electronic Teammate system. A robust monitoring process is in place via the quarterly review of the audit tracker undertaken by the Audit Committee. The work of this group is now considered business as usual with robust monitoring process in place via the review and audit tracker.

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Recommendation	Operational lead	Timescale (Jan-19 → Aug-20)	Progress Update
Ockenden 2b Integrated reporting There is a need for further urgent and sustained Board attention to full integration of the systems, structures and processes underpinning financial, corporate and clinical governance and the Board will need to assure itself that it has effective integration and timely oversight and scrutiny of workforce planning, financial planning, performance and quality going forward.	Acting Board Secretary	On track (green) Jan-19 to Oct-19; Fully Implemented (dark blue) Nov-19	Two cycles of Health Economy reviews were completed following the Interim Accountability framework the second cycle was informed by learning from the first review and outcomes fed back. Accountability reviews were stood down temporarily during COVID-19 period and are due to be reinstated from September. A quarterly planning cycle is now in place with regular reporting to Board / Committee. Work is currently underway to review and strengthen governance and accountability across the organisation. A Board Workshopo will be held in August, facilitated by the Kings Fund to agree Board priorities and strategic objectives. This will be followed by a second workshop to populate the Board Assurance Framework and the corporate risk register based on the agreed priorities and objectives. This will then provide a clear direction for the organisation supporting transparent lines of accountability, and consistency of behaviours. A clear accountability framework is to be established that ensure the cascading of objectives from Board level right through the organisation. The work of this group is now considered business as usual with a robust process for reporting in place and monitoring any future changes through integration arrangements and structured assessments will be monitored through clear process going forward.
Ockenden 14 Board Development The work of Swaffer and the WHO/ United Nations should be introduced to the Board in a Board seminar/ Development day in the second quarter of 2018-19 and a programme of introduction to the whole of BCUHB should commence in the third quarter of 2018- 19 with reports to the Board on the introduction and utilisation of 'Prescribed Dis-engagement' every quarter.	Acting Board Secretary	On track (green) Jan-19 to Oct-19; Fully Implemented (dark blue) Nov-19	This action was completed through the Health Board participating in a dementia friendly awareness session delivered on 10th January 2019 and this training will form part of any future board members induction. A further dementia friendly awareness session was held for senior managers as members of the Executive Management Group on 3rd July.
Ockenden 2c Workforce Development BCUHB will need to provide significant amounts of targeted workforce and organisational development support in the form of extra team members to support the MH&LD and specifically OPMH with recruitment and retention expertise across medical, nursing and support services going forward. The MH&LD will need to utilise this support to creatively explore different ways of working and new and effective ways of recruiting and retaining staff. There will need to be efficient, timely and effective recruitment processes in place at all times to support MH&LD going forward	Executive Director of Workforce	Risk to delivery (yellow) Jan-19 to Jul-19; On track (green) Aug-19 to Oct-19; Fully Implemented (dark blue) Nov-19	An organisational improvement plan for retention is in place and the Workforce & Organisational Development (WOD) teams are working together to improve retention in hotspot areas. WOD teams are also working with the Assistant Directors of Nursing to improve retention on identified wards and examine exit interview data. The WOD senior workforce group has now been superseded by the Workforce Improvement Group and monitoring progress on Mental Health workforce objectives. A number of nursing student graduates are due to qualify in March 2020 eligible for registration within the

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HASCAS & Ockenden Recommendations progress update to Quality, Safety & Experience Committee 28th August 2020

Recommendation	Operational lead	Timescale																			Progress Update
		Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	
																						MHLD Division. Work is ongoing to recruit to fill substantive posts. Appointments have been made to posts to address Mental Health Measure performance support the Mental Health Measure A dashboard is developed to monitor workforce performance for the MH&LD division. Improvements can be seen in areas of turnover and time to hire
Ockenden 3 Policy Review Ensure a review of all clinical policies within all BCUHB divisions to include quality checks on how the policies and guidelines were ratified, their due date of review and a full understanding of those policies that are overdue for review. This review will need to be undertaken of all BCUHB policies held on the intranet and a BCUHB Board 'amnesty' announced for submission of all paper copies of policies and guidance held within individual clinical areas in hospitals and across the community. Once an appropriate archive of these policies are created they should be destroyed so that they cannot be returned to clinical practice as a 'work around solution' to lack of access to policies and guidance electronically. BCUHB should then undertake a comprehensive review of all existing BCUHB policies to ensure the needs of older adults are specifically considered within all relevant policies.	Acting Board Secretary																						Ockenden recommendation 3 is linked to HASCAS recommendation 11 in terms of the policy work, which continues to upload revised policies onto the BCUHB new website. Consultant Nurse for Dementia is linked in with this work to ensure consideration of dementia as a quality impact within policies. A policy working group has been established to review policies and subsequently reduce the significant focus within QSE committee meetings to sign off revised policies. The work for this recommendation is agreed as business as usual with work ongoing to continue to upload the revised policies and agreed monitoring arrangements established.
Ockenden 4a Staff engagement The BCUHB board and the MH&LD divisional senior management team is recommended first to ask front line staff 'what does the term 'staff engagement' mean to you, 'what would effective staff engagement look like for you?' and then to develop a system of bespoke meaningful and sustained staff engagement first across mental health and specifically older persons mental health. The Board may then wish to consider how effective their engagement is with staff across BCUHB and decide whether a new Board approach is required to staff engagement across the whole of BCUHB	Executive Director of Workforce																						The Staff Engagement strategy approved in 2016 identified key activities and achievements required to successfully realise the strategy and the Health Board have received six monthly updates on progress and achievements since the launch. One of the elements included in the strategy was the adoption of a tool which would give the Health Board the ability to measure staff engagement on an ongoing basis. 'Be Proud' Pioneer Programme is specifically aimed at teams to improve and sustain staff engagement so that they can better understand challenges and barriers to engagement and provide support to build improved engagement behaviours. Quarterly surveys are in place to continue to measure staff engagement.

■ Fully Implemented	■ on track for delivery ■ risk to delivery requires attention

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		🟨	🟨	🟨	🟨	🟩	🟩	🟩	🟩	🟩	🟩	🟦										The work for this recommendation is considered as business as usual with work ongoing to review and monitor the ongoing work through the Workforce Improvement Group.
Ockenden 4b & 4c Staff surveys The Ockenden review team was informed that the NHS staff survey across Wales is completed every 3 years and is next due in 2019. WG may wish to consider an annual staff survey in line with that carried out in England. Aside from any potential decision by WG, the BCUHB Board should commence a formal annual BCUHB staff survey starting with the all Wales staff survey at BCUHB on an annual basis from 2020.	Executive Director of Workforce	🟨	🟨	🟨	🟨	🟩	🟩	🟦														The 2018 NHS Wales annual staff survey has been undertaken and the results revealed a number of positive improvements since the 2013 and 2016 survey. The next national NHS Staff Survey will take place in 2020. The Organisational Survey has been redesigned and tailored to the Health Boards needs with additional Wellbeing and Equality & Diversity questions. The results of the first BeProud organisational engagement survey report saw a 20.29% response rate, which equates to 1400 individuals from a range of disciplines across the Health Board. BCUHB's internal staff engagement survey has been launched and will run on a quarterly basis with an improvement planning process integral to its monitoring. The actions undertaken for this recommendation are now considered business as usual with the work ongoing for the staff surveys being monitored through the Workforce Improvement Group.

Legend:
- 🟦 Fully Implemented
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Ockenden 4d clinical engagement BCUHB must take urgent and sustained steps to ensure the continued involvement of all clinical colleagues in the leadership and management of BCUHB	Executive Director of Workforce	risk	risk	risk	risk	on track	on track	on track	on track	on track	on track	Fully Implemented										Three Medical and Dental conferences have now been held the third one reviewed points raised at the previous two conferences and provided an update on actions taken to address topics that were raised. 3D staff listening methodology has been developed and used widely throughout the Health Board by staff engagement ambassadors. An interactive toolkit together with a range of materials are also available online for staff to access and use. 3D is also an integral part of the Be Proud Pioneer team toolkit. Clinical Leadership meetings are established on a quarterly basis A Ward Managers Development programme has been established to develope management and leadership skills and competencies to enable individuals to build effective capability within their roles as clinical leaders. A Matrons development programme has also been established which commenced at the end of 2019. A bespoke engaging leadership development programme has been developed in partnership with our external provider Carter Corson. The programme is called 'Leading for Transformation' and has held 5 cohorts with 75 senior leaders engaged. Clinical engagement work is now considered business as usual and encompassed within the workforce objectives with all development programmes mainstreamed into the Organisational Development team's work on an ongoing basis.
Ockenden 5 Partnership working BCUHB needs to work effectively at a strategic level with the voluntary sector and a wide range of multi-agency partners to develop, provide and sustain services to older people and older people with mental health needs and dementia across North Wales	Assistant Director Health Strategy	risk	risk	risk	risk	risk	risk	risk	risk	on track	on track	on track	on track	on track	on track	on track	on track	on track	on track	on track	on track	Proposal to devolve the centrally held Voluntary Organisation budget and establish a commissioning forum approved by the Executive Team and a paper on the refresh of third sector working was finalised in September 2019 and has also been shared with the Stakeholder Reference Group and Community Voluntary Councils. This will be taken forward as business as usual resumes. Third sector budgets are devolved to divisions for local management. This will support local ownership, management and decision-making in relation to these budgets and services and increase assurance and governance in relation to service expectation and outcomes for the relevant population across all such grants and contracts. Revised set of principles have been developed working with the Stakeholder Reference Group sitting alongside plan and a refresh of the strategy with the sector. Third sector contracts have been rolled forward in light of the pandemic. Confirmation of arrangements for

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		🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	review and management is being discussed with the contracts team.
Ockenden 7 Concerns Management Whilst it is acknowledged that on many occasions since 2009, BCUHB has made an effort to improve the timeliness of responses to concerns in line with the requirement of Putting Things Right (2011) this has not yet been sustained on an ongoing and long term basis. It is clear that the BCUHB Board have very little knowledge of the actual everyday experience of families, service users and service user representatives who try to make complaints to BCUHB as an organisation. Service user representatives also raised the reluctance of families and service users to complain and the fear they have of complaining	Associate Director of Quality Assurance	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	Revised national targets are in place through the new National Delivery Framework. The Health Board reported 72% compliance in May against the national target of 75%, this is the highest the Health Board has achieved and the best position in Wales. Work on the complaints process redesign recommenced in June 2020 with implementation of a new process planned for January 2021. The national work on the Once for Wales Concerns Management System re-commenced in July 2020 with a revised launch date of a new complaints module for 01 April 2020. The national work on the Once for Wales Patient Feedback System re-commenced in July 2020 with a revised launch date of late summer subject to the national procurement process. The Health Board sent 3 representative to the virtual tender evaluation workshop. Work progresses on an internal real time patient feedback option so it can be considered alongside the national offer A new virtual complaints contact centre is in place allowing incoming calls to be received resiliently by complaints staff across North Wales regardless of base. This allows for Welsh language requirements to be better met, for queries to be actioned more rapidly, and for complaints to be dealt with as Early Resolutions more effectively.
Ockenden 10 Reviewing external reviews BCUHB needs to undertake a review of all external reviews (including those by HIW, the NHS Delivery Unit and others) where any findings, recommendations and requirement may have concerned older people and specifically the care of older people with mental health concerns. The exercise needs to be completed across all Divisions and all sites by the end of the second quarter 2018/2019, (the end of September 2018) and reported to the BCUHB Board by November 2018.	Acting Board Secretary	🟩	🟩	🟩	🟩	🟩	🟩	🟦														Following the review undertaken by the Corporate Nursing Team to strengthen assurances the BCU/HIW management plan introduced to provide additional assurance processes continues to be implemented. All open/outstanding actions arising from these inspection reports continue to be monitored/managed on a monthly basis by the Quality and Safety Group. The work of this recommendation is now considered business as usual with agreed monitoring arrangements in place.
Ockenden 11 Estates OPMH BCUHB should prepare a detailed estates inventory across the care settings for all of older people including but not limited to OPMH. Firstly this should include clarity and specificity of all outstanding	Director of Estates & Facilities	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	A site-by-site schedule (inventory) of outstanding repairs and maintenance work for MH&LD buildings has been completed. Work is continuing through Operational Estates to complete any outstanding jobs and the schedule is updated monthly to monitor

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estates issues including outstanding repairs and estates issues raised as concerns with internal audits and external reviews and inspections. The estates inventory should be prepared for each ward, clinic, department, inpatient unit and hospital department where care is provided to older people and older people with mental health issues. This includes where care is provided to people with dementia. The estates inventory should include for each area an audit based on the work for Enhancing the Healing Environment.																						progress and report to the group. A detailed inventory of previous External Audits and Inspections by HIW & CHC relating to MH&LD OPMH facilities has been prepared and all outstanding actions are now completed. Work Stream 2 commenced in April 2019/20 while still awaiting approval of additional resources as identified within Work Stream 1 Funding agreed to recruit project management support to undertake the ward assessment and undertake additional repairs and maintenance. Funding has been allocated to recruit additional Maintenance craft operatives to work directly with MH&LD. Outstanding repairs are reviewed on a monthly basis. Actions placed on hold due to COVID-19 and access / lock down controls.
Ockenden 13 Culture change There will need to be sustained, visible (in clinical areas), stable leadership within MH&LD division over a longer period of time to ensure that the culture within mental health and specifically OPMH continues to develop in a positive way. The cultural change that is necessary towards dementia needs to happen across BCUHB and to happen from Board to Ward. This cultural change needs to happen not just within MH&LD but everywhere within BCUHB where care and treatment may be provided to persons with dementia, their families and friends.	Executive Director of Workforce																					The Health Board is strengthening its offer of skilled level dementia training for clinical staff. Current training is aligned to the 'Good Work' framework and modules are being developed further by placing additional emphasis on the important role of the carer. This work is underway with TIDE, an involvement network for carers of people living with dementia, hosted by the Life Story Network CIC. Its mission is to be the voice, friend and future of all carers and former carers of people with dementia. TIDE is supporting carers to share their experiences by training them to acquire appropriate skills and competencies in delivering training. The project is overseen by the Consultant Nurse for dementia The national Staff Survey Project Group continues to implement approaches that develop and build an "in-house" ongoing sustainable approach to measuring colleague experiences as agreed by the Welsh Partnership Forum and in line with Welsh Government strategies. The new approach will help develop the NHS Wales culture so that colleagues regularly give and receive feedback. Organisational Improvement Plan has been developed following a number of staff engagement events as well as drawing on data from the qualitative element of the staff survey and has been approved by Board. As the organisation approaches the end of the first quarter, a process is in place to feedback these outcomes to our staff through as many communication channels as possible. The Organisational Development team have worked closely with the Communications team to develop a Communication Strategy to support this.

	Fully Implemented		on track for delivery		risk to delivery requires attention

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																						All divisions are progressing their improvement plans and developing their communication approach to ensure staff receive feedback on local actions. The 'You Said, We Did' template has been shared with divisions but any local communications channels can be used to update staff. The work for this recommendation is now considered business as usual and will continue to monitor progress via the Workforce Improvement Group.

■ Fully Implemented	■ on track for delivery	■ risk to delivery requires attention	

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 28th August 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quality Governance Self-Assessment Action Plan
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Acting Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience and Liz Jones, Assistant Director of Corporate Governance
Craffu blaenorol: Prior Scrutiny:	Review by responsible director and executive director
Atodiadau Appendices:	1. Quality Governance Self-Assessment Action Plan
Argymhelliad / Recommendation:	

The Committee is asked to:
1. Consider and approve this first draft version of the Quality Governance Self-Assessment Action Plan.
2. Confirm that update reports will be required at each future meeting until such times as the actions are complete and the Committee assured.

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**	

Sefyllfa / Situation:

Following submission of the Quality Governance Self-Assessment to Welsh Government on 01 January 2020, an action plan (attached at Appendix 1) was developed that recorded each action identified in the submission and a lead officer and target date.

The Committee is asked to be mindful and note that due to COVID-19, this is the first time this action plan has been presented and that many of the actions within it have been affected by due to clinical and operational prioritisation. The Acting Associate Director of Quality Assurance has extended deadline dates to reflect the COVID-19 delay.

Cefndir / Background:

Following well publicised events at Cwm Taf Morgannwg University Health Board, the Royal College of Obstetricians and 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 QSE Committee is asked to consider and approve this first draft version of the Quality Governance Self-Assessment Action Plan.

It is proposed that updates are provided to each future meeting of the committee until such times as the actions are complete and the Committee assured.

BCUHB Quality Governance Self-Assessment Action Plan

[For the purposes of the following table, 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]

Recommendation 1 - Organisational quality priorities and outcomes to support quality and patient safety are agreed and reflected within an updated version of the Health Board's Quality Strategy/Plan.			
Action	**Lead**	**Deadline**	**Update**
Strategic Focus on Quality, Patient Safety and Risk [baseline level of assurance – Medium] 1a. Production of an updated QIS: The QIS is currently being reviewed and is undergoing an Internal Audit Review. The findings from the Audit will be used to shape the revised QIS alongside the agreed priorities for the Health Board. Timeline for approval – workshop proposed for February 2020, then QSE and approval at May 2020 Board.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021	Development of the Quality Strategy has been on hold due to the need to respond to the Covid-19 pandemic. A plan for resuming this work and producing an updated Quality Strategy (including engagement) is due for presentation at QSG in September 2020 with a view to a new stragey being in place for 2021-2024.
1b. Production of a Clinical Strategy: A detailed timeline for the Clinical Strategy is being developed.	David Fearnley, Executive Medical Director	TBC	The timeline, and further development of the Clinical Strategy has been disrupted by

			Covid-19. This work will be picked up again as part of the return to business as usual. In the immediate COVID period significant work has been underway through the COVID Clinical Pathways Group and Clinical Advisory Group (now Clinical Strategy Group) to develop standard clinically developed pathways across the Health Board.
1c. Production of Communication Plan: Alongside the development of the QIS, Clinical Strategy and Annual Plan will be a communication plan which will ensure effective dissemination across the Health Board.	Matthew Joyes, Acting Associate Director of Quality Assurance & David Fearnley, Executive Medical Director	TBC	The development of the Communication Plan will follow the timeline of the key strategic documents to which it is linked This work will be picked up again as part of the return to business as usual.

Recommendation 2 - The Board has a strategic and planned approach to improve risk management across the breadth of its services. This must ensure that all key strategies and frameworks are reviewed, updated and aligned to reflect the latest governance arrangements, specifically:

   i.   **The Board Assurance Framework (BAF) reflects the objectives set out in the current Integrated Medium Term Plan (IMTP)/annual plan and the organisation's quality priorities.**

   ii. **The Risk Management Strategy reflects the oversight arrangements for the BAF, the Quality and Patient Safety (Clinical) Governance Framework and any changes to the management of risk within the organisation.**

iii. The Quality and Patient Safety Governance Framework supports the priorities set out in the Quality Strategy/Plan and align to the Values and Behaviours Framework. Terms of reference for the relevant Board committees, including those for Audit, Quality and Safety and Risk, and at divisional /group levels, reflect the latest governance arrangements cited within the relevant strategies and frameworks			
Action	**Lead**	**Deadline**	**Update**
[Baseline level of assurance – low/medium] 2a. Once ratified by the Board, monitor implementation of updated Risk Management Strategy and audit key performance indicators, formally reporting results to the Risk Management Group.	Justine Parry, Assistant Director of Information Governance and Risk	01/10/2020	The Risk Management Strategy and Policy was ratified by the Board on the 23rd July for full implementation on the 1st October 2020. A Board workshop has been set for 22nd September to populate the BAF and CRR. Supporting Procedures and processes are being updated and shared across the Health Board ready for full implementation. Compliance with the revised risk management arrangements will commence from 1st October 2020. The Terms of Reference and Cycle of Business for the Risk Management Group have been updated to reflect the required changes in formal reporting to the Audit Committee. These also include the requirement for monitoring of risks, auditing of key

			performance indicators, improvements in processes / systems and sharing lessons learnt.
2b. Provide Chairs' Assurance Report from the Risk Management Group on progress and outcomes to the Audit Committee.	Justine Parry, Assistant Director of Information Governance and Risk	01/10/2020	The Terms of Reference for the RM Group has been updated to reflect this change in reporting which commenced in January 2020. Due to COVID-19, the RM Group was stood down, but is now meeting bi-monthly and will re-commence these reports to the Committee.
2c. Deliver training to key individuals and groups across whole Health Board to provide consistent approach for the management of risk, the hierarchy for training will be developed alongside strong monitoring arrangements.	Justine Parry, Assistant Director of Information Governance and Risk	01/10/2020	See 2a above – linked to launch of new Strategy. Board workshop set for 22nd September with following dates for risk leads being arranged.
2d. Ensure the RM Group meets at least 4 times during the year.	Justine Parry, Assistant Director of Information Governance and Risk	01/06/2020	See 2a above – linked to launch of new Strategy. Terms of Reference for the RM Group has been updated to reflect meeting bi monthly.
2e. Ensure all risks within DATIX are realigned to the new 3 tier model.	Justine Parry, Assistant Director of Information Governance and Risk	01/10/2020	See 2a above – linked to launch of new Strategy. RM Strategy will be fully implemented from 1st October 2020. An RM Improvement Plan has been developed for 2020/21 and will be monitored through the RM Group (which reports to Audit Committee). Work is already

			underway with Divisions to complete validation exercises and move to the new 3 Tier system following the agreed procedures, which will be monitored by the RM Group. The alignment of divisional governance teams under corporate oversight will further support this work.
2f. Principal risks to be presented to the Board at a further workshop to agree and review in line with the current CRAF arrangements.	Dawn Sharp, Interim Board Secretary	30/09/2020	Workshop organised for the 22nd September 2020
2g. Ensure the new approach to the BAF will align to the organisational priorities from a risk and quality perspective.	Dawn Sharp, Interim Board Secretary	30/09/2020	Workshop organised for the 22nd September 2020
2h. Develop Patient Safety Strategy and review all other pillars of the Quality and Patient Safety Governance Framework to ensure full alignment with the work programme to strengthen governance across the organisation.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021	Development of the Quality Strategy has been on hold due to the need to respond to the Covid-19 pandemic. A plan for resuming this work and producing an updated Quality Strategy (including engagement) is due for presentation at QSG in September 2020 with a view to a new stragey being in place for 2021-2024.
2i. Undertake Governance Review led by the Deputy CEO This review will seek to ensure that there is clear alignment and escalation of risks to the Board as appropriate and reflect the latest	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021	The governance review has been on hold as a result of Covid-19, and is now being taken forward. Executive Team discussion on future structures and groups took

governance arrangements as cited within the relevant strategies and frameworks.			place on 26.5.20. A revised paper on QSE sub-structure is being presented in August 2020 with a six month implementation period.

Recommendation 3 - There is collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads:			
i. *The role of Executive Clinical Directors and divisional/group Clinical Directors in relation to quality and patient safety is clearly defined*			
ii. *The roles, responsibilities, accountability and governance in relation to quality and patient safety within the divisions/groups/directorates is clear*			
There is sufficient capacity and support, at corporate and directorate level, dedicated to quality and patient safety.			

Action	Lead	Deadline	Update
[Leadership of Quality and Patient Safety. Baseline level of assurance – Low] 3a. Establish Clinical Leads for new pathways and networks: In addition to Clinical Directors, Lead Consultants and Lead Clinicians, the Health Board will be establishing Clinical Leads for the new pathways and networks as part of the new digitally enabled clinical strategy.	David Fearnley, Executive Medical Director	31/12/2020	Executive Team discussion took place on 20.5.20 regarding the future model of clinical engagement, capitalising on the success of the Clinical Advisory Group established as part of the Covid-19 response. The CAG has demonstrated how clinical input and leadership can augment the (Covid-19) clinical pathway development process, and how this might be optimised for

			business as usual in future. Broadening the membership of CAG's successor group, and utilisation of key individuals such as Cluster Leads, will provide enhanced options for identifying Clinical Leads for pathways and networks.
3b. Governance Review being led by Deputy CEO to clarify and make recommendations to strengthen any arrangements where felt appropriate; this will include the composition of the local governance teams across BCUHB.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021	The governance review has been on hold as a result of Covid-19, and is now being taken forward. The alignment of governance teams under corporate oversight is underway and a proposal is being taken to QSE on its sub-structure in August 2020; further review of local governance will follow during the next stage.
3c. Learning from the HIW review of Maternity Services and Birth Centres to be used to strengthen internal processes.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/12/2020	This work has been paused due to Covid-19. A review of HIW processes is due to start in September 2020. The Health Board will also consider the findings of the national maternity review due at the end of the year. The strong relationship with HIW has been maintained during COVID, and tracking of actions from inspections has been maintained. A new tracking database for HIW actions and evidence has been developed.

| 3d. Governance review to further support work already undertaken by assessing if failings and gaps identified within Cwm Taf exist within BCUHB and ensure that where these are identified strengthened and improved.   This will include the use of data and dashboards for and how these are reported through to the Board. | Matthew Joyes, Acting Associate Director of Quality Assurance | 31/12/2020 | The governance review has been on hold as a result of Covid-19, and is now being taken forward. The alignment of governance teams under corporate oversight is underway and a proposal is being taken to QSE on its sub-structure in August 2020; further review of local governance will follow during the next stage. A refreshed Quality Dashboard is in development with an expected launch of September 2020. |

| Recommendation 4 - *The roles and function of the Quality and Safety Committee is fit for purpose and reflects the Quality Strategy, Quality and Patient Safety Governance Framework and key corporate risks for quality and patient safety. This should include assessment of ensuring sub-groups/committees have sufficient support to function effectively; the content, analysis, clarity and transparency of information presented to the committee and the quality framework in place is used to improve oversight of quality and patient safety across the whole organisation.* |||||

Action	Lead	Deadline	Update
[*Organisational scrutiny of quality and patient safety.* *Baseline level of assurance – Low/Medium]* 4a. Governance Review will provide further opportunity to ensure fitness for purpose of the overall structure, reporting and escalation. Following the review implementation of the recommendations of the will be monitored by QSE.	Gill Harris, Deputy CEO and Executive Director of Nursing & Midwifery	31/12/2020	The governance review has been on hold as a result of Covid-19, and is now being taken forward. Executive Team discussion on future structures and groups took place on 26.5.20.

4b. Function and remit of QSE Committee, and cycle of business, to be reviewed to ensure that the Committee is operating effectively and sufficient focus is given to the quality, safety and experience priorities for the organisation. This will also provide an opportunity for the CBMG to reflect on the reporting arrangements across the different committees to ensure sufficient clarity and oversight at Board level.	Dawn Sharp, Acting Board Secretary	31/12/2020	This work has been paused as a result of Covid-19.
4c. Broadening of the visibility of the QPSE dashboard as well as other metrics within the internal viewing system IRIS to be undertaken alongside the development of the Clinical Strategy.	Matthew Joyes, Acting Associate Director of Quality Assurance	30/09/2020	The timeline, and further development of the Clinical Strategy has been disrupted by Covid-19. This work will be picked up again as part of the return to business as usual. In the immediate COVID period significant work has been underway through the COVID Clinical Pathways Group and Clinical Advisory Group (now Clinical Strategy Group) to develop standard clinically developed pathways across the Health Board. The proposed Clinical Effectiveness Group has a remit around the measurement of quality along clinical pathways. A refreshed Quality Dashboard is in development with an expected launch of September 2020.

Recommendation 5 - Independent/Non-Executive Members are appropriately supported to meet their responsibilities through the provision of an adequate induction programme and ongoing development so they can effectively scrutinise the information presented to them.			
Action	**Lead**	**Deadline**	**Update**
[Baseline level of assurance – Medium] 5a. Ensure that the Board Development and Workshop programme is strengthened to include all elements within the IM role e.g. Consultant Interviews. And consider feedback from the work with the King's Fund which will further support the development programme for IMs	Dawn Sharp, Acting Board Secretary	31/12/2020	Ongoing Board Development and Workshop programme in place. A workshop has been arranged for 20 August 2020.
Recommendation 6 - There is sufficient focus and resources given to gathering, analysing, monitoring and learning from user/patient experience across the organisation. This must include use of real-time user/ patient feedback.			
Action	**Lead**	**Deadline**	**Update**
[Baseline level of assurance – Medium] 6a. Greater emphasis to be placed on the "learning element of listening to patients and services users" throughout 2020 as described in the Patient Experience Strategy, this will include the "You said, We did" approach.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021	A refresh of the Patient and Carer Experience Strategy was paused in March due to Covid-19. This has now recommenced and plans are underway for a refreshed strategy to be in place to cover 2021-2024 aligned with the

Action	Lead	Deadline	Update
			Quality Strategy and Patient Safety Strategy.
6b. Review the processes for concerns (incidents, complaints, claims, etc.) - the Community Health Council will be a key part of this work.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/12/2020	The review of the complaints and incidents processes commenced during early 2020, but was paused in March due to Covid-19. This is now being taken forward again with an implementation date of 01 January 2021.
6c. Hold a workshop planned jointly with the CHC, to strengthen how the complaints and patient experience teams within the Health Board, and the CHC, work more closely together.	Matthew Joyes, Acting Associate Director of Quality Assurance	28/02/2020	**COMPLETED.** The workshop with the CHC was held and following internal review a new senior complaints lead has been appointed to maintain oversight of all CHC complaints develop relationships.

Recommendation 7 - There is visibility and oversight of clinical audit and improvement activities across divisions/groups/directorates and at corporate level. This includes identification of outliers and maximising opportunities for sharing good practice and learning.

Action	Lead	Deadline	Update
[Baseline level of assurance – Low] 7a. Embed arrangements following adoption of revised Clinical Audit Policy.	Melanie Maxwell, Senior Associate Medical Director	31/12/2020	The Clinical Audit Policy was approved by the Audit Committee; arrangements will be embedded as part of the return to business as usual.

Action	Lead	Deadline	Update
7b. Review the clinical audit plan and reporting arrangements, including identification of outliers and learning, to ensure that it is outcome focussed and facilitates quality improvement activities across the organisation – monitor progress through the governance reporting structure going forwards.	Melanie Maxwell, Senior Associate Medical Director	31/12/2020	This work has been paused due to Covid-19.

Recommendation 8 - The organisation has clear lines of accountability and responsibility for quality and patient safety within divisions/groups/directorates.			
Action	**Lead**	**Deadline**	**Update**
[*Arrangements for quality and safety at directorate level.* *Baseline level of assurance – Low/Medium]* 8a. Complete work to formally identify a Clinical Director for each speciality - as part of the governance review, ensure that reporting lines and structures are fully considered and recommendations to strengthen/improve made.	David Fearnley, Executive Medical Director	31/12/2020	This work was paused due to Covid-19 and will be recommenced as part of the governance review.

Recommendation 9 - The form and function of the divisional/group/directorate quality and safety and governance groups and Board committees have:			
i. Clear remits, appropriate membership and are held at appropriate frequently.			
ii. Sufficient focus, analysis and scrutiny of information in relation to quality and patient safety issues and actions.			
iii. Clarity of the role and decision making powers of the committees.			
Action	**Lead**	**Deadline**	**Update**
[Baseline level of assurance – Low/Medium] 9a. Implement actions from the governance review (see section 4 above), where necessary in order to further strengthen this governance element.	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021	This work was paused due to Covid-19. See section 4 above.
Recommendation 10 - The organisation has clear and comprehensive risk management systems at divisional/group/directorate and corporate level, including the review and population of risk registers. This should include clarity around the escalation of risks and responsibilities at directorate and corporate level for risk registers and the management of those risks. This must be reflected in the risk strategy.			
Action	**Lead**	**Deadline**	**Update**
[Identification and management of risk. *Baseline level of assurance – Low/Medium]* 10a. Move to Enterprise Risk Management model and from a 5 Tier model to a 3 Tier version, to strengthen escalation and de-escalation processes.	Justine Parry, Assistant Director of Information Governance and Risk	01/10/2020	See section 2. Included in the revised Risk Management Strategy and Policy, which was ratified by the Board on the 23rd July 2020 for full implementation on the 1st October 2020.

Action	Lead	Deadline	Update
10b. Implement and monitor revised Risk Management Policy.	Justine Parry, Assistant Director of Information Governance and Risk	01/10/2020	See section 2. Revised risk management monitoring arrangements will commence on the 1st October 2020, and are included in the updated Terms of Reference and Cycle of Business for the RM Group. This requirement has also been captured within the Risk Management Improvement plan which will also be monitored by the Risk Management Group.
Recommendation 11 - The oversight and governance of DATIX and other risk management systems ensures they are used as an effective management and learning tool. This should also include triangulation of information in relation to concerns, at a divisional/group/ directorate or corporate level, and formal mechanisms to identify and share learning.			
Action	**Lead**	**Deadline**	**Update**
[Management of incidents, concerns and complaints. *Baseline level of assurance – Medium]* 11a. Ensure the Patient Safety Strategy strengthens reporting arrangements and focus on learning from all opportunities.	Matthew Joyes, Acting Associate Director of Quality Assurance		See section 2. This work was put on hold due to Covid-19. This has now recommenced and a new strategy is expected to be in place to cover 2021-2024 aligned with the Quality Strategy and Patient and Carer Experience Strategy.
11b. Ensure the Listening and Learning from Patient Experience Report and CLIC (Concerns,	Matthew Joyes, Acting Associate	31/03/2020	**COMPLETED.** A new format Patient Safety Report and Patient and Carer Experience Report for

Litigation, Inspections, Claims) Report are reviewed and improved in order to provide the QSE Committee with further improved data and analysis, and a link to improvement activity	Director of Quality Assurance		QSE are both in place. Q4 reports were submitted to QSE and Q1 reports for 2020/21 have been produced.
11c. Ensure that the review of concerns/incidents/complaints/claims also includes a focus on HIW and CHC inspections/ visits as well as a link into risk management structures/ BAF in order to further strengthen triangulation	Matthew Joyes, Acting Associate Director of Quality Assurance	31/12/2020	The reports mentioned above in 11b contain HIW and CHC information following integration of the corporate teams under the Acting Associate Director of Quality Assurance.

Recommendation 12 - The organisation ensures staff receive appropriate training in the investigation and management of concerns (including incidents). In addition, staff are empowered to take ownership of concerns and take forward improvement actions and learning.

Action	Lead	Deadline	Update
[Baseline level of assurance – Medium] 12a. Enhance the training programme for concerns with the introduction of a modular series of training and a passport scheme	Matthew Joyes, Acting Associate Director of Quality Assurance	31/03/2021	This work was put on hold due to Covid-19. New training will be in place to support the new processes being implemented from January 2021.

Recommendation 13 - The organisation has an agreed Values and Behaviours Framework that is regularly reviewed, has been developed with staff and has a clear engagement programme for its implementation.			
Action	**Lead**	**Deadline**	**Update**
[Organisational learning and culture. *Baseline level of assurance – Medium]* 13a. Ensure continued focus on delivery of the organisational and Divisional Improvement plans.	Sue Green, Executive Director of Workforce & OD	31/03/2021	This work has paused due to Covid-19 and will be refreshed to include the learning from the initial COVID response.
13b. Deploy a single improvement system across the organisation	Sue Green, Executive Director of Workforce & OD	31/03/2021	This work has paused due to Covid-19.
Recommendation 14 - The organisation has a strong approach to organisational learning which takes account of all opportunities presented through concerns, clinical audit, patient and staff feedback, external reviews and learning from work undertaken within the organisation and across the NHS.			
Action	**Lead**	**Deadline**	**Update**
[Baseline level of assurance – Low/Medium] 14a. Establish clinical summits (chaired by the Executive Medical Director) with clinical leaders and the executive team, to review the quality of the main pathways (e.g. looking at safety, national clinical audit data, outcomes and experience measures) as a key aspect of delivering a new digitally enabled clinical strategy.	David Fearnley, Executive Medical Director	31/03/2021	This work has paused due to Covid-19. See sections 7 and 11.

14b. Ensure national clinical audits are explicitly embedded in the new clinical strategy and pathways – and used to benchmark the Health Board so that organisational learning can be improved.	Melanie Maxwell, Senior Associate Medical Director	31/03/2021	See section 7

Mortality reviews at BCUHB

Agenda

- A description of the process to provide assurance to QSE
  - Describe a whole-system flow

- Describe the 'new' Medical Examiner inputs into mortality reviews and its impact

- Describe the mortality reporting process during Covid 19

Mortality : reporting to learning

- Should be a 3 phase process

    - Reporting

    - Reviewing

    - Learning

    - [Improvement]

Processes for reporting mortality in BCU

Learning stage

QSE Committee

Mortality assurance report showing:
- summary of deaths per service (e.g. three year trend plus quarter and monthly change)
- themes from all deaths (from reviews across BCU)
- areas for improvement (services to provide assurance) overall progress of actions

Reducing Avoidable Mortality Steering Group
- produces QSE mortality assurance report

QSG

Service level reports showing:
- deaths data (numbers of deaths as above)
- themes and areas for improvement reported in more detail with action plans

Review stage

Mortality and Morbidity Meetings

Stage 2 Review

Esp. maternity, child, MHLD deaths

Serious incident review

Putting Things Right

Stage 1 Review

Medical Examiner

Reporting stage

Datix report of death

(new Datix module under development)

Coroner

Registration of death

ONS

Hospital death

Community death

Verification of Life Extinct

Medical Examiner Service for Wales

- Provide an independent scrutiny of **all** deaths *not involving the Coroner.*
  - Employed by NHS Wales Shared Services Partnership
  - This role will be undertaken away from the place they generally work
  - Will commence with acute service deaths (in patients) with roll out to community/primary care **completed by April 2021**

- Experienced doctors with additional training in death certification and documentation review.
  - Various specialty backgrounds - primary & secondary care

- Ensure an accurate cause of death recorded/ identify concerns for further investigation. Takes views of bereaved into account.

- Recruitment completed in North Wales - plan to commence service from Autumn

Medical Examiner Service Model

Office of the Lead Medical Examiner for Wales
- Ensure Service compliance with legislation and national guidelines
- Strategically plan and operationally manage all Wales service
- Collate and analyse data
- Provide summary reports to stakeholders at local and all Wales levels
- Liaise with HB/Trust Clinical Governance systems, Welsh Government, National Medical Examiner

Medical Examiners
- Peripatetic team covering the whole of Wales
- Scrutinise all deaths using Mortality Stage 1 process
- Liaise with Attending Practitioner, Coroner, Registrar
- Issue confirmation of the Cause of Death Certificate
- Initiate Stage 2 Mortality Review or Coroner investigation process where required

Medical Examiner Officers
- Locally based in ME Offices on main Hospital sites (19)
- Prepare Case Files for ME scrutiny
- Liaise with the bereaved, care professionals, local Governance Teams, Bereavement Officers, Coroner's Officers, Registration Service Offices

Mortality Review during Covid Pandemic

- Stage 1 – death screening continued, Stage 2 suspended for the current time.
  - Any death that required incident reporting was logged.
  - most common reason for referral to stage 2 was because the death had been referred to the Coroner.
- Death certification legislative changes introduced
  - Certification completed by GMC registered doctor –independent (of care team) review
- On-going surveillance through internal systems to monitor site/community inpatient deaths
- Participated in weekly national Medical Director meetings – non-covid and covid mortality surveillance (HB level)
- Focus of mortality work was ensuring processes in place for managing Covid deaths

Changes delivered through OMD:

- Standard Operating Process for reporting Covid deaths
  - Reporting deaths likely to be of media interest
  - Completion of the e-form notification to PHW

- Escalation Plan for Excess Deaths (draft)
  - Standard Operating Process for recognition of life extinct by non-medical healthcare workers for unexpected deaths
  - Revised current Nursing Policy for verification of expected death (currently in consultation phase)

- Responding to media inquiries/ freedom of information requests etc.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 28th August 2020
Cyhoeddus neu Breifat: Public or Private:	Public (the presentation to be delivered is embargoed until presented)
Teitl yr Adroddiad Report Title:	Healthcare Inspectorate Wales (HIW) Annual Report 2019-2020
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Acting Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience
Awdur yr Adroddiad Report Author:	Erika Dennis Business Manager, Corporate Nursing
Craffu blaenorol: Prior Scrutiny:	Review by responsible director and executive director
Atodiadau Appendices:	HIW Annual Report

Argymhelliad / Recommendation:
The Committee is asked to receive for assurance the report and the presentation from the Healthcare Inspectorate Wales (HIW) Senior Inspector for the Health Board.

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	X	Er gwybodaeth For Information	

Sefyllfa / Situation:

The purpose of this paper is to provide the Committee with the Healthcare Inspectorate Wales Annual Report 2019-2020 which will be presented to the QSE Committee on 28 August 2020 by Emma Scott, Senior Healthcare Inspector / BCUHB Relationship Manager at HIW. The HIW Annual Report for 2019-20 was received by the Health Board on 5 August 2020. Subsequently, this has allowed limited time for the Health Board to review the findings in advance of the Committee. Below is an overview of the report and an update on the Health Board's position, based on the findings listed in the report.

Overview

Over the past year, HIW have carried out 206 visits to various wards, establishments, Health Boards and healthcare providers across Wales in the NHS and in the independent sector (179 in 2018-19). For BCUHB, HIW completed the following inspections;

- 7 hospital inspections (2 in 2018-19)
- 6 general practice inspections (5 in 2018-19)
- 8 dental practice inspections (21 in in 2018-19)
- 3 mental health inspections (3 in in 2018-19)

Further details of the inspection type and locations are located on **slides 5, 6 and 7** of the PowerPoint provided by HIW. As noted above, there has been an overall increase in the amount of inspections

which have been undertaken by HIW. There is also a noticeable increase in the amount of hospital inspections and a significant decrease in the amount of dental practice inspections.

Key themes / findings

Whilst it is good to know that patients felt they were treated with respect by staff and the quality of the care they received was of a good standard, it is concerning to hear that there are still issues across the Health Board in relation to the following areas;

- Training being provided and kept up to date, as well as the overall standard of record keeping.
- Lack of action as a result of HIW inspections (particularly evident across the two hospital Mental Health inspections conducted in 2018/19).

For assurance, please refer to the table below which confirms the progress of actions arising from HIW inspections of our Mental Health & Learning Disabilities Service. There are no outstanding actions from 2017. These are located in the archived HIW Corporate Tracker held by Corporate Quality Assurance. All actions for 2018 are implemented (complete) and some actions remain in progress for 2019 and 2020.

Overall, **79%** of actions have been implemented by Mental Health & Learning Disabilities. A total of **15** actions from 2019 remain in progress. The Business Manager (Quality Assurance and Regulation) is working with leads within the Division to ensure that these actions are implemented in a timely manner, to provide support and to escalate any issues to the Quality and Safety Group (QSG)

Mental Health & Learning Disabilities Inspection	Inspection	Action Status		Grand Total
		Implemented	In Progress	
Bryn y Neuadd (West) Acute, Psychiatric and Rehabilitation unit	January 2020	14	4	18
Kestrel Ward (West) Child and Adolescent Mental Health Service (CAMHS)	June 2018	19		19
Ty Derbyn (East) Community Mental Health Team (CMHT)	October 2019	34	11	45
Cemlyn Ward (West) Older Persons Mental Health	September 2019	3	4	7
Grand Total		**70**	**19**	**89**

The most common Health and Care Standards themes which relate to the actions noted in the table above are as follows;

- Safe and Clinically Effective Care
- Managing Risk and Promoting Health & Safety
- Medicines Management
- Timely Access
- Health Promotion, Protection and Improvement

The Mental Health & Learning Disabilities Service are responsible for their local action plans, as are each Division/Speciality. The Corporate Quality Assurance Team ensure oversight of HIW improvements plans, reporting monthly to the Quality Safety Group (QSG), and up to QSE Committee ad hoc. This ensures that actions are continuously monitored, reviewed and allows for escalation and assurance.

With reference to **slides 11 and 12**, it is important to highlight to the Committee that not all dental and general practice inspections are BCUHB managed. As such, only 2 of the 14 inspections relate to BCUHB managed practices (namely general practices). For the remainder which are not managed practices, the Primary Care Directorate have worked with practices to support completion of improvement plans.

However, as with hospital inspections, there are issues with records, infection prevention control measures and audits. As such, there is significant improvement required.

Hospital Inspections

As confirmed by HIW, 7 hospital inspections (secondary care) took place at BCUHB during 2019-20;

1. **Unscheduled Care**, Emergency Department, Ysbyty Gwynedd, June 2019
2. **Midwifery & Women's Services**, Midwifery Led Units, Glan Clwyd, September 2019
3. **Trauma & Orthopaedics**, Ysbyty Glan Clwyd, July 2019
4. **Unscheduled Care**, Emergency Department, Wrexham Maelor, August 2019
5. **Midwifery & Women's Services**, Midwifery Led Units, Ysbyty Gwynedd, November 2019
6. **Midwifery & Women's Services**, Midwifery Led Units, Wrexham Maelor, January 2020
7. **Midwifery & Women's Services**, Birth Units x 3 (West), January 2020

	Midwifery & Women's Services		Midwifery & Women's Services Total	Trauma & Orthopaedics		Trauma & Orthopaedics Total	Unscheduled Care		Unscheduled Care Total	Grand Total
Row Labels	Implemented	In Progress		Implemented	In Progress		Implemented	In Progress		
2019	54	4	58	33	6	39	37	15	52	149
2020	95	10	105							105
Grand Total	149	14	163	33	6	39	37	15	86	254

The table above provides an overview of progress against actions for all 7 hospital inspections. Of the total **254** actions across all hospital site inspections, 219 actions have been implemented (completed) by services which is **86%**. The remaining **14%** of actions are in progress. The Business Manager (Quality Assurance and Regulation) continues to work with Heads of Services and Divisional Leads to ensure that those actions are reviewed monthly and a report on progress is provided to QSG.

From the 7 hospital inspections, HIW have identified the following areas for improvement **(slide 9)**;

- Poor infection prevention and control compliance in some areas
- Learning from audit, concerns and incidents
- Overall governance and leadership within the community birthing units.

In addition to the progress against actions, it is important to consider what improvements have been implemented. As a direct result of the above, listed below are some of the improvement actions which our services have taken to ensure the provision of safe care and quality of care;

- Freestanding Midwifery Units (FMUs) were temporarily closed. As such, the maternity teams were temporarily relocated to non NHS premises that have been risk assessed for clinical activity which are exclusively used for antenatal clinics. This has been updated again as a result of Covid-19 and HIW updated accordingly.
- Standard Operating Procedures developed and ratified at QSG
- Quality Assurance audits undertaken and reported to QSG via exception reports
- Infection Risk Assessments undertaken with support from the Infection Prevention Control (IPC) team, including input from Health & Safety and Estates where applicable
- Local improvement plans developed with updates reported from local level meetings such as clinical governance, up to QSG
- Business cases submitted in order to increasing the support of demand and patient flow

Next Steps

Publication of the report is scheduled for 28 August 2020.

The report will be presented to Board on the 24 September 2020 by Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery.

The report will feature in future reporting to QSG to ensure it continues to be considered throughout the year.

Cefndir / Background:

HIW inspect the NHS in Wales, from general practices to hospitals. HIW assess compliance based on the Health and Care Standards 2015, the Independent Health Care (Wales) Regulations 2011, and National Minimum Standards (NMS) for Independent Health Care Services in Wales. They also have a specific responsibility to ensure that vulnerable people receive good care in mental health services. As such, HIW also inspect mental health and learning disability settings and considers compliance with legislation.

There is an agreed internal Standard Operating Procedure (SOP) for HIW along with a timeline which confirms the HIW timescales for issuing the Health Board with any immediate concerns and/or improvement plans for completion, based on the findings from the inspections.

Corporate Quality Assurance is responsible for;

1. Managing all HIW correspondence and improvement plans
2. Quality assuring all HIW correspondence
3. Managing the Corporate HIW Tracker Tool and expediting actions / updates from Divisions
4. Act as the conduit between the Health Board and HIW
5. Preparing monthly exception reports for Quality & Safety Group

Each improvement plan is captured in the Corporate HIW Tracker Tool which allows for further review of actions once they have been implemented. The aim of which is to provide further assurance and to ensure oversight of improvements required.

Asesiad / Assesent & Anaysis

Strategy Implication

The provision of quality care in a safe environment is paramount to the Health Board's Quality Strategy, and Living Healthier Staying Well. These are part of our overall key objectives.

Financial Implications

Costs will be incurred in each service / area and will differ depending on HIW recommendation / Health Board action, and some costs will be part of the maintenance / refurbishment programme. Failure to provide safe care, can result in a complaint, claim and compensation of which there can be significant financial implications.

Risk Analysis

There is a risk of harm to staff if the estate or facilities is not fit for purpose. If staff are unable to provide suitable care, there is a risk of harm to the patient. There is also a reputational risk, particularly in terms of the press following any negative reports and immediate concerns.

Financial risk is associated with costs of any claims.

There is a risk of non-compliance with regulations. When standards are not met, HIW make recommendations for improvement, these feed into the NHS Wales Escalation and Intervention Arrangements.

In addition, if HIW do not receive sufficient assurance that action has been taken to address issues, they can take enforcement action.

Members are asked to note, that one of the matters raised in the HIW inspection report for Midwifery & Women's Services (ensuring that policies and procedures are reviewed and updated within appropriate timescales), are reflected on the corporate risk register under risk ID 2052, Tier 2, with a current score of 12 (High) and a target score of 4 (Moderate). Mitigating actions currently in place include;

1. Full list of Clinical written control documents (WCDs) have been compiled and sent to Compliance and Assurance Manager on 5 December 2019.
2. Compliance and Assurance Manager will review and input into the main database format developed.
3. New list to be cross referenced against existing database and cascade extraction to identify duplicates/omissions (Office of the Board Secretary).
4. Final list to be reviewed and segmented into priority/area for submission to QSG prior to moving into newly developed intranet site (Office of the Board Secretary).
5. Stratification of list in progress in preparation for migration onto internet by Office of Board Secretary identified gaps will be presented to QSG by the Office of Board Secretary this will form part of the Office of the Board Secretary work plan.

Further actions are in place to help achieve our target score.

Legal and Compliance

There is a risk of non-compliance with regulations as per the risk analysis

Impact Assessment

This report is purely administrative, there are no associated impacts or specific assessments required. At present, Covid-19 has placed a significant impact on the work carried out by HIW and as such, all routine inspections and scheduled reports have been placed on hold.

Board and Committee Report Template V1.0 December 2019.docx

Cyfarfod a dyddiad: Meeting and date:	28 August 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	BCUHB Annual Quality Statement (AQS) 2019 / 2020
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes Acting Associate Director of Quality Assurance and Assistant Director of Patient Safety and Experience
Awdur yr Adroddiad Report Author:	Erika Dennis Business Manager, Quality Assurance and Regulation
Craffu blaenorol: Prior Scrutiny:	AQS Editorial Group monthly meetings Stakeholder Reference Group 3 March 2020 Healthcare Professionals Forum 19 March 2020 Audit Committee 19 March 2020 Quality Safety and Experience Committee 3 July 2020
Atodiadau Appendices:	Appendix A - Annual Quality Statement Editorial Group, Terms of Reference (ToR) Appendix B - Welsh Health Circular titled "Annual Quality Statement 2019 / 2020 Guidance" Welsh Government Appendix C - Annual Quality Statement 2019/20 final draft

Argymhelliad / Recommendation:

The Committee are asked to:

1. Note the Annual Quality Statement Editorial Group, Terms of Reference (Appendix A)
2. Note the Welsh Health Circular titled "Annual Quality Statement 2019 / 2020 Guidance" Welsh Government (Appendix B)
3. Approve the Annual Quality Statement 2019/20 final draft (Appendix C)
4. Take into consideration the fact that prior scrutiny has been challenging due to Covid-19. Subsequently, there has been limited time and resources available for the AQS. Nevertheless, the Business Manager has worked with divisional leads and senior managers to ensure completion of the AQS to a good standard. The AQS has been aligned with and signposts to the Annual Accounts, Quality Improvement Strategy and Putting Things Right Annual Report 2019-20. All data contained in the AQS has been reviewed and confirmed as up to date and relevant.

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	X	Ar gyfer Trafodaeth For Discussion	X	Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	

Sefyllfa / Situation:

The purpose of this paper is to provide the Committee with the final version of the AQS 2019 / 2020 and to request approval for publication, subject to the areas noted in the publication section further on.

On 23 December 2019, the Health Board received confirmation from Welsh Government that the AQS was scheduled to go ahead for 2019/20. The plan of work commenced and Editorial Group members were approached and proformas were issued to various services to complete with examples of good practice.

The Editorial Group initially met on 21 January 2020 and agreed the Terms of Reference (ToR) (same as last year) **Appendix A**, and reviewed the Welsh Health Circular from Welsh Government, **Appendix B**.

Prior to Covid-19, the AQS 2019 / 2020, **Appendix C**, was scheduled to be reported to the following meetings/committees;

- Stakeholder Reference Group 3 March 2020
- Quality Safety Group 13 March 2020 (cancelled due to Covid-19)
- Healthcare Professionals Forum 13 March
- Quality Safety & Experience Committee 17 March 2020 (deferred due to Covid-19)
- Audit Committee 19 March 2020
- Local Partnership Forum 07 April 2020 (cancelled due to Covid-19)

With the final draft noted at;

- Quality Safety Group 30 April 2020 (cancelled due to Covid-19)
- Quality Safety & Experience Committee 05 May 2020 (deferred due to Covid-19)
- Board 14 May 2020 (deferred due to Covid-19)

The final approved AQS 2019 / 2020 would then be published on 31 May 2020 in line with Annual Report / Accounts.

Revised Cycle of Business

- Quality Safety & Experience Committee 3 July 2020 and 28 August 2020
- Audit Committee via Chairs Action (following QSE in August)
- Board 24 September 2020

It is important to note that, of those meetings which did take place despite Covid-19, any feedback received was acted upon.

On 27 March 2020, the revised timeline for the AGS/AQS/Annual Report/Accounts was confirmed by the Acting Board Secretary. As such, the new publication date for the AQS was confirmed as **30 September 2020**. This has since been brought forward as detailed in the 'Publication' section below.

An **Internal Audit review** has taken place on 31 July 2020, 6 August 2020 and the review is to be finalised on 13 August 2020.

<u>Challenges and progress made</u>

Progress with the AQS has been challenging due to the lateness in receiving the Welsh Health Circular **Appendix B**, and due to the pressures of Covid-19 which has impacted our services across the Health Board. It has also impacted the level of engagement from staff with the AQS.

In addition, the lack of engagement and implementation around the Quality Improvement Strategy (QIS) 2017-2020 has also made it difficult to look back and provide assurance on the quality aims set in the QIS which should be alinged to the AQS. This has been discussed at QSG and as such, the Quality Strategy for 2021-2024 will have a clear engagement and implementation plan for which work has commenced. This will help us to strengthen the AQS next year. The AQS confirms that the Quality Strategy will be the vehicle for ensuring quality and providing assurance.

The AQS highlights the areas that are important to us as a Health Board in terms of quality for next year. This can be found in the 'Forward Look 2020-2021' section on **page 50** which has been lifted from the Health Board's 3 Year Outlook Plan which is both visual and provides an overview of our vision, purpose and our ambitions and priorities.

Clear signposting links to the Annual Accounts, Quality Improvement Strategy and Putting Things Right Annual Report 2019-20 and other reports can be found in the 'Useful Information' section on **page 53**.

The Welsh Health Circular confirms inclusion in the AQS of a joint statement by the Chief Executive and Chairman. This has been lifted from the Annual Report and Accounts which has been approved by both the Chief Executive and the Chairman (**pages 4 and 51**)

Despite the challenges the Business Manager has worked with key directorates, senior managers, Internal Audit, and the AQS Editorial Group to ensure that the AQS has been completed to a good standard and that it reflects all of the good work and improvement work which has taken place over 2019-20, along with the challenges we have faced as a Health Board. Furthermore, to ensure that the AQS meets the standards set out in the Welsh Health Circular. A mapping exercise assisted with this.

<u>Covid-19</u>

Feedback from Audit Committee on 19 March 2020, was to incorporate Covid-19 in to the AQS, as such, this is included in the AQS on **page 51** by way of a statement from the Chief Executive which has been lifted from the Annual Report and Accounts. This provides a personal reflection and an overview of the challenges and areas of good practice achieved during and as a result of Covid-19.

<u>Publication</u>

Office of the Board Secretary have requested that publication of the AQS be brought forward to align with the Annual Report and Accounts (publication 31 August 2020). The Health Board's **Welsh Translation** team are aware of the revised publication date and are now in receipt of the AQS for translation.

However, the AQS will not be ready for publication end of August as the Health Board's Welsh Translation team are unable to complete translation of the AQS until week commencing 7th September 2020. In addition, pending any comments and feedback received from QSE.

The AQS will still be published in line with Welsh Governments deadline (30 September 2020) and alternative arrangements will be made with the Annual Report and Accounts providing reference to the AQS (a suggestion has been made that rather than inserting the link to the AQS, the report signposts to the Health Board's website where the AQS will be uploaded upon publication).

Moving forward, future reporting for the AQS will change as per new reporting requirements in line with the Health and Social Care (Quality & Engagement) (Wales) Bill, which will build on and replace the existing AQS, as confirmed in the Welsh Health Circular.

Cefndir / Background:

The Welsh Health Circular, **Appendix B**, provides the background for the AQS.

Welsh Government draw particular attention to the Health and Social Care (Quality & Engagement) (Wales) Bill which includes a more broader duty of quality. In addition, the statement incorporates the *Health and Care Standards for Wales* and the *NHS Wales Outcome Delivery Framework*, providing an opportunity to include improvements the Health Board are making in line with *A Healthier Wales*.

There is also an element of looking back at what has been achieved in terms of progress against the priorities outlined in our Quality Improvement Strategy 2017-2020. This has also proved challenging due to the lack of engagement and implementation around the QIS.

In addition, the Committee are asked to note that the Communication Team has monitored engagement levels with the AQS and the last version in 2019, has received no views on our website. Almost all of the information included in the AQS is already (or will be at the time of publication), available elsewhere. This feedback has previously been shared with Welsh Government as there does not appear to be a demand there and producing the AQS costs the Health Board in time and resources.

However, the AQS is a requirement and a good opportunity to reiterate all the good work that has taken place in 2019 and improvements for the Health Board. To date, a great deal of information has been received across the Health Board and the AQS will confirm how we engage and communicate this work all year round. Over the coming weeks, the editorial group members will meet again to review the AQS and to approve the second final draft.

Asesiad / Assessment & Analysis

Strategy Implications

The statement will be aligned to the agreed strategic and business plans as it will incorporate progress against our strategic priorities such as Care Closer to Home, Excellent Hospital Care and Improving Health and Reducing Health Inequalities.

The statement will also look back on progress against the priorities outlined in our *Quality Improvement Strategy 2017-2020* and provide a forward look in accordance with our *Three Year Outlook and 2020/21 Annual Plan* echoing the 'Quadruple Aim' in the Parliamentary Review and A Healthier Wales. It will also align to the Putting Things Right Annual Report 2019/20.

Financial Implications

This report is purely administrative, there are no associated resource implications related to this report itself. There may of course be potential financial implications for each Division in terms of resource requirements but this report is not presented to consider these.

Risk Analysis

This report is purely administrative. There was an associated risk logged as an audit recommendation;
- *The AQS should be compiled and published covering key areas stated in latest WHC guidance and to properly reflect and convey Health Board services, achievements, improvements, challenges and performance*.

This status of which is now approved and closed as the AQS for 2019/2020 covers all key aspects of the Welsh Health Circular and as such, the report will be published covering key areas stated in latest WHC guidance and to properly reflect and convey Health Board services, achievements, improvements, challenges and performance.

Legal and Compliance

Compliance with Internal and External Audit requirements. The completion of the AQS is a requirement of Welsh Government and progress will be regularly reported to committees with the final version for the approval of Board on 10 September 2020.

Impact Assessment

This report is purely administrative. There will however be an EQIA (Equalities Impact Assessment) completed prior to publication of the AQS on 30 September 2020.

Betsi Cadwaladr University Health Board
Terms of Reference

Annual Quality Statement Editorial Group

1.	ACCOUNTABILITY

The Annual Quality Statement Editorial Group is accountable to the Associate Director of Quality Assurance.

2.	REMIT

To support the Executive Director of Nursing and Midwifery and Quality, Safety & Experience Committee in discharging their responsibilities for the production of the Annual Quality Statement.

3.	CHAIR

Chair held by the Corporate Nursing and Vice Chair held by Corporate Nursing.

4.	LEAD DIRECTOR

Executive Director of Nursing and Midwifery.

5.	MEMBERSHIP

Members
- Corporate Nursing Team (Chair)
- Primary Care representative
- Service User Experience representative
- Head of Performance Assurance
- Communications Team Representative
- Head of Equalities and Human Rights

6. AUTHORITY

6.1   The group are authorised to seek any additional information it requires from any employee of BCUHB and all employees are directed to co-operate with any request made by the Group.

7. Quorum and Attendance

7.1   Due to the tight timescale of this years AQS and feedback from the Editorial group, the group will review the AQS electronically/virtually and feedback comments within the time scale set by Chair once draft document available.

7.2   Any member of BCUHB staff can, where appropriate, be invited to be part of the Editorial panel by the Chair.

8. CONDUCT OF MEETINGS

7.1   Due to the tight timescales for publication the Editorial group will be conduct business electronically following development of a draft document to review and comment.

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9. RESPONSIBILITIES & FUNCTIONS

8.1   To provide leadership, commitment and operational support to the Annual Quality Statement process.

8.2   To co-ordinate the development of the BCUHB Annual Quality Statement.

8.3   To ensure systems are put in place to review and monitor the ongoing submissions of reports including developing and implementing a system for urgent escalation to Director of Quality Assurance.

8.4   To ensure the timetable for completion is adhered to and deadline for the production of the final document is met.

8.5   To ensure all information provided has been agreed through local governance processes relevant to the area work.

8.6   To ensure appropriate and relevant stakeholder engagement prior to publication of the final document.

8.7   To ensure final publication of the Annual Quality Statement within the Welsh Government timescales in adherence with guidance available at time of publication.

10.   REPORTING

9.1   Issues of significance from the Editorial Group will be escalated to the Director of Quality Assurance throughout the process of the development of the document.

11.   CHAIR'S ACTION ON URGENT MATTERS

10.1   There may, occasionally, be circumstances where decisions which would normally be made by the Editorial Group need to be taken in between correspondence. In these circumstances, the Chair, will update the Director of Quality Assurance.

DATE OF ACCEPTING THE TERMS OF REFERENCE AND APPROVAL

Date:

Chair of Group signature:

WHC/2019/042

WELSH HEALTH CIRCULAR

Issue Date: 23 December 2019

Llywodraeth Cymru
Welsh Government

<u>STATUS</u>: INFORMATION

<u>CATEGORY</u>: QUALITY & SAFETY

Title: Annual Quality Statement 2019 / 2020 Guidance

Date of Expiry / Review March 2021

For Action by:
NHS Wales

Action required by: 29 May 2020

Sender: Jan Firby
Healthcare Quality Delivery
Population Healthcare

DHSS Welsh Government Contact(s) :
Mandy Stone
Population Healthcare
Health and Social Services Group
Welsh Government
Cathays Park
Cardiff
CF10 3NQ

Enclosure(s): Annual Quality Statement 2019-20 Guidance

The Annual Quality Statement 2019-20

1. Background

The Annual Quality Statement (AQS) provides an opportunity for organisations to 'tell the story' of good practice and initiatives being taken forward, as well as confirming what **went well** and what **not so well** and the **actions being taken as a result**. All NHS organisations are required to publish an AQS, as part of the annual reporting process.

NHS organisations need to be mindful that the Health and Social Care (Quality & Engagement) (Wales) Bill includes a new, broader duty of quality which requires NHS bodies in Wales to exercise their functions with a view to securing improvement in the quality of health services.

The Bill is at a relatively early stage in the Assembly's legislative scrutiny process. If the Bill is passed by the Assembly, we hope to bring the new duty into force in Summer 2021.

Detailed guidance will be developed with stakeholders to support its implementation. The Welsh Government will also supply training materials so staff are aware of the new duty and what it means in practice.

The Bill contains annual reporting requirements which require NHS bodies to assess the extent to which the steps they have taken to comply with the new duty of quality have led to improvements in outcomes. This new reporting requirement will build on and replace the existing Annual Quality Statement to form the basis of the mechanism through which the duty will be reported. Revised guidance will be co-produced ahead of the new requirements being introduced.

In the interim, annual quality statements will continue very much as in previous years but with an eye on the future requirements under the Bill. This Welsh Health Circular therefore provides guidance on the content and structure of the statement for 2019-20.

2. What should a Statement include and look like?

The AQS is for each organisation's resident population and provides an opportunity to let the public know, in an open and honest way, how it is doing to ensure its services are addressing local need and meeting high standards. Bringing together a summary highlighting what has been done to improve the quality of the services it provides and commissions, in order to drive both improvements in population health and the quality and safety of healthcare services. In developing the AQS it should enable LHBs and trusts to:

- provide an assessment of how well they are doing across all services, across the patient pathway, including social care and the third sector;
- promote good practice to share and spread more widely;
- confirm any areas which need improvement;
- build on the previous year's AQS, report on progress, year on year;
- account to its public and other stakeholders on the quality of its services; and
- engage the public on the quality of services received from their health board / NHS Trust to help inform the AQS content.

Engagement with the public will be important to understand what matters to them and what they would like to see in their local quality statements.

The statement needs to encompass all key themes in line with the *Health and Care Standards for Wales* and the *NHS Wales Outcome and Delivery Framework.* It also provides the opportunity to reflect improvements being made to services in line with the expectations set out in *A Healthier Wales*, the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015.

It should be presented in a way that can be understood by those who use the services provided, written in plain English and be jargon-free, using visual graphics to underline key messages. To ensure national consistency in approach, more detailed advice is provided in annex 1.

Organisational communications leads will need to work closely with their quality and safety colleagues to ensure the content and format of the statement is as would be expected of a public-facing report. We expect the communications departments to be actively involved and engaged with the promotion of the AQS through the use of internet, intranet and approved social network sites such as Facebook and Twitter.

A communications strategy should also be developed to aid publication and promotion of the AQS.

3. What does it need to cover?

The AQS should combine an element of looking back at what has been achieved with a forward look using data and information available for the reporting year. In looking back, LHBs and trusts should seek to answer the following questions:
- are we meeting standards and delivery requirements and are we improving outcomes, across the whole patient pathway?
- are we genuinely seeking to understand the patient/user experience and is it improving?
- are we meeting or exceeding our improvement goals?
- are we being open and learning from errors and concerns?

Examples of initiatives or work to demonstrate commitment to the following should also be included:

- Wales for Africa and other international health partnerships
- embedding a rights based approach which challenges ageist attitudes and stereotypes, making rights real in public service.
- mitigating risk in achieving high quality care and being honest about performance.
- identifying and celebrating areas of local innovation in service delivery and transformation to ensure spread and sustainable improvement
- integration and partnership working.

4. Publishing the AQS

As the AQS is a public document it should be presented in a way which is accessible to all. A bilingual AQS must be published electronically on organisations' websites, with hard copies being made available on request. Organisations should also take into account the needs of their local populations and consider making the statement available in other formats or languages where there is a need to do so, considering going beyond meeting the legal requirements in such matters.

Organisations may want to consider using a number of ways to 'tell the story'. This could be through a mix of case studies and patient stories as well as quantitative data presented clearly and succinctly, signposting the reader to more detailed or technical information as required. It should provide a balance between positive information and an acknowledgment of where services need to improve.

The AQS must be produced on a financial-year basis, which aligns with the financial and performance data reporting periods within NHS organisations' Annual Accounts. Statements must be published no later than **29 May 2020**, in line with the annual accounting and reporting timetable.

It is recognised that this can present difficulties in accessing timely data at the year end to meet publication deadlines. To overcome this it is suggested that quantitative information be presented in one of three ways, depending on data availability at the time of reporting:

1. If a full financial year of data is available, then data for the 1st April to 31st March should be included.
2. If a full financial year of data is not available, data for a calendar year, 1st January to 31st December, should be used to show performance trends supported by commentary on projected end of year delivery where possible.
3. If the measure is qualitative in nature or the data is not available either on a financial or calendar year basis then NHS organisations should provide commentary on past and anticipated end of year delivery. Cross correlation, where appropriate with your Annual Report is recommended to reduce duplication and to provide more collaborative approach.

5. Assuring the Annual Quality Statement

The Board is accountable for each organisation's quality statement and must therefore assure itself, through its internal assurance mechanisms, including internal audit, that the information published is both an accurate and representative picture of the quality of services it provides and the improvements it is committing to. The Chair and Chief Executive will need to include a statement confirming this. Organisations may also wish to include statements demonstrating engagement from other stakeholders, such as Community Health Councils and social care when agreeing their statement.

Annual Quality Statement
Template for 2018/19

1. **Statement from the Chair and Chief Executive**

2. **Introduction**
This section should set the context, describing the population needs of the organisation which have been identified and how these will be meet. Summarising the steps being taken to engage with its population and users and the improvement priorities set last year and any in-year challenges including unexpected events which may have influenced this.

3. **Looking Back Over the Past Year**
This section should be set out in line with the individual themes below. It should aim to ensure a consistent national approach as far as possible, whilst at the same time providing the opportunity to reflect local priorities. When providing specific examples, it is suggested they are chosen to reflect the local context. **Not all of the areas set out below will be relevant to each organisation, so organisations should draft their response in the spirit of this guidance and adapt their content to suit the services or programmes which they provide.**

Each theme should provide examples of achievements and improvements as well as challenges, including actions in response to any quality triggers or external reviews which may have taken place during the year. It should show how the organisation has listened to, learnt from and is working with all its partners including social care and the third sector.

➤ **Staying Healthy**

Examples of actions to promote and protect health – examples drawn from obesity, smoking, alcohol, exercise, immunisation rates etc. and/or examples of health improvement programmes implemented. Examples of innovative services in primary and community care to help people maintain good health and live independently.

➤ **Safe Care (Services)**

This section should specifically include examples of actions to improve safety, including nutrition and hydration, falls, pressure ulcers and progress in reducing healthcare associated infections. Progress and learning from case note mortality reviews and other sources of mortality data, serious incidents, safeguarding issues and independent reviews and descriptions of any never events and learning should be included in this section.

➤ **Effective Care (Services)**

Examples of achievements and challenges across individual service delivery plans in providing evidence based effective pathways of care, including efforts to ensure integration and joint working with social services. This section may

need to signpost to more detailed reports for some areas e.g. cancer, stroke, mental health, primary care, children etc. A few examples of participation and learning from national clinical audit, clinical outcome reviews and peer review. This could be linked to local improvement priorities also participation in and learning from research, development and innovation.

➢ **Dignified Care**

A summary of progress against actions agreed in 'Dignified Care', as well as examples of improvements or challenges which have impacted on meeting the needs and overall experience of patients with dementia, cognitive impairment or sensory loss. Summary of actions being taken to ensure the provision of good continence care, including improvement actions where needed. Improvements made following inspections undertaken by Healthcare Inspectorate Wales.

➢ **Timely Care (Services)**

A summary of progress and actions taken to improve timely access to and discharge from services including GP access, unscheduled care, ambulance handovers, delayed transfers of care and preventing late night/early hours discharges from hospital, working with social services where required. This could include a summary of participation in the national unscheduled care programme. Examples of actions taken to reduce risk of harm associated with delays in accessing services/care, including participation in the national planned care programme.

➢ **Treating People as Individuals**

Examples of services/care designed to meet individual need e.g. communication needs, sensory loss, disability and maintaining independence, supporting carers as well as improving services for vulnerable groups. Listening and learning from individual feedback, including the Evans Review of Putting Things Right (PTR) and progress and examples in implementing the National Service User Experience Framework. This should include or signpost to PTR data and learning.

➢ **Our staff**

A summary of the workforce profile and challenges e.g. actions taken to ensure safe staffing levels, tackle recruitment difficulties, etc. and numbers of and the support provided by volunteers. Examples of actions taken following staff feedback/surveys etc. Examples of actions to develop and support staff to deliver compassionate care and make improvements: including through the provision of training and development in areas such as dementia, cognitive impairment and sensory loss, as well as staff appraisal. This section should also include progress in embedding the Improving Quality Together Framework (IQT), individual and team awards.

The OPC also sets out 3 areas relating specifically to staff, including staffing levels, training and responding to the views of staff. LHBs and trusts should increasingly demonstrate how such issues are considered throughout the year

and how findings etc are brought together to support the evidence provided within the Annual Quality Statement. These expectations align with those set out within the Health and Care Standards Framework.

It is suggested the Wales for Africa disclosure is captured within this theme. You may wish to include reference to information such as the number of staff granted 'volunteering' time, number of staff otherwise engaged with health links work, or any international learning opportunities undertaken. This section also provides an opportunity to draw attention to any other wider strategic international links and projects, and to draw attention to activity undertaken locally to implement the principles of the Charter for International Health Partnerships in Wales:

http://www.internationalhealth.wales.nhs.uk/sitesplus/documents/1100/IHCC%20Charter%20for%20IHP%20%28Interactive%29%20E.pdf

4. Forward Look
This section should summarise how each organisation has used this process to identify areas for focus and improvement for the coming year, working with all its partners including social services. It should set out clear, measurable improvement actions against each of the themes above. It should also describe how the organisation will track progress during the year, including evidence from how it listens and learns to drive continuous improvement.

5. Engagement and Feedback
The document should also be seen as a tool for engagement and a key element in the organisation's communication strategy. Organisations are encouraged to engage with all their stakeholders or partners in agreeing the final statement and include any endorsements/engagement statements as appropriate. They should also include details of how the reader can contact the organisation to comment on the statement or to seek further information.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Annual Quality Statement

1 April - 31 March 2020

Care Closer to Home

Excellent Hospital Care

Health Improvement, Health Inequalities

Contents

Where is the information you want to know?

"The different colours represent the 7 areas of the Health Care Standards."

About this report

The Annual Quality Statement (AQS) provides information on the quality of care across our services and illustrates the improvements and developments we have taken forward over the last year to continuously improve the quality of the care we provide. This report follows the format of the Health and Care Standard themes:

Staying Healthy - you are well informed and supported to manage your own physical and mental health.

Safe Care - you are protected from harm and protect yourself from known harm.

Effective Care - you receive the right care and support as locally as possible and contribute to making that care successful.

Dignified Care - you are treated with dignity and respect and treat others the same.

Individual Care - you are treated as an individual with your own needs and responsibilities.

Our Staff - we have enough staff with the right knowledge and skills available at the right time to meet your need.

If you would like to access more of our published reports, or if you wish to get in touch with us, further information on how you can do this can be found in the 'Useful Information' section on page 53.

Introduction and Welcome

The purpose of our Board is to govern the organisation effectively. We aim to build confidence in the quality and safety of the care that we provide. For more information about Betsi Cadwaladr University Health Board (BCUHB) Board Members, please find us on our website: https://bcuhb.nhs.wales/about-us/

Joint statement from Mark Polin, Chairman and Simon Dean, Interim Chief Executive

In addition to the significant challenges we face as a Health Board, the global coronavirus pandemic has caused major change and disruption to the way we all live our lives, and the impact on the NHS has been both wide-ranging and severe.

There were significant changes and improvements during 2019/20, although it was evident that the Health Board continued to face challenges in a number of areas. The Health Board remains in Special Measures, although progress has been made on all the issues that led to this being imposed originally and a number of aspects have been removed as issues of concern.

It is important to also recognise those areas where improvements have been delivered, or where strong performance has been maintained.

The Health Board has one of the best records in Wales for protecting its residents through the various immunisations programmes that it promotes and operates, and this continued through the year. We were also amongst the best performers in Wales in respect of the time before patients who have been diagnosed with cancer start their treatment. Furthermore, we delivered a sustained reduction in the number of patients whose discharge from hospital was delayed, which has helped us manage the increased volume of patients requiring emergency admission.

There have also been improvements with regard to how we respond when things do not go as they should. Our performance in reporting and responding to serious adverse incidents has gone from the worst in Wales to the best, and we have delivered significant improvement in the speed with which we respond to complaints. We have also reduced the number of 'never events' that occurred during the year.

We are confident that the Annual Quality Statement for 2019-20 provides a clear overview of the areas of good practice and improvement we have made as a Health Board, together with emphasising the challenges we face now and over the next fiscal year, particularly in response to Covid-19.

North Wales Community Health Council

The North Wales Community Health Council (NWCHC) is the independent health watchdog for North Wales. It represents the interests of patients and the public who use BCUHB health services.

The NWCHC monitors and scrutinises BCUHB health services to improve the patient experiences; one of the many ways the NWCHC does this is by visiting health premises. All visits are undertaken by NWCHC volunteer members.

During 2019, NWCHC members visited all of our District General Hospitals and community hospitals, Emergency Departments and Mental Health Units. There have been in excess of 500 visits by NWCHC to our sites during this period when NWCHC members spoke to patients, their relatives and carers as well as staff about all aspects of health care experiences.

The NWCHC has focussed much of its work around BCUHB Mental Health Services. The NWCHC continues to be concerned that this service remains under special measures with an apparent lack of progress against the recommendations made by the HASCAS and Ockenden reviews. Much of the feedback provided to the NWCHC during visits to various healthcare settings (including primary and community sites) has led to NWCHC having grave reservations about the unique I-CAN service model developed as a way forward for many aspects of providing mental health support.

The BCUHB Transforming Care team and other directorates continue to work collaboratively with the NWCHC. The NWCHC visiting reports remain a part of the Ward Accreditation Programme.

To find out more about the work of the NWCHC, please contact:

· E-mail – admin@waleschc.org.uk
· Telephone – 01248 679284 (ext 3)
· Website – www.communityhealthcouncils.org.uk
· Write to – NWCHC, Unit 11, Chestnut Court, Parc Menai, Bangor LL57 4FH

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL

CIC GOGLEDD CYMRU / NORTH WALES CHC

Betsi Cadwaladr University Health Board (BCUHB)

The purpose of the Board is to govern the organisation effectively. We aim to build confidence in the quality and safety of care that we provide. For more information about Board members, please use the following link: https://bcuhb.nhs.wales/about-us/health-board-meetings-and-members/

This document forms part of our annual reporting. In addition to this report, our Annual Report and Annual Governance Statement can be found at the following link:

https://bcuhb.nhs.wales/about-us/governance-and-assurance1/annual-report-and-accounts/

This report and supporting documents can be made available in other languages or formats on request from the Corporate Communications Team:

Email: bcuhbpressdesk@wales.nhs.uk

Telephone: 01248 384776

Address: Communications Team
Block 5
Carlton Court
St. Asaph Business Park
St. Asaph
LL17 0JG

There are many opportunities to get involved and share your ideas about how we can improve health in North Wales.

We are keen to hear from you, whether as a member of the public, patient or carer, or if you have a compliment or a suggestion.

It is your local health service.
Help us to help you!

You can also sign up to our involvement scheme. By registering, (please use the link below) you will get our newsletter, hear about how you can share your views and ideas and get updates on activities and events. We want to involve everyone irrespective of age, disability, gender, gender identity, race, religion or belief or sexual orientation.
http://www.bcugetinvolved.wales/register

About BCUHB

BETSI CADWALADR UHB
POPULATION
698,400 persons
North Wales has an increasing and ageing population. The population is expected to increase to 734,700 by 2036; the percentage of the population aged 85 years and over is expected to increase by 154% between 2011 and 2036.

LIFE EXPECTANCY
BCUHB

82.4 YEARS   78.9 YEARS

The difference in life expectancy between the most and least deprived is 7.4 years for men and 6.1 years for women. In Wales, there has been a plateauing in increasing life expectancy since 2011.

OLDER PEOPLE
15% of households in BCUHB are occupied by one person aged 65 years and over, which is just above the average for Wales (14%). Conwy has the highest percentage of one person households with people aged 65 years and over (17%).

Isle of Anglesey, Gwynedd and Denbighshire are also higher than the BCUHB average.

Flu immunisation uptake in 65 year olds and over in

CHILDREN & YOUNG PEOPLE
Almost a quarter of children and young people under the age of 20 years live in poverty in Wales. Across BCUHB, this ranges from 18% in Gwynedd to 25% in Denbighshire.

70% of 5 year olds in BCUHB are of healthy weight compared to 74% in Wales.

88% of 4 year olds in BCUHB are up to date with vaccinations. This ranges from 84% in Denbighshire to 90% on the Isle of Anglesey.

BURDEN OF DISEASE
This chart shows the greatest cause of Disease burden in Wales, as measured by Disability Adjusted Life Years (DALY).

'Other conditions' includes mental & substance use disorders, other non-communicable diseases and neurological disorders.

Disability-adjusted life years [2]: Cancers 19%, Cardiovascular diseases 18%, Musculoskeletal disorders 11%, Other conditions 52%

FALLS
1 in 3 older people will suffer a fall each year. Only 1 in 3 will return to former levels of independence and 1 in 3 will end up moving into long term care.

Yet many falls are preventable.
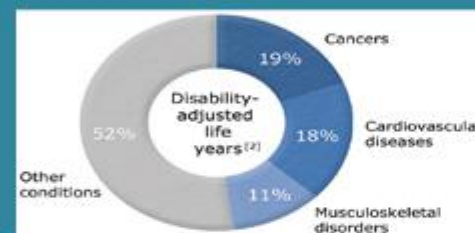
DEPRIVATION
Around 12% of the population of BCUHB live in the most deprived fifth in Wales. The Health Board has some of the most deprived areas in Wales, particularly along the North Wales coastline.

MAIN CAUSES OF MORTALITY
Heart disease, cancer and respiratory disease are the leading cause of death in BCUHB.

This chart shows the main causes of death as a percentage of all deaths in BCUHB

Cancer	28
Cardiovascular	26
Respiratory	14
All Other	32

CANCER
4 in 10 cancers are preventable.

MENTAL WELLBEING
16% of people in BCUHB report feeling lonely which is lower than Wales (17%). Across the Health Board, this ranges from 13% in Flintshire to 20% in Wrexham. 83% of people in BCUHB report having a high sense of life satisfaction compared to 81% across Wales.

BEHAVIOURS AFFECTING HEALTH

	BCUHB (%)	Wales (%)
Smoking	18	18
Use e-cigarettes	7	6
Drinking above guidelines	18	18
Physical activity	55	53
Fruit & vegetable consumption	23	24
Overweight/obese	54	60
Follow 0/1 healthy behaviours	10	10

Looking Back Over the Past Year

We have made significant progress against the priorities outlined in our **Quality Improvement Strategy 2017-2020**. The key priorities include reducing avoidable deaths, reducing harm and providing reliable care by strengthening our patient care pathways through our services and delivering what matters to patients accessing our services. Among the key things we have done to support these improvements are:

- The Maternity Dashboard has been introduced and captures BCUHB compliance against national standards for maternity care in Wales. The Inpatient and Community Dashboards are populated and reviewed monthly at the Women's Quality, Safety & Experience Sub Group and Women's Board meetings. For assurance, where themes or trends are identified, the meeting Chair may request an audit or thematic review is performed and presented at a future date for further information

- Using crude mortality as an indicator, we can identify any variation from normal and initiate investigation at case-note level to ascertain lessons to be learned. The Emergency Department at Ysbyty Glan Clwyd now have a process in place to review all deaths within 5 days and to capture lessons learned. Reviews now have a structured judgement approach (SJR hybrid) and are tracked on our information Reporting Intelligence System (IRIS).

- In November 2018, we introduced our Ward Accreditation programme which assesses wards and units across the region on a range of quality measures. As of January 2020, there have been 90 unannounced visits / Ward Accreditations to wards. These 90 accreditations include Acute, Community, Childrens, Critical Care, Women's and Mental Health & Learning Disabilities.

- Over the 3 years of the strategy, we recorded 17 Never Events compared to 15 in the three years prior. This is well within common cause variation and as such, there has been no change in the overall rate of Never Events. For assurance, a thematic review will take place and our next QIS strategy will ensure that there is a greater focus on patient safety.

- We have seen a decrease in clostridium difficile and MRSA blood stream infections over the past 3 years. The Infection Prevention & Control team have commenced several new initiatives during 2019, which will assist with trends and the ability to prioritise risks to the population, and increase screening.

  Looking ahead, the aim is to complete a review of progress against the Quality Improvement Strategy and plan for the next three years by engaging with our patients, staff, partners and our communities. We will also reshape our Quality Strategy by January 2021. The Quality Strategy will be the vehicle for ensuring quality and providing assurance.

How we have measured our performance

	Improved performance	Sustained performance	Decline in performance	Performance Summary	Target Achieved*
STAYING HEALTHY - People in Wales are well informed & supported to manage their own physical & mental health	3 measures	0 measures	2 measures	⬆	1 measure
SAFE CARE - People in Wales are protected from harm & supported to protect themselves from known harm	3 measures	0 measure	12 measures	⬇	1 measure
DIGNIFIED CARE - People in Wales are treated with dignity & respect & treat others the same	1 measure	0 measures	1 measure	↔	
EFFECTIVE CARE - People in Wales receive the right care & support as locally as possible & are enabled to contribute to making that care successful	1 measure	0 measures	7 measures	⬇	
TIMELY CARE - People in Wales have timely access to services based on clinical need & are actively involved in decisions about their care	6 measures	1 measure	19 measures	⬇	3 measures
INDIVIDUAL CARE - People in Wales are treated as individuals, with their own needs & responsibilities	1 measure	0 measures	4 measures	⬇	2 measures
OUR STAFF & RESOURCES - People in Wales can find information about how their NHS is resourced & make careful use of them	3 measures	0 measures	2 measures	⬆	1 measure
SUMMARY	18 measures	1 measures	47 measures	⬇	8 measures

*Relates to those measures with an absolute monthly / quarterly target for December 2019 / Quarter 3 2019/20

Note - this scorecard relates to the April 2019 to December 2019 period

Our performance is measured across seven key domains or areas, aligned to the Welsh Government's Health Care Standards and National Performance Frameworks.

The summary dashboard (left) shows our performance across the range of indicators the Welsh Government uses to measure all Health Boards in Wales. The NHS Wales delivery framework and reporting guidance 2018 to 2019 provides further information.

We have demonstrated overall improvement in relation to helping people to stay healthy and in delivering dignified and individual care. However our performance has declined in respect of delivering timely care and when measured against the indicators for safe and effective care.

Each month we provide detailed briefings to our Board on our performance, outlining the Key Actions being taken to address poor performance, what the Outcomes of those Actions are and the Timeline for when we expect performance to consistently achieve the target.

For 2019/20, we have only included the nationally mandated Measures in our reporting to reflect the priorities of the organisation and improve the health, care and experience of the North Wales population.

The need to plan and respond to the Covid-19 pandemic has had a significant impact on the organisation, the wider NHS and society as a whole. It has required a dynamic response, which has presented a number of opportunities in addition to risks. The need to respond and recover from the pandemic will continue, both for the organisation and wider society, throughout 2020/21 and beyond. The organisation's Governance Framework will consider and respond to this need.

Progress against our strategic priorities

Improving Health and Reducing Health Inequalities	Care Closer to Home	Excellent Hospital Care
- Healthy Weight: We have developed the Tier 2 (Adult) Obesity service - We continue to review and identify opportunities for improving access to children's weight management services - Smoking Cessation: We have increased opportunities through stabilising the Help me Quit in Hospital - Wellbeing: We have developed the 'I Can' campaign and 'Let's get moving North Wales' partnerships - We have progressed our partnership plan for Children. - We continue to improve our outcomes through 'First 1000 days' programmes - Immunisation: We have developed BCUHB's first Strategic Immunisations Plan which outlines how we will optimise uptake of key vaccinations across the life course, with a specific focus on Flu and MMR - Reducing Health Inequalities: We are progressing our work on reducing health inequalities – we have worked with partners to develop initiatives which target food poverty, housing and homelessness - We have developed integrated multiagency Health & Wellbeing Centres	- Healthcare Support Workers (HCSW) at Ysbyty Alltwen are leading a project which aims to prevent delays for patients leaving hospital by offering support for those, who are ready to leave hospital but may be waiting for a care package, in their own home. - A pilot scheme to help patients get fit for major surgery in order to reduce the risk of complications following their operations has been introduced at Wrexham Maelor Hospital - Community NHS staff are ramping up sepsis monitoring as part of Wales-wide improvement programme. New equipment is helping district nursing staff identify sepsis. - Wrexham Maelor Hospital is the first in Wales to offer same day discharge hip replacement surgery, some patients are able to go home on the same day due to surgeons using a new method of delivering post-operative care - Specialist teams of Occupational Therapists are helping Glan Clwyd patients get ready for returning home following a pilot study, which reduced length of stays by almost 50 per cent	- Doctors in training have ranked Ysbyty Gwynedd's Emergency Department as one of the best places to train in the UK. Results from the recent National Training Survey by the General Medical Council shows over 85% of doctors in training are pleased with the quality of clinical supervision, experience, and the teaching they receive at the Emergency Department. - A new system designed to speed up diagnosis for people with suspected cancer has been introduced in North Wales. We have issued guidance to GPs to help them determine whether patients with symptoms of colorectal cancer can be referred directly for an investigation, bypassing an outpatient appointment and saving time. - People living with dementia and their carers have joined health experts in praising the 'first class' memory support provided across North West Wales. The Gwynedd and Môn Memory Service has been given a top quality mark by the Royal College of Psychiatrists for the third successive time for providing the highest standards of care for people living with dementia and other memory problems.

Staying Healthy

Smoking

Staff in the BCUHB Smoking Cessation Services have treated 3.08% of the smoking population which was the second highest performance in Wales, although it is acknowledged that this does not achieve the 5% target.

Of those people treated by the services, 38.46% were validated as having stopped smoking. Although an improvement on last year, this remains below the 40% target and continuing to improve this remains a priority for the next two years (2020 to 2022).

Respiratory Health Project

20% of the population of Blaenau Ffestiniog have been identified as being smokers. This, combined with the legacy of the slate mining industry has contributed to poor respiratory health and 11% of those patients registered at the GP practice (Canolfan Goffa Ffestiniog) were identified as suffering from chronic respiratory conditions.

The practice were identified as one of the highest prescribers of inhaled corticosteroids within the BCUHB, which prompted the cluster to identify ways to develop more effective strategies and treatments to improve respiratory health.

Steffan John, an independent pharmacist prescriber specialising in respiratory health conducted 6 sessions, which included:

- Identification of patients and inviting patients to respiratory clinics

- Education and training of healthcare professionals in COPD diagnosis and management

- Review and improve inhaler techniques

Protecting people against Flu

Protecting people against the risk of flu is a major element in helping the NHS reduce the demand for emergency care over the winter period. The number of people eligible to be vaccinated and receiving vaccinations has increased year on year in both the under 65 and over 65 age groups. The increased volume of vaccinations given demonstrates the hard work our staff have done to promote the need for vaccination. As a result, by 31st March 2020, 2,444 more people in North Wales had been vaccinated compared to the year before.

The national target is for 75% of the eligible groups (people aged over 65, and those aged below 65 who are at greater risk from infection) to be vaccinated. North Wales had the highest take up rate in Wales, at 71.4% for those over 65 and 46.9% for those under 65. This is an improvement for the over 65 age group. However, the increased number of people aged under 65 who were eligible to be vaccinated last year meant that the take up rate fell, even though the number of people in this group who were immunised increased. This shows that we need to continue our efforts to encourage people to protect themselves.

Prevention

Three Year Strategic Immunisation Plan 2019-2022

Through the development of our three year Strategic Immunisation Plan (2019-22), BCUHB has committed to protecting and improving 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 key stakeholders and taking every opportunity to immunise our public, patients and staff.

A range of routine vaccinations programmes are being delivered across North Wales by BCUHB and primary care contractors. Further selective, medical, occupational and travel immunisations are also provided, including influenza vaccinations for pregnant women and people with chronic conditions; Tuberculosis, Hepatitis B and influenza vaccinations for staff involved with direct patient care; and travel vaccines for people travelling to certain countries.

Betsi Cadwaladr University Health Board
Strategic Immunisation Plan 2019 -22

Childhood Immunisation

BCUHB has historically performed better than the national average for uptake of most childhood immunisations, although there is variation based on geographical area and uptake rates decline from infancy through to later childhood. In 2019/20, 90.3% of resident children in North Wales were up-to-date with scheduled vaccines on reaching their fourth birthday. This is higher than the other health board areas and Wales. However, uptake in the least disadvantaged areas in BCUHB is generally much higher than in the most disadvantaged areas and so there is an inequity. We have appointed a further two immunisation co-ordinators who are targeting the areas most in need.

Measles, Mumps and Rubella (MMR)

Uptake of the first dose MMR vaccine in children aged two years in BCUHB was just below the 95% target at 94.9% in 2019/20. However, two areas - the Isle of Anglesey and Wrexham – exceeded the target. MMR uptake at age five years in BCUHB was below the 95% target at 91.0% in 2019/20. No areas in North Wales reached the target. We continue to work with our communities to promote immunisation and dispel myths.

Healthy Weight Services

BCUHB continue to progress towards establishing a tier 2 service with the inclusion of a commercial weight provider as part of the package of service options. The Kind eating and Foodwise programs have expanded during 2019/20 with an increase in patient contacts.

We have been scoping models of good practice and performance to develop our tier 3 children's obesity service during 20/21. This work will contribute to the delivery of 'Healthy Weight: Healthy Wales' long term strategy to reduce and prevent obesity.

During 2019, our Infant Feeding Strategy was launched The vision is to create a supportive culture in North Wales that enables parents to make the choice about infant feeding in an informed way that optimises nutrition and helps develop close, loving relationships with their baby.
Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid down in early childhood.

Let's Get Moving North Wales collaboration continues to work together to improve the health and wellbeing of the population of North Wales, through increasing opportunities to be more active.

Winter Wellness Campaign

Our East Area Team's Winter Wellness Campaign was a public facing awareness raising campaign provided to offer advice and support to members of the community on the importance of keeping well particularly through winter. The campaign covered five themes which include: Skin Care, Hydration, Falls Prevention, Choose Pharmacy and Flu Vaccination and Supporting Carers. Initially, a week of Roadshow events were held in Wrexham and Flintshire. Subsequently members of the team have been promoting the campaign in Food Festivals and Bite Size Health in the Workplace events.

Children's Outpatients: Free Fruit

BCUHB catering, dietetics and paediatric department alongside the Awyr Las charity collaborated in 2019 to trial offering free fruit to children in the paediatric outpatients area. The trial initially ran within the Wrexham Maelor paediatric outpatients but has since rolled out to the other main hospital sites. On average 40-60 pieces of fruit are being delivered four times a week with no wastage reported. The reception area actively promotes the offer with colourful posters and fruit themed activities for the children, such as colouring and word searches. Parental feedback has been so positive and the offer has continued with the support of the catering team.

Young People for Young People: increasing resilience

Hannah Mart, Children and Young Person's Sexual Violence Adviser, based at the Amethyst Sexual Assault Referral Centre has been working with a group of young people to develop a resource booklet entitled 'Sharing Stores / Rhannu Straeon'. The aim of the resource was to provide

information and advice to other young people about and the criminal justice process and how to cope with it, to support their recovery, reduce their isolation and increase their resilience. In addition, it can be used to help professionals to understand the experience of the CJS journey from the perspective of the survivor and better support them.

The project developed momentum and in addition to the booklet a film and podcast was developed. The 'Sharing Stores / Rhannu Straeon' film and podcast was launched officially in September 2019. The project was submitted as an application to the Problem Orientated Police Awards (POP). Hannah and some of the young people involved were invited to the Awards ceremony to present the project, although it didn't win the judges were so impressed with the work they decided to award the judges discretionary fund of £3000 to the project.

Safe Care

Safe, Clean Care- reducing healthcare associated infections

There has been continued focused improvement and reactive work relating to infection prevention, as well as the inclusion of the Safe Clean Care campaign for the past year. This includes reducing unwarranted variation, a deep dive scrutiny of all trajectory infections, developing a link practitioner programme, with our first in house educational event.

An Independent Reviewer revisited the Health Board and gave a positive report back to the Executive team on the further progress during the last year. In addition, an internal audit was carried out and assurance levels overall were increased from the previous year in relation to Safe Clean Care and Infection Prevention & Control. A snap shot audit on urinary catheters took place in September 2019 and preliminary results suggest that less than 2% of those patients had an infection associated with urinary devices. This is alongside the achievements to date in reduction of Meticillin Resistant Staphylococcus Aureus (MRSA) blood stream infections, which has decreased per 100.000 population from 2.72 to 1.87.

However, we recognise there are still particular infections to concentrate on, such as gram-negative infections and the collaborative work programmes in primary and community care with other specialist services.

Focus on Quality Improvement – Falls and Hospital Acquired Pressure Ulcer Collaborative

BCUHB introduced a programme of focused improvement work that includes the Ward Accreditation Programme, which commenced mid October 2018, quickly followed by the Hospital Acquired Pressure Ulcer Collaborative (HAPU) in late November 2018 and then the Inpatient Falls Collaborative in June 2019.

All key programmes of focused improvements provide an opportunity for BCUHB to embed the principles of a common Quality Improvement language and methodology as well as embedding a set of standards to frame our quality, safety and patient care agenda and to maintain the momentum of the improvements and principles of the Safe Clean Care campaign (SCC).

Improving Safety and Reducing Harm

By using a collaborative approach, we have focused improvements relating to our key harms (Inpatient Falls and Hospital Acquired Pressure Ulcers). The collaborative is a small number of identified wards who have come together with support from Quality Improvement team & subject experts as a faculty through a planned sessions face to face and virtually has led the embedding of a common language and understanding of quality improvement for all levels of ward staff. It has helped us identify standards for all of our wards to follow in terms of identifying and reducing harm from Hospital Acquired Pressure Ulcers and then for Inpatient falls once collaborative completed.

Outcomes to date include standardise reporting of incidents, streamlining and easy access to educational resources, development of chair awareness audit engaging visitors and the public in reducing harm from falls.

Welsh Government Reportable Incidents

Where serious adverse incidents occur, it is important that these are thoroughly investigated, that we learn from what has happened and put in place measures to prevent them recurring and improve patient safety. We report serious incidents to the Welsh Government and aim to demonstrate, within an agreed timescale, that we have taken appropriate measures to reduce the risks of similar incidents happening in future.

This is an area where the Health Board has improved its performance significantly in the nine months from April to December 2019, from having the the worst performance in Wales in December 2018 to the best in December 2019 at 84%. This is an issue the Health Board takes very seriously and work continues to further improve learning from incidents to improve outcomes and experiences for our patients

Further information can be found in our Putting Things Right Annual Report 2019-20 which can be access via our website. Further details can be found in the 'Useful Information' section on page 53.

Never Events

Never Events are serious adverse incidents that our systems and processes should ensure are never able to happen, and we are committed to achieving this. We have reduced the number of never events, with four reported during the nine months between April and December 2019 compared to eight reported during the same period in 2018/19.

All never events are reported directly to our clinical executives as soon as possible following the incident, and are fully investigated under the serious incident framework. This process fully engages the patient, family and carers throughout. The investigation is chaired by a Director and carried out by the Senior Investigation Managers with support from the Welsh Government Delivery Unit. This ensures that robust investigations are carried out, all relevant lessons are learned and shared across the organisation, and any necessary actions are taken to prevent an incident from recurring.

Unfortunately, a further Never Event was reported in March 2020 bringing the total number for the 12 months of 2019/20 to five, compared to eight in 2018/19.

Further information can be found in our Putting Things Right Annual Report 2019-20 which can be access via our website. Further details can be found in the 'Useful Information' section on page 53.

Mortality

The Crude Mortality of Patients under 75 years of age, is based on the number of deaths in a specific period divided into the total inpatient admissions of that period (of patients under 75 years of age). For the year 2018/19 we reported a rate of 0.77%, while for the same period in 2019/20 we have seen a slight increase to 0.78%.

The Office of the Medical Director are working with our acute, community and mental health hospitals to use the all-Wales mortality review process to look at the way we review the care of patients who die. They are also working with Improvement Cymru on an all-Wales basis, to enhance the reviews further and make the required improvements identified by the reviews.

All Health Boards must conduct Universal Mortality Reviews within 28 days of a death occurring. Performance against this measure has improved from 87.8% reported in December 2018 to 92.8% reported in December 2019. We will continue to focus on this to ensure that we consistently achieve the 95% target rate throughout 2020/21 and beyond.

Ward Accreditation

Launched in November 2018, our Ward Accreditation programme assesses wards and units across the region on a range of quality measures. Wards which demonstrate excellent care are awarded a bronze, silver or gold award following an in depth assessment by nursing leaders.

Work of the Ward Accreditation programme continues with all wards having received an unannounced visit. To date 95 wards have been visited of which one has received a Gold ward. The programme will continue and is fully embedded within BCUHB as a way of supporting our teams with implementing a set of standards, sharing improvements and celebrating success.

Gold Award

WELL LED TEAMS	Leadership and Team Culture Governance, data and improvements Staffing and Training
COMMUNICATION WITH MDT	Patient Flow and Discharge At a glance boards, MDT huddles & handover
PATIENT COMMUNICATION	Patient focused communication Staff attitudes and behaviours Responding to our patients
NURSING CARE AND PROCESSES	Nursing processes (meals, medicines) Needs specific care Record keeping
HEALING ENVIRONMENTS	Clean and well organised Patient-friendly spaces Patient activities

Staff on Hydref Ward at the hospital's Heddfan Psychiatric Unit have been awarded BCUHB's Gold Accreditation for providing the highest standards of care.

Hydref Ward is the first in North Wales to be awarded the gold accreditation. The ward provides support for older adults living with a range of mental health conditions, including bipolar disorder, severe depression, personality disorders and schizophrenia.

Psychiatric Intensive Care Unit: improving safety

Our Wrexham based Psychiatric Intensive Care Unit staff were named the Nursing Times' Team of the Year for their work to bring laughter and joy to people most seriously affected by mental ill health. Staff from Tryweryn Ward at Wrexham Maelor Hospital's Heddfan Unit beat stiff competition from NHS teams from across the UK.

The prestigious award has been given in recognition of "incredible" changes the team have made to the eight-bed Tryweryn Pychiatric Intensive Care Ward, which provides care and support for people who are so acutely unwell that they cannot be safely treated on a general mental health ward. This has seen the introduction of a of a range of new activities and therapies on the ward, including joint yoga sessions, hand massages and baking, as well as a new 'rant and relax room', which has been designed by patients.

Caniad Service Manager Denise Charles said: "Different people let off steam in different ways. If someone is feeling like they're not able to express themselves, they may become very distressed. Instead of needing to safely restrain them, we can guide people towards the safe room and encourage them to either let it all out, or just lay under the weighted blanket. We comfort them".

"Since introducing the changes, Tryweryn Ward staff have managed to halve the number of restraints performed, while patient satisfaction scores have increased significantly in the same time. "There is now much more laughter on the ward because it's patient-led".

Ward Manager Matt Jarvis said: "It's all very simple really – just asking how we can support people's individual needs, and actually listening to what they have to say".

Nutrition and Hydration: improving safety

In addition to continuing to promote optimal nutrition and hydration across BCUHB throughout 2019 – 2020, the nutrition teams, incorporating Dietetics, Nutrition Nurses and Catering services, supported a large piece of work to enable a pan BCUHB change to inpatient malnutrition screening.

From 2018 to 2019, members of the BCUHB "*Fundamentals of Nutrition, Catering & Hydration Standards*" (FINCHS) Group contributed to an All Wales review of malnutrition screening. It was concluded in 2019, that in all acute and community inpatient settings (bar Mental Health and Maternity Services), it was appropriate to change from using the long-utilised 'MUST' (**M**alnutrition **U**niversal **S**creening **T**ool), to using an alternative validated tool called 'WAASP' (**W**eight, **A**ppetite, **A**bility to eat, **S**tress factor, **P**ressure ulcer) Nutritional Risk Assessment Tool. Evidence suggests the tool is able to more sensitively capture patients at risk of inpatient malnutrition.

Following this work, all Welsh Health Boards were instructed by the Welsh Health Circular to change the documentation used for Adult Inpatients Nutritional Screening from 2 December 2019.

FINCHS continued to work across BCUHB and with All Wales stakeholders, including Nursing and Informatics to ensure appropriate Risk Assessment Booklets were designed and disseminated, plus e-learning platforms were updated to reflect the new tool. To support implementation, the BCUHB Dietitians and Nutrition Nurses delivered a comprehensive education programme from early September 2019 until the New Year.

The WAASP tool is now embedded across BCUHB in all the appropriate inpatient areas.

WAASP IS COMING...

The new All Wales Nutritional Screening Tool is coming to your ward on 1st December 2019!

Prepare yourself by completing the ESR E-Learning by the end of September

000 NHS Wales – Food Record Chart

Safeguarding

The examples below are just some of the steps we have taken to provide assurance, make improvements and to learn, from a Safeguarding perspective.

Internal Audit Report 2019/20

A detailed review of service delivery against the requirements of the Health and Care Standards, Safeguarding legislation and guidance took place in 2017-2018 with limited assurance given. A follow up review of the period of 2019-2020 found substantial assurance with no recommendations made as report findings had evidenced significant improvements had been made.

Safeguarding Maturity Matrix

The Safeguarding Maturity Matrix (SMM) is a self-assessment quality monitoring tool used by all Health Boards/Trusts in Wales. In November 2019, the five standards assessed were; Governance and Rights Based Approach, Safe Care, ACE Informed, Learning Culture and Multi Agency Partnership Working. The highest achievable score is five for each standard, with a maximum score of 25.

BCUHB achieved a score of 14 in 2018, and a score of 23 in 2019. This demonstrates excellent progress, and is the highest score in Wales. This was achieved by the implementation of improved Governance, Performance and Assurance Frameworks, evidenced based learning, and the development of Communication Pathways.

Learning culture in safeguarding

The Corporate Safeguarding Team provide BCUHB assurance against Internal, Regional and National Reviews for both adults and children. A good example is a recommendation from a Child Practice Review recommending all agencies develop a critical incident debrief model. On the 4th May 2010, the Corporate Safeguarding Team launched the Trauma Risk Management (TRiM) which is supporting staff who suffer a traumatic event.

Effective Care

Effective Pathways of Care: Self Care Pathway
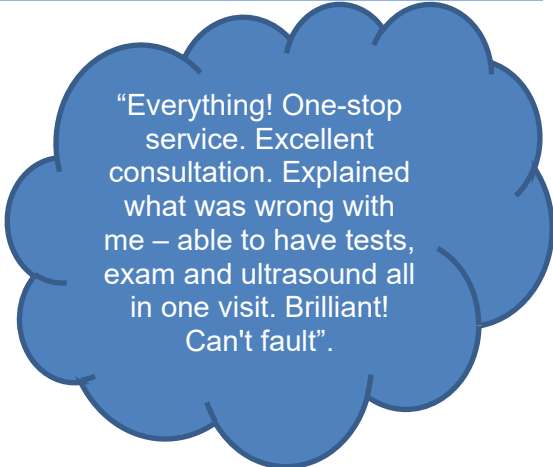
The purpose of the Emergency Department (ED) Direct Discharge for the East area, was to redesign the pathway of care for the management of six specific fractures and injuries. All patients with acute fractures have traditionally been referred to a fracture clinic soon after injury. However, many simple stable fractures and injuries can be discharged from the ED with standardised advice leaflets, access to telephone advice and no further follow up in fracture clinic.

➡ Implementation commenced on the 1st Oct 2018 and data was collected prospectively for 12-months. Patients diagnosed with one of the six specific injuries were put onto the 'Self Care Pathway' (SCP) receiving the appropriate treatment and an advice leaflet, prior to being discharged from the ED.

➡ The ED physiotherapist collated patients put onto the SCP, reviewed the notes/X T Rays with an Orthopaedic Consultant on a weekly basis, to ensure patients' were safely, and appropriately discharged from the ED. Patients either remained on the SCP, were referred to Occupational Therapy (OT) for onward management (mallet injuries only) or were recalled to attend fracture clinic. At 8 weeks post injury, the ED physiotherapy practitioner carried out a telephone review for patients who remained on the SCP without any routine follow up. Additionally, the ED software system was used to examine how many patients were referred to fracture clinic with one of the 'six' injuries, rather than being treated on the SCP:

➡ 255 (67%) out of a possible 378 patients were put onto the SCP, with 231 (91%) remaining on the SCP after the orthopaedic review. Only 2 (1%) patients who were accurately put on the SCP, re-attended the ED with ongoing pain/disability and were subsequently seen by an orthopaedic consultant and fracture clinic respectively. Of 62 patients contacted on the telephone review, 98% reported normal function and near/full recovery from their injury. 231 fracture clinic appointments were not needed.

This work has improved the pathway of care without compromising the overall outcome and subsequently, less travel time and time off work for the patients' to attend an appointment and fewer fracture clinic appointments, thus reducing the workload of the fracture clinic.

Effective Pathways: 'One Stop Shop' – Shoulder Clinic

Implementation of the 'One Stop Shop Shoulder Clinic' started on 1st April, 2019. The purpose of implementing a 'One Stop Shop' shoulder clinic within the musculoskeletal triage service (CMATS) was to improve the pathway of care for patients with shoulder conditions. This service enables patients to attend one appointment and receive a musculoskeletal assessment with immediate access to diagnostic ultrasound scanning and injection if indicated.

"Everything! One-stop service. Excellent consultation. Explained what was wrong with me – able to have tests, exam and ultrasound all in one visit. Brilliant! Can't fault".

➡ Between April 2018 and August 2019, 131 patients were seen in the one stop shoulder clinic. Following clinical assessment, 61% of these patients proceeded to ultrasound scan, 39% of patients
did not require a scan.

➡ There were 142 GP referrals for shoulder ultrasound to the radiology department. There has been a 44% reduction in shoulder ultrasound activity when compared scans performed between April 2019 and August 2019.

➡ The average waiting time for ultrasound within the radiology department between April 2018 and August 2018 was 9.4 weeks. The average waiting time between April 2019 and August 2019 was 6.1 weeks. This demonstrates a 35% reduction in patient waiting times during April 2019 and August 2019.

Wrexham Maelor Hospital Annual Symposium: Quality Improvement (QI) and Audits

This was the second "Annual QI-Audit symposium" at Wrexham Maelor, which was attended by 94 staff members from various disciplines. It included 10 selected QI projects/audits presented by medical and nursing staff and was very well received by all attendees with excellent feedback. Three prizes were awarded for the best projects and the first prize was won by the orthopaedics team for their brilliant results with "Personalised total hip replacement pathway" at Maelor. Quotes from attendees included:

"Excellent. A wide range of subjects and inspirational for innovative change".
"Good practice to carry forward. Very informative and current, pro-active projects, very encouraging and a pleasure to hear".
"A variety of projects from various specialities! Wonderful presentations given throughout. Good quality projects! Excellent-excellent!".

Clinical Audit, Outcome Review and Service Evaluation

BCUHB continues to use a variety of quality improvement methods to identify how well care and treatment is delivered for our patients and carers. One of these approaches includes using 'Clinical Audit' to measure practice against agreed standards. The standards are based upon the best available evidence, which may be national guidance, clinical expertise or research findings. In this way quality improvement needs are identified and acted upon.

It is important that we look at the right topics for clinical audit at BCUHB, therefore a process of prioritising the projects we conduct which are motivated by factors important to improving outcomes and listening to feedback from patients and carers along with learning from feedback, incidents, concerns and research. These include the Welsh Government's *NHS Wales National Clinical Audit and Outcome Review Plan: 2019/20*. Here clinical audit projects and outcome reviews enable learning and comparison against other organisations in England and Wales.

An example of where a National Clinical Outcome Review has led to direct local engagement is the MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. Several immediate improvements have been identified and actioned, supporting improved care provision for high risk women in the following ways:

- Improved initial booking risk assessment form
- Training updates for all staff via sending out a link to a Perinatal Institute educational video with regards to symphysis fundal height measurement
- Face to face assessment of the practice of SFH measurement to ensure appropriate practice is in place and is standardised across BCUHB.

This will support increase detection of small for gestational age babies at risk of stillbirth.

Another positive example is of the impact that evaluation projects can make locally is one that supports the improvement demonstrated by a BCUHB education programme for staff; guiding and supporting them in caring for patients and the creation of Strategic delivery Groups & Subgroups around Palliative and end of life care.

Research, Development and Innovation

In addition to the work noted above, research is a daily part of our work. It helps to improve the health and wellbeing of the people of North Wales. We are always looking at new ways to prevent, manage and treat disease and of bringing hope to people living with illness. The research staff are mostly the same doctors and health professionals you will see at your appointments. A Research and Innovation **Strategy** has been launched for 2020-2025 (below).

Purpose: We exist to add value to population health and wellbeing through research, improvement and innovation.

Vision: To create new knowledge for the benefit of the population, nurture innovation and improve health care delivery so that our people are happier, healthier and can prosper in this region.

| Values: | Put patients first | Work together | Value and respect each other | Learn and innovate | Communicate openly & honestly |

Guiding principles: Work as one, Appreciate difference, Learn together, Engage and co-produce, Lead with generosity

Strategic objectives
#1 Build a strong community
#2 Maximize potential of research & innovation
#3 Realise the benefits for the region
#4 Innovation Readiness

Case Study: A group of people in North Wales were provided with a unique opportunity to take part in a study to discover whether it can improve their quality of life following cancer treatment.

The CLASP study, an online programme called Renewed for people who have had prostate, breast or bowel cancer, were offered to people who had finished their main cancer treatment in the last 10 years or are having active surveillance for prostate cancer. Renewed is an online programme that can help people to be more active, reduce their stress levels, manage their weight, eat a healthy diet and feel less tired.

Everyone who took part in the study, which finished at the end of October 2019, were asked to complete an online questionnaire after six months and a year. The questionnaire asks them about their feelings and whether the programme has helped them to improve their quality of life. The Health Board were the best recruiters in Wales for people following cancer treatment.
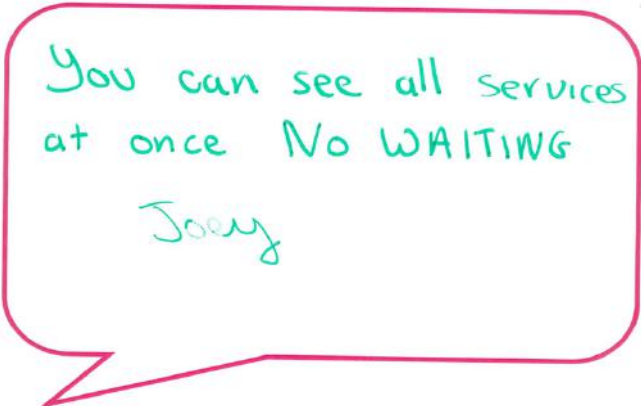
The Health Board participated in a number of COVID-19 trials and the RECOVERY trial has shown that dexamethasone, a steroid, significantly reduces the risk of dying from COVII-19 for seriously ill patients requiring respiratory intervention – a major breakthrough. Despite the challenges COVID-19 has created, the outbreak has inspired clinicians to develop innovative projects to help them better communicate between themselves and their patients.

Integration and Joint Working: Community Care Hub

The Community Care Hub is led by Dr Karen Sankey and Dr Dewi Richards and was established in the Salvation Army, Wrecsam in January 2017. Dr Sankey has been a GP for 25 years, but she feels modern general practice is "not fit for purpose", particularly for vulnerable groups, who tend to "just fall through the cracks".

The Community Care Collaborative Hub provides a one-stop shop for every service that people may need. It is a drop-in session which occurs every Friday bringing together 29 agencies. The 'Everyone in the Room' model brings together all the agencies that people need in the same room, at the same time every week. This system means people do not have to worry about missing appointments or needing paperwork they do not have access to. On average, it supports 60 people each week who are homeless, sleeping rough or have mental health or substance misuse problems. In the last financial year, 850 people accessed its services. The PALS have been working alongside the other 28 agencies since September 2019.

Stroke care

The improvement in performance against the Stroke Care measures that we achieved in the first half of 2019/20 did not continue into the winter months in respect of the number of patients being admitted to a specialist unit within four hours and the numbers seen by a specialist consultant

within the first 24 hours of admission. In part, this has been because emergency care pressures had an impact upon the availability of stroke beds. However, performance in the year is an improvement on 2018/19 for both measures.

In response, awareness sessions are being held with staff working in our Emergency Departments (ED) to highlight the need for early referral to the Stroke Team. A proposal to ring-fence an appropriate number of beds only for use by Stroke patients is being considered.

Dignified Care

Dementia Care

The past year has seen a lot of positive work happening around dementia care at BCUHB. Whilst over 10,000 of our staff have now completed training in dementia we also partnered with TIDE, a dementia carer organisation, to train an additional 1,000 frontline staff to become more aware of the needs of families and carers. In support of this we also partnered with North Wales Police to launch the Herbert protocol which helps a person with dementia who may get lost to be found quickly and returned home safely and by doing so reducing the distress of becoming lost or of losing a loved one.

Our second Consultant Nurse for dementia, Suzie, joined us and has initiated a community of practice for all dementia support workers across the organisation to equip them with the knowledge and skills they need as they develop new roles in community hospitals and mental health units. Under our Dementia Strategy we saw a number of hospitals and units being accredited by the Alzheimer's society as Dementia Friendly and Ysbyty Gwynedd became our first District General Hospital to be accredited. In a similar way, all of our Memory Assessment Services across North Wales were again successfully accredited by the Royal College of Psychiatrists. These accreditations show services performing to national quality standards aimed at delivering high quality dementia care.

Dementia Care: a peaceful setting

In early 2019 we introduced a new care suite at Wrexham Maelor Hospital which will provide a peaceful setting for people with dementia to spend their final days. The facility at the hospital's Heddfan Older Persons Mental Health Unit will ensure that people with dementia can receive end of life care in a dignified setting away from the main hospital environment, if this is their wish and that of their family.

The refurbished suite, which will support patients on Gwanwyn Ward, has dedicated facilities to enable families to stay close to their loved one and follows our commitment to John's Campaign, which advocates for carers' right to stay. It forms part of our efforts to improve the quality of Older Person's Mental Health services and act on the recommendations of external reports by the Health and Social Care Advisory Service and health investigator Donna Ockenden.

"People with dementia have as much right as any other person to a dignified death with an assurance of compassionate and high quality care. As a health board, we recognise the need for preferences and decisions about end of life care to be identified as early as possible and we advocate for people to be able to have

Sensory Loss: "It Makes Sense"

On November 28th 2019, the fifth hosting of the All Wales Sensory loss conference that precedes the "It Makes Sense" annual campaign took place. The purpose is to highlight provision of care, service and support for the sensory loss community and shine the spotlight on those who provide vital support. The event this year was hosted by BCUHB and organised by the Patient and Service User Experience Team.

The event was compromised of guest speakers and presenters to showcase their specific sensory loss organisation or supporting elements, there were updates of developing awareness of sensory loss groups, supporting mechanisms and roles specific organisations have with providing such things as accessible Health care, patient support, carers and relative support and training. The event also provided workshops to aid in the understanding of sensory loss across the spectrum of sight loss, blind, visually impaired, deaf, hearing loss and the mental health of those who have a sensory loss.

➡️ The event was also planned as a unique networking meeting for delegates, health care professionals and the sensory loss community to come together under one roof for the purpose of sharing, supporting and highlighting changes, updates or new innovation for sensory loss.

➡️ The event attracted over 140 delegates from all over Wales and England who had an interest in sensory loss ranging from service users to Ophthalmic consultants and University students, supporting organisations, National Charities and regional and local third sector groups who provide for specific sensory loss communities within their areas.

Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. Their purpose is to check that people in Wales receive good quality healthcare.

The Health & Care Standards help us to provide a delivery of high quality services in the NHS in Wales. These standards were developed by Welsh Government in line with the NHS Outcomes and Delivery Framework through a broad range of consultation with stakeholders. Healthcare Inspectorate Wales assess healthcare provision against these standards. Each inspection considers how the service meet the Health and Care Standards under three domains: the quality of the patient experience; the delivery of safe and effective care; and the quality of management and leadership.

BCUHB has in place a process for managing HIW inspections, concerns and enquiries with a tested the assurance methodology, which provides opportunity for rigorous and meaningful action planning and tracking. In addition, it provides assurance through our governance reporting structure up to BCUHB's Quality, Safety and Experience Committee for scrutiny and oversight.

2017 - 2020 Status
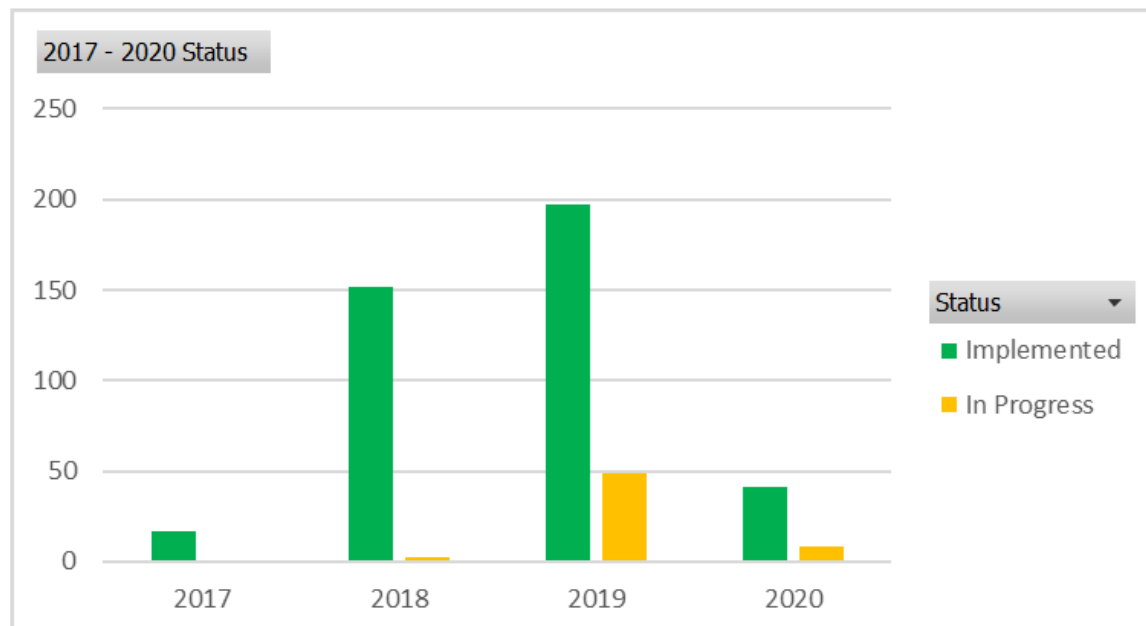
As shown (left), each year BCUHB has improved the progress we make with ensuring that any actions agreed following HIW inspections and recommendations are implemented in line with the Health and Care Standards.

In addition, work has been undertaken to ensure that there is sufficient assurance for each action, prior to closure through monthly reporting to BCUHB's Quality and Safety Group, which is chaired by the Deputy CEO / Executive Director of Nursing and Midwifery.

As a Health Board, we appreciate the work of Healthcare Inspectorate Wales as it enables us as an organisation to strengthen and improve the services we provide. As such, we welcome further opportunities to work closely together to provide assurance and to make a difference for our service users and residents.

Continence Care

Training and Education has taken place via our Electronic Staff Record (ESR) database, with all BCUHB healthcare professionals, and staff in the private sector - (in Residential and Nursing homes) having access to the following training; Continence update, Catheter Management, Bowel Dysfunction, Continence throughout the Lifespan. Urinary catheterisation and catheter care in adults is available as an e-learning package. Some sessions such as catheter update are well attended. Other sessions have had to be cancelled to due to poor attendance. Additional training sessions such as bowel care have been added as required. Team leaders and managers have a responsibility to ensure their staff have the knowledge and skills to manage patients with continence care needs in their clinical area. Care agency staff can also receive specific training depending on patient continence care need.

Clinical placements with the continence advisors in their nurse-led clinics are offered to health professionals, pre-registered students and junior doctors. Assessment of patients with bowel and/or bladder dysfunction is the responsibility of all BCUHB clinical and nursing staff, the continence service team are available to offer advice, support and joint visits as necessary.

The formulary nurse position offers advice and support to staff and patients with urology devices e.g. catheters/sheaths. Her remit is also looking at prescribed items, ensuring items on BCU formulary, used and prescribed correctly thus reducing wastage and cost.

Monthly Multidisciplinary Team meetings take place across BCUHB with Gynaecology, Urogynaecology, Urology, Continence Advisors and women's health physiotherapy to discuss complex cases and further management.

The All Wales Continence Forum (AWCF) have developed Continence / Risk Assessment Toileting tool to be rolled out across all BCUHB acute wards in the near future as part of the new Risk assessment booklet. In addition, the AWCF have also produced guidance for the provision of continence containment products for adults in Wales. A consensus document for the provision of containment products for adults with urinary and or faecal incontinence, undergo a comprehensive assessment and have access to an equitable service.

Timely Care

Advanced Paramedic Practitioner Project: Transforming Care

Advanced Practice Paramedics provide a rapid response service to patients requiring home visits, which would previously have been provided by their GP. The purpose of this project is to support GP practices in North Wales to improve the quality of care, transform the way that care is delivered in the community, and help sustain Primary Care services by reducing emergency admissions, improving patient access, releasing capacity for GPs to focus on planned care appointments in their Practices.

The scheme will support Primary Care sustainability, improve patient access, and deliver more services in the community.

Unscheduled Care: a whole system approach

During 2019/20, we initiated a whole system approach for Unschduled Care, ensuring delivery of the winter plan, with a focus on pre-hospital attendance and admission avoidance. In collaboration with the Wesh Ambulance Service NHS Trust, we developed the SiCat system, linked to the ambulance control centre, to provide clinical advice and alternatives to hospital attendance or admission. The Health Board developed community resource teams with the aim of keeping patients in their own homes and to help patients return to their home as early as possible after an admission. Combined with these initatives, our teams worked on improvement of in-hospital flow, including the development of assessment and ambulatory care services on acute sites and improved discharge planning.

During the early part of declaration of the Covid-19 pandemic in March 2020 the number of attendances at Emergency Departments fell significantly, recovering to near normal levels by the end of Quarter 1 of 2020/21.

Unscheduled Care

Flow in our services: The Same Day Emergency Care in Ysbyty Glan Clwyd commenced on 3rd July 2019. This has been developed as an ambulatory emergency unit that will see, treat and discharge patients on the same day, many of whom would previously have stayed in hospital for several days and reduce non-admitted breaches and admissions and help to prevent overcrowding in ED.

Wrexham Maelor Hospital have reconfigured their Emergency Floor area to provide assessment space, including ambulatory emergency care and a frailty unit. The new space was opened on 4th November 2019 with the aim of reducing the number of patients waiting over 12 hour in ED, reducing admissions and reducing the length of stay across the Hospital.

SAFER principles (Senior review; All patients; Flow; Early discharge; Review) continue to be embedded across the sites and the number of patients with delayed transfers of care continues to improve with a focus on stranded patient reviews developing a specific focus on patients over 21 days in both Acute and Community Hospitals. This involves Local Authority, Area Colleagues and Hospital staff for more collaborative working in providing better care for patients and in the right setting. A standard operating procedure for SAFER has been developed to clearly define how this can be used to support patient flow, patient experience and keep our patients safe.

Discharge from our hospital services: Placements were trialled in wards in community and acute sites across BCUHB with the prompt for patients to ask questions about the reason for their admission, what is happening to them today and planning for their discharge and this concept has been adopted by the Delivery Unit across Wales. It is key that we engage our patients and carers in all aspects of their care (What Matters) and understand their needs from the time of their admission, to support early safe discharge.

We are working closely with the Welsh Ambulance Service to develop our longer-term service model for call handling and triage. The SICAT (Single Integrated Clinical Assessment & Triage) service continues to develop. Our ambition is to work with all our partners and our public as part of our emerging services strategy to strengthen these so patients can receive the best care as close to home as possible. Planning work is underway to build this into the 111 service. We have secured recent funding to pilot an expansion of this service to support patients in nursing and residential homes in the East area to prevent hospital admissions.

Planned Care: Referral to Treatment (RTT)

Referral to Treatment measures the total time a patient waits after they have been referred by their GP until they start their active hospital treatment. This includes time spent waiting for outpatient appointments, diagnostic tests, scans, therapy services and inpatient or day-case admissions. The two targets for Wales are that 95% of patients are treated within 26 weeks and that no patients wait longer than 36 weeks.

While referrals for planned care have reduced since the start of the Covid-19 pandemic, the length of waits has increased due to the postponement of non-essential surgery, clinics and diagnostic services during the initial pandemic response. Alternative ways of reviewing patients have been introduced; however, the speed of introduction, very close to the year end, means that not all of our reporting systems have been adapted to capture these new ways of working in time to be reflected in the performance data in this report.

At the end of December 2019 76.74 % of patients had been waiting for fewer than 26 weeks. By the end of March 2020, 76.41% waited fewer than 26 weeks for treatment.
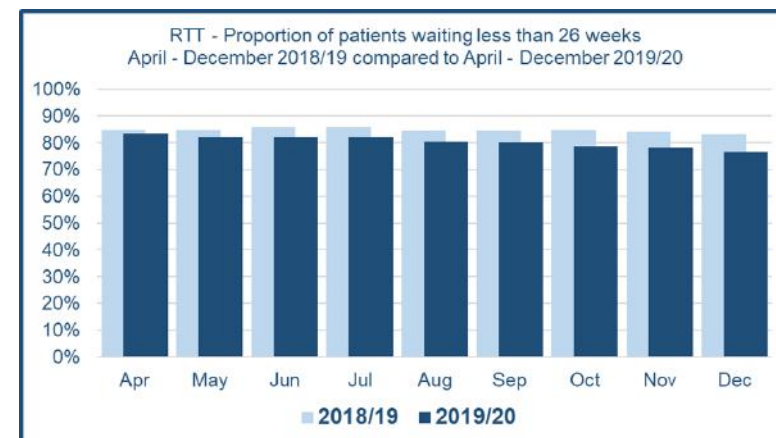
RTT - Proportion of patients waiting less than 26 weeks
April - December 2018/19 compared to April - December 2019/20

Planned Care

Doctors in training have ranked Ysbyty Gwynedd's Emergency Department as one of the best places to train in the UK. Results from the recent National Training Survey by the General Medical Council shows over 85% of doctors in training are pleased with the quality of clinical supervision, experience, and the teaching they receive at the Emergency Department.

A new system designed to speed up diagnosis for people with suspected cancer has been introduced in North Wales. We have issued guidance to GPs to help them determine whether patients with symptoms of colorectal cancer can be referred directly for an investigation, bypassing an outpatient appointment and saving time. More than 500 people are diagnosed every year in North Wales with a colorectal cancer, such as bowel, colon and rectal cancer. https://bcuhb.nhs.wales/news/health-board-news/new-system-to-speed-up-cancer-diagnoses-introduced-in-north-wales/

People living with dementia and their carers have joined health experts in praising the 'first class' memory support provided across North West Wales. The Gwynedd and Môn Memory Service has been given a top quality mark by the Royal College of Psychiatrists for the third successive time for providing the highest standards of care for people living with dementia and other memory problems. The 'Memory Services National Accreditation Certificate' recognises exemplary practice across key areas identified by mental health professionals, service users, carers and GPs. https://bcuhb.nhs.wales/news/health-board-news/new-award-for-first-class-gwynedd-and-anglesey-memory-service/

Staff in the Same Day Emergency Care (SDEC) unit (Central Area), which opened on July 3, have helped hundreds of people who had visited their GP or the hospital's Emergency Department avoid admission to hospital. Teamwork between nurses, doctors and radiography staff helped 70 per cent of visitors return home on the same day following treatment, allowing them to recover at home while also increasing capacity in the Emergency Department. The unit aims to assess, diagnose and provide treatment to eligible patients before safely discharging them home to recover or to wait for further test or treatment. Previously, those same patients would have had to be admitted to hospital while waiting for further care. https://bcuhb.nhs.wales/news/health-board-news/more-than-500-people-seen-over-first-month-at-new-emergency-care-unit-designed-to-help-people-avoid-hospital-admissions/

Cancer Diagnosis and Treatment

For December 2019, 98.0% of patients who were not initially referred as an urgent suspected cancer, but who were subsequently diagnosed with cancer, started their active treatment within 31 days of diagnosis. This is in line with the national target for delivery of treatment for this patient group.

This group of patients remains the highest volume of patients diagnosed and treated for cancer in North Wales. By December 2019 we had treated 1,747 patients, who were referred this way, for cancer which was 365 fewer than in 2018/19. The Health Board achieved or exceeded the 98% target rate for 7 of the 9 months to December 2019.

The 31 day target was also delivered throughout Quarter 4, ending the year at 98.3% for March 2020.

In the 9 months from April to December 2019, the number of patients referred and subsequently treated on the urgent suspected cancer pathway was higher than in 2018/19, at 1,366 compared to 1,290. The increase in demand is one of the reasons we did not achieve the 85% target rate for starting treatment within 62 days of referral. However, at 83.3%, we are the third best performing Health Board in Wales against this measure.

Weekly and bi-weekly escalation meetings continue to be held on each Hospital site with each specialty team to minimise delays. Managers receive a weekly cancer briefing outlining current and forecast performance to maximise opportunities to actively improve performance.

The impact of Covid-19 upon the availability of diagnostics, as described in an earlier section, has contributed to a deterioration in performance against the 62 day pathway target towards the end of Quarter 4, achieving 79.40% in March 2020.

Since the start of the pandemic, we have also noted a reduction in the number of urgent referrals of patients with suspected cancer. There is concern that patients have been delaying seeking attention for potentially serious conditions, and additional communications and publicity have been issued to encourage patients with symptoms to continue to present to their GP.
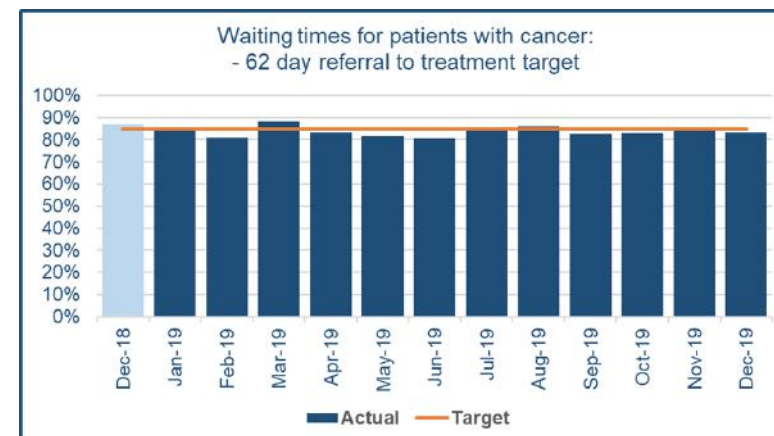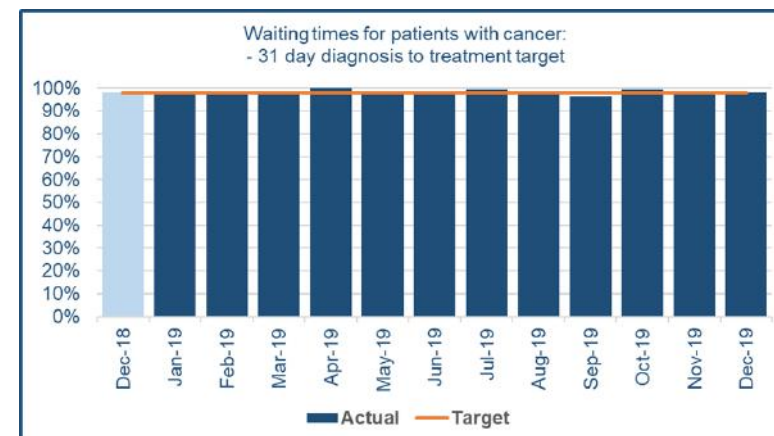
Treating People as Individuals

Improving services for vulnerable groups

In 2019, a Wrexham based health visitor was named the winner of the Advancing Equality Award at a glittering gala evening at Venue Cymru to mark the BCUHB Achievement Award 2019. The awards, sponsored by Centerprise International, celebrate the outstanding achievements of NHS staff from across North Wales.

Jackie has been recognised for what colleagues describe as an 'inspirational' commitment to providing health and wellbeing support to asylum seekers and refugees from Syria and other war torn countries. Since 2001 Jackie has supported the resettlement of hundreds of asylum seekers, trafficked women and refugees in the Wrexham area. Wrexham is one of four dispersal areas in Wales and the only area in North Wales which receives asylum seekers from the Initial Assessment Unit based in Cardiff. On arrival in Wrexham, Jackie coordinates their health and wellbeing assessments and provides ongoing support to ensure that asylum seekers can access a range of health services. She also runs drop in sessions which bring a range of support services together under one roof.

Support for individuals with Learning Disabilities

There are specialist learning Disability Acute Liaison Nurses (ALNs) covering the 3 District General Hospital's, within office hours, in BCUHB. They provide support to individuals with learning disabilities, their families and carers when they are accessing mainstream hospital services.
This service was introduced as a result of a plethora of evidence which highlighted that having a Learning Disability means that hospital services are not always aware of how to meet the care needs. This can result in delays in treatment, and worse case scenario, lead to premature, avoidable deaths (Confidential Inquiry into premature deaths of people with Learning Disabilities 2013, Death By Indifference MENCAP 2010)
The ALNs also provide education and training to hospital staff at all levels, and have also trained around 120 Learning Disability Champions with plans to continue to recruit more.

BCUHB also has a Patient Contact Notification system. This e-mails the ALNs when a person who is known to have a Learning Disability is admitted. This ensures that the person is identified as having a learning disability early in their admission to hospital. There are also Learning Disability Primary Liaison Nurses and skilled Health Care Support workers in the community. Their role is to improve access for individuals with a Learning Disability to mainstream primary care services and to improve the uptake of the annual health checks by working with service users, carers and families as well as services.

Listening and Learning from Feedback

The Patient and Carer Experience team has collected 22,247 real-time survey responses from patients, cares and relatives across North Wales, about their experiences of using our services within 2019. In addition to providing feedback in relation to the all Wales NHS Patient Related Experience Measures, the survey asks service users to share their opinions about:

➡ 'What was good about your experience?'
➡ 'Was there anything that could be improved' and
➡ 'Promoting Equality in everything we do'

Feedback provided from patients and carers provide us with the vital information on how we are doing which enable us to share what is working and make improvements where necessary. Overall, the feedback told us that our services contribute to a positive experience, with an overall satisfaction rating of 8.97/10. In addition to real time feedback, the Patient and Carer Experience Team received 2,201 comment cards, emails, letters, responses and feedback received by our Patient Advice Liaison and Support (PALS) officers.

Your feedback is extremely important to us and is used to focus service improvement efforts. We continue to aim to develop patient and carer feedback in order to listen to the voice of all the people who use our services, from the very young to the older person. Feedback from patients and carers will continue to be the most valuable source of information which helps inform the development of services.'

2019 saw the launch of PALS services in Ysbyty Gwynedd and Ysbyty Maelor Wrexham following a successful pilot of the PALS service in Ysbyty Glan Clwyd. All three localities have three PALS officers based in accessible hubs located in each main entrance of the hospitals and two Patient Experience Co-ordinators.

Following the launch of the PALS hubs we have seen a significant increase of patient liaison due to the prime locations and have formed / strengthened good working relationship with our colleague's.

Putting Things Right (PTR)

BCUHB recognises that patient safety and experience, public engagement and involvement is a vital aspect of the Health Board's governance arrangements. The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (the Regulations) came into force on 1st April 2011, to enable Responsible Bodies to effectively handle concerns.

The aim of the regulation is to streamline the handling of concerns and under the '*Putting Things Right'* (PTR) arrangements, all NHS Wales organisations should aim to "investigate once, investigate well", ensuring that concerns are dealt with in the right way, the first time around. The term "Concern" relates to any complaint, claim or reported patient/service user safety incident about NHS treatment or service.

This means, that whenever concerns are raised about treatment and care, whether through a complaint, claim or patient safety incident, those involved can expect to receive a prompt acknowledgement and response, about how the matter will be taken forward, be dealt with openly and honestly and have an appropriate investigation undertaken into the concerns raised.

Patient safety is paramount and is focused on the prevention of harm to patients by improving the way in which care is delivered so that errors are prevented, learning occurs from the errors that do occur alongside fostering a culture of patient safety, that involves health care professionals, partner organisations, patients, carers, families and the general public.

BCUHB's annual PTR Report has been prepared in line with the PTR Regulations to provide an overview of the 2019/2020 position in terms of how the Health Board has managed concerns during this time. It provides an overview of themes and trends emerging from Concerns including some of the lessons learned.

In October 2019, we were very pleased to welcome our new Assistant Director of Patient Safety and Experience who has brought a wealth of experience to support our commitment to patient safety and experience.

We would encourage you to view the report as it provides valuable information from learning to learning and improvement work, our priorities over the next year and key strategies and frameworks. Details of how to access the report can be found in the 'Useful Information' section of this report on page 53.

Supporting Welsh Speakers

BCUHB's Language Choice Scheme has been greatly expanded during the past year and is now in operation on wards within all three BCUHB acute hospitals and at numerous community hospitals. Orange magnets – adorned with the instantly recognizable orange 'Working Welsh' logo – are placed on bedside white boards (and also on staffing boards), in order to identify Welsh speakers and facilitate the process of pairing patients and staff who can speak the language.

Welsh language training has developed to be an integral part of developing Welsh language skills of BCUHB staff. Our comprehensive programme has attracted funding of over £200,000 a year from Gymraeg Gwaith/Work Welsh, a scheme funded by Welsh Government, which also includes funding to employ a Welsh Language Training Support officer for BCUBH since April 2018. Since being part of the Cymraeg Gwaith / Work Welsh scheme in April 2018, 9.4% of the workforce have registered, completed and received Welsh language training.

As well as the work welsh initiative our BCUHB Welsh Language Tutor offers courses tailored to the needs of BCUHB staff members - on a language level, and to the type of work they undertake from day to day, allowing staff members to gain the relevant Welsh language skills in order to offer a bilingual service and therefore meet the needs of their patients

Our staff

Challenges recruiting and retaining our staff

BCUHB employs 18178 staff (March 2020), allowing for part time workers, this equates to 15594 full time equivalent (FTE) staff. Recruiting and retaining key staff to meet increasing demand remains a challenge which is reflected in our vacancy rates.

As at March 2020, BCUHB had a 8.9% overall vacancy rate which has gradually improved from a high of 9.5% in January 2020.

Nursing and Midwifery
- There remains a shortage of skilled nurses, BCUHB has a Nursing & Midwifery vacancy rate of 12.3% (March 2020). However, this has been helped by the recruitment of 50 FTE Nursing and Midwifery staff in the final quarter of 2019.
- Across the 2019/20 year nursing staff leavers have been matched with newly recruited staff resulting in just 2 full time equivalent (FTE) fewer nurses in post at the end of the year, however the Nursing and Midwifery workforce budget has increased by 85 FTEs. This demonstrates the struggle for recruitment to keep pace with increased demand.

Medical and Dental
- BCUHB has an overall Medical and Dental staff vacancy rate of 9.6% (March 2020), however some specialisms face particular challenges. Vacancy rates for our most senior Medical and Dental staff are a little better at 7.8% (Consultants, March 2020).
- Medical and Dental recruitment / retention is matching an increase in demand with the Medical and Dental workforce growing by 37.5 FTEs over 2019/20 whilst budgets increased by 37.4 FTEs

Recruitment to Nursing, Midwifery, and Medical & Dental staff groups remains a challenge for BCUHB, as it is for all other Health Boards, owing to a general shortage of skilled staff. This issue is particularly acute within the following hard to fill specialisms; GPs, Mental Health and Learning Difficulties, General Surgery, Rheumatology, Care of the Elderly, Radiology (particular the specialisms relating to Breast), Gastroenterology and Obstetrics and Gynaecology.

So what are we doing about it?

In light of the challenges above, retention of skilled staff remains a key priority. Numerous improvement actions have been enacted as a result of feedback from the last NHS Wales Staff Survey. Over the last 12 months, all Divisions have developed their local improvement plans. In addition, an organisational wide plan has been implemented. Actions taken include the launch of a revised exit interview process, a review of internal communications which resulted in the launch of a new staff app and proactively managing early signs of stress at work by upskilling managers .

To increase Executive team visibility, all Executive Directors are now involved in presenting Seren Betsi awards to staff. In order to ensure staff feedback is a continuous process the organisation invested in a tool, which has been branded as 'ByddwchynFalch/BeProud. The tool offers a simple way to understand the science behind staff engagement in terms of cause and effect; provides clear practical recommendations to improve staff engagement; provides regular trend analysis and organisational and team level diagnosis of culture. Organisational surveys are conducted every 3 months, 29 teams have already undergone focussed team level journey of improvement.

BCUHB remains committed to investing in developing our staff. All Leadership & Management Development programmes have been reviewed to ensure compassionate leadership is threaded throughout each programme. Processes have been reviewed to ensure compassionate and values based conversations take place at appraisal. Appraisals have increased by 6.1% since April 2019 to 73% in March 2020.

Promoting Train/Work/Live

In order to address the challenges for skilled staff recruitment, BCUHB will continue to market itself through Welsh and UK wide recruitment events, promoting the Train/Work/Live North Wales brand. At a local level, BCUHB is planning for Recruitment Events days where candidates can be interviewed and receive an offer the same day. We have further streamlined the N&M and M&D Recruitment process to ensure recruited staff start safely and as soon as possible.

➡ Specific focus is being placed on wards with high vacancy numbers where social media campaigns are being run through Facebook, Twitter and Instagram.

➡ Whilst we hope to address the majority of our recruitment needs locally, we accept that there is still a need to source candidates from further afield so in Q1 2020/21 BCU will continue to build on our successful International Recruitment Programme with a commitment to source a further 50 Registered Nurses through this route.

➡ For Medical and Dental staff a dedicated weekly Medical Recruitment Panel will plan, monitor and speed up recruitment activity. BCU are also working with external recruitment specialists to help source new recruits into hard to fill specialisms.

Newly Qualified Nurses

From September, those student nurses on a Welsh Bursary will be expected to remain in Wales for 2 years post qualifying. They do not have to stay in an NHS role but this will improve our retention of students in particular in Paediatrics where we often lose staff to tertiary settings in England.

Improving Quality Together

Through the BCU QI hub, training has been delivered for the last 18 months. So far 123 staff have signed up for Silver Improving Quality Together (IQT), with 73% of them completing all study days. The Silver IQT training now forms part of ward managers training, with two cohorts of managers attending training to date. The improvement training has been standardised through the development of standard operating procedure.
The BCUQI hub has opted to go live earlier than launch date (April 2020) of the new improvement in practice training which is replacing Silver IQT with the first cohorts (17 staff) now half way through their face to face training.

As part of the improvement training the BCUQI hub has developed a QI database for improvement projects to be loaded to and shared across BCUHB so others can adopt and learn, the database is also open for others to load there improvement work to as well. The database can be accessed via https://www.bcuqi.cymru/database-1.

Wales for Africa Programmes: International Health Partnerships

The BCUHB continues to be a signatory to the Charter for International Health Partnerships (IHP), which recognises the legitimacy of international health engagement, with the aim of bringing knowledge, and skills back to Wales to improve the health of Welsh Citizens along with sharing best practice and working with a range of nations. By engaging in international initiatives, we can learn from others and work to reduce inequalities whilst sharing our own experiences. BCUHB recognises the importance of being engaged in the international health agenda and this is reflected by the International Health Group (IHG) being Chaired by the Executive Director, Nursing & Midwifery / Deputy Chief Executive.

As well as benefitting people in poorer countries who have fewer resources and less developed healthcare systems, involvement in humanitarian overseas work also benefits our staff in a number of ways. These include improving their teaching skills, building leadership confidence, generating ideas for health service delivery within limited resources, learning about the delivery of healthcare to people from different cultures and also gaining direct experience of global diseases that may pose a risk to the population of Wales. This enhanced skill and knowledge can then be used by our colleagues when they return from overseas, for the benefit of patients in North Wales. Teams of local nurses, doctors, midwives, public health specialists, pharmacists, IT experts, researchers and others are involved in our international health links work, most notably as part of the Wales for Africa Programme.

In North Wales, there are active links to healthcare in the Quthing district of Lesotho, hospital care in Hossana Hospital, Ethiopia and primary care and eye care in Hawassa, Ethiopia. More recently, a healthcare in Busia County, Busia County Referral Hospital in Kenya. Over the past year, BCUHB has supported the work of the links by hosting the International Health Group (IHG), developing national guidance, awareness-raising, and by enabling staff to participate in reciprocal visits involving Wales for Africa partners.

Members of the IHG have made a number of overseas visits – including those to Lesotho, Tanzania, Libya, Ghana & Uganda as part of the International Learning Opportunities (ILO) scheme; to Ethiopia to provide hospital informatics support as well as ophthalmology, cardiology and basic emergency department training; to Lesotho to provide mental health and HIV anti-stigma training; and to Kenya on a fact-finding visit as part of plans to establish a new link. Following a successful visit to Busia County Referral Hospital in Kenya, the link is now preparing to undertake a comprehensive health needs assessment (HNA) within Busia County and a second visit is planned for May 2020. The Kenya Link HNA has been funded by the Welsh Government's Wales for Africa Grant Scheme, and is administered by Wales Council for Voluntary Action. BCUHB holds a list of 150 individuals who are either actively undertaking international work, involved in supporting this work, or who have expressed an interest in becoming involved in volunteering. Currently work is in place for planned review of volunteering to strengthen the ability of individuals to participate in opportunities such as IHP. The board encourages all links to work in partnership with local Universities (Bangor and Glyndwr) Universities.

Volunteers

It is recognised that volunteers play an important role in delivering NHS services by adding significant value to the activities of paid healthcare staff. The Robins Scheme is one example of this with their befriending and wayfinding roles. We currently have over 100 Robins across the health board available to support in a variety of roles across our acute and community hospitals.

BCUHB responded to the need to recruit a further pool of generic public volunteers to meet the anticipated demands of the Covid-19 pandemic and as a result, a further 700+ volunteers were cleared and ready to support during the crisis. 221 public volunteers have supported us during the pandemic and continue to do so in a variety of support roles – from delivering medication, to supporting Personal Protective Equipment (PPE) deliveries, to assisting patients, to manning reception desks.

We have and continue to be supported by third sector organisations and charities, including the Royal Voluntary Service, the British Red Cross and our own Charity partner Awyr Las, who have all greatly contributed to provide volunteers and support when needed.

Chaplains and Spiritual Care

The Chaplaincy Service delivers pastoral care to staff as well as our patients and their families. In addition, daily pastoral care of our staff, the Chaplaincy, over the last year has introduced new initiatives that encompass a wider spectrum of our world of spirituality. The introduction of guided mindfulness sessions and spiritual concerts have enhanced our service. One such initiative is the monthly gong bath for staff members at Ysbyty Gwynedd - which has proved very successful. These teatime sessions have been over-subscribed and planning is underway for the introduction of yoga sessions soon. Our new Chaplaincy Centre at Ysbyty Glan Clwyd is now operational and provides a modern, multi-faith spiritual centre. The Chaplaincy Centres have also been opened out for use by community self-help groups such as Alcoholics Anonymous and community choirs.

Celebrating success: Staff Awards

Our workforce is our most important asset in achieving our purpose of 'Improving Health and Delivery Excellent Care'. We recognise their hard work and commitment through our staff recognition programme, which includes the monthly "Seren Betsi Star" award. Externally achieved successes, including awards from professional bodies or community organisations, are recognised through the Health Board's communications team. An annual staff awards night also celebrates outstanding achievement and effort of Health Board staff and volunteers. In 2019, more than 300 people attended a gala dinner to recognise excellence in Healthcare in North Wales.

22/11/19

Seren Betsi surprise for Neonatal Nurse helping families take active role in their infant's care

A dedicated Glan Clwyd nurse whose innovative approach to involving families in the care of their poorly or newborn babies has won a healthcare award.

21/11/19

North Wales Cancer Centre takes part in unique study

A group of people in North Wales were provided with a unique opportunity to take part in a study to discover whether it can improve their quality of life following cancer treatment.

12/11/19

Wrexham critical care nurses scoop top award for work to support bereaved families

A team of nurses who help bereaved relatives come to terms with the loss of a loved one have won a top health award.

Be Proud Pioneer Programme Pass it on / Celebration event

As part of the Be Proud staff engagement programme for teams, a celebration event was held at the end of the cohort 1 to recognise, share and celebrate the excellent work of the teams on their 26-week journey. This involved sharing what tools and approaches they used to influence staff engagement within their teams, some images seen below.

Equality: Fairness, Rights and Responsibilities

At BCUHB our vision is to create a healthier North Wales, that maximises opportunities for everyone to realise their full potential, and helps towards reducing health inequalities.

To inform the BCUHB's strategic direction it is essential that we have a clear overview and understanding of the major issues facing people with different protected characteristics. This year we have undertaken a review of our equality objectives. We have drawn on evidence from a range of sources including the Equality and Human Rights Commission research 'Is Wales Fairer?', gathered and analysed relevant information and maintained engagement with communities, individuals and experts to help to further inform our priorities and objective-setting. The Strategic Equality Plan can be accessed via the following links;

English:https://bcuhb.nhs.wales/use-of-site/publication-scheme/class-five-our-policies-and-procedures/equality-and-human-rights/strategic-equality-plans/

Welsh:https://bipbc.gig.cymru/use-of-site/cynllun-cyhoeddi/class-five-our-policies-and-procedures/cydraddoldeb-a-hawliau-dynol/cynlluniau-strategol-cydraddoldeb/

The promotion of equality and human rights in everything we do is a key underpinning principle within all health board plans and the responsibility of the whole organisation. Progress and more information about the work we have done to advance equality this year is published in our Annual Equality Report 2019-2020;

English:https://bcuhb.nhs.wales/use-of-site/publication-scheme/class-five-our-policies-and-procedures/equality-and-human-rights/equality-and-human-rights/annual-report-2019-20/

Welsh:https://bipbc.gig.cymru/use-of-site/cynllun-cyhoeddi/class-five-our-policies-and-procedures/cydraddoldeb-a-hawliau-dynol/cydraddoldeb-a-hawliau-dynol/annual-equality-report-2019-20/

Special Measures

BCUHB has been in special measures since June 2015. Work has been ongoing to make improvements in line with the expectations of the Special Measures Improvement Framework (SMIF) issued by Welsh Government. During the first half of this reporting period, the Framework covered four themes: leadership & governance, strategic & service planning, mental health and primary care. In November 2019, the Minister for Health & Social Services issued a revised SMIF covering the four themes of leadership and improvement capability, strategic vision and change, operational performance and finance and use of resources. This latest version of the SMIF is split into Part A: expectations to be met as a minimum in order to be de-escalated from special measures, and Part B: characteristics BCUHB will need to demonstrate it is sustaining and building upon in order to step down to routine arrangements status.

The organisation undertook a self-review in December 2019 against Part A expectations. The self-review identified progress made over the past year. This included quality improvements such as the increased use of integrated dashboards for a range of data/intelligence; the requirement under the Ward Accreditation Programme for wards to undertake quality improvement projects driven by concerns and patient feedback and a range of "Going for Gold" quality improvement roadshows.

Initiatives to improve patient safety during special measures include the launch of an upgraded Harms Dashboard; establishment of the In-Patient Falls Collaborative to support areas with higher levels of harm, and delivery of winter plan initiatives such as increasing multidisciplinary team capacity and projects to support patients' recovery in their own homes. Infection control work has led to a reduction in the number of cases of MRSA.

The work undertaken has led to a variety of improvements to the patient journey, such as the launch of the new Patient Advice and Liaison Service with hubs established at each District General Hospital; reconfiguration of beds and processes on the Wrexham site to create ambulatory and short stay medical capacity located close to the Emergency Department; and the SiCAT model of assessment and triage which has demonstrated a significant contribution to signposting patients to alternative care pathways.

Despite the progress made against the expectations of the revised Special Measures Improvement Framework, that a number of milestones, most notably in the key areas of finance, planning and performance (planned and unscheduled care), have not been fully achieved and it is recognised that there is considerable further work to be done to address the ongoing challenges. The Board remains fully committed and determined to achieve the required improvement in order to secure de-escalation from special measures.

Forward Look 2020/2021

Our vision and purpose is to create a healthier North Wales, that maximises opportunities for everyone to realise their full potential and reduce health inequalities in our population. Therefore, putting quality first in everything that we do to deliver outstanding healthcare to our local population is essential, and we will continue to do so. We have seen so many members of staff embrace quality improvement, and continuously raise standards and improve outcomes for our patients. Our Three Year Outlook and 2020/21 Annual Plan is the end product of a fully integrated process, which has taken account of service, quality and safety, financial and workforce considerations to ensure we have a coherent, consistent, and ambitious set of actions and deliverables.

This work will be guided by the principles within the Well-being of Future Generations Act, and together with our partners across the public and voluntary sectors.

Our **ambition** for 2020/23:

Exit Special Measures

Maximising our partnership working to deliver on the health inequalities and health improvement agenda	Implementing our model of Primary Care to ensure people have easy and timely access to services and deliver health and care support as close to people's homes as possible	Implementation of digitally enabled clinical pathways supporting timely access to safe and effective planned and unscheduled care in accordance with clinical need with the best possible outcome

Engage more widely and refine our digitally enabled clinical strategy proposals. Resources will be required for delivery of this ambitious strategy, which will include investment in digital systems and the requisite supporting staff, new workforce skills and capabilities, organisational development support, and a steering group to oversee the development of the strategy.

Our priority for action in **2020/21** is to make significant progress towards achievement of the following objectives.

Quality Improvement

Strategic Vision and Change Developing a digitally enabled clinical strategy with our staff and partners	**Improved Operational Performance and Governance** Focussing our improvement in the following key metrics: - Planned care / Referral to treatment - Unscheduled care
Strengthened Leadership and Improvement Capability Supporting our key service transformation programmes: - Health inequalities and health improvement - Care closer to home	**Financially Sustainable** - Using our resources effectively - Moving towards a sustainable financial position

Covid-19

When I joined the Health Board as Interim Chief Executive in February 2020, it was difficult to envisage quite what was to unfold over the next few months. The global coronavirus pandemic has caused major change and disruption to the way we all live our lives, and the impact on the NHS has been both wide-ranging and severe.

I have been extremely impressed with the work done by colleagues across the organisation in responding to this unprecedented public health emergency. The energy and commitment in preparing for the expected number of cases and working tirelessly over the last few months is evident and very much appreciated by the Board.

The situation facing the Health Board changed drastically in late February and through March as the country faced up the threat of the cononavirus pandemic. We began preparing so that we would be ready to face a surge in emergency admissions and in demand for intensive care facilities. At the same time, we had to plan how we would continue to deliver emergency and essential care to patients with other serious health conditions in a safe manner. The response that followed demonstrated the enthusiasm, dedication and innovation of staff across the Health Board as they implemented radical changes to how our services operate.

Hospitals were reconfigured to create additional ward and intensive care capacity and to provide segregated facilities for patients with and without Covid-19. To support social distancing there was a major shift to telephone and virtual consultations taking place online, and a significant increase in remote and home working. We started work with key partner organisations to develop three 'rainbow' field hospitals that could provide additional emergency bed capacity if this was required.

As I write this report, we now know that North Wales experienced a slower increase in case numbers than other parts of the UK and, so far, our preparations meant we have been able to manage the volume of patients that have called upon our services. Tragically, we lost two members of our frontline staff to Covid-19, and I must pay tribute to Andy Treble, a member of the operating theatre team at Wrexham Maelor Hospital, and Rizal "Zaldy" Manalo, a Staff Nurse at Glan Clwyd Hospital.

I will close my statement by offering my thanks to staff across the Health Board for their efforts, throughout the year and, especially, over recent months. These have been exceptional times for the NHS, which demanded and received an exceptional response from colleagues for which I am extremely grateful.

Simon Dean, Interim Chief Executive

Engagement – sharing our news with our communities

News

28th July 2019

Ysbyty Gwynedd's UK's emergency department voted ninth best in UK for doctor training

By Dale Spridgeon

A BANGOR hospital emergency department is the ninth best in the UK for overall satisfaction by trainee doctors.

The National Training Survey by the General Medical Council showed that more than 85% are pleased with the quality of clinical supervision, experience, and teaching at Ysbyty Gwynedd's emergency department.

Betsi Cadwaladr
August 8, 2019

This #transferdeadlineday join a winning team - the king of deadline day Harry Redknapp is urging you to sign up with our Robins volunteers. Find out how you can volunteer with the NHS in North Wales...

Betsi Cadwaladr @BetsiCadwaladr · Feb 19

🎉Huge congratulations to staff working on Hydref Ward at the Heddfan Unit, Wrexham Maelor Hospital, who are recipients of our first Gold Ward Accreditation. More here: bcuhb.nhs.wales/news/health-bo...

We use a range of channels to share news, updates and information with our communities, including traditional and digital media.

This means we are able to engage with our communities is a variety of ways that allows them to access up-to-date information at any time.

Useful Information

Publication of the AQS is aligned to the Annual Report and Accounts, which are part of the Health Board's public annual reporting which set out our service delivery, environmental and financial performance for the year and describe our management and governance arrangements.

Our Quality Improvement Strategy 2017-2020 sets out how we will provide safe, high quality care for everyone we treat. It describes our current position - what we are doing well, and where we need to improve - and sets out the range of actions we are taking to make those improvements. Our Quality Strategy for 2020-2023 is underway and will include good engagement.

The Putting Things Right Annual Report 2019-2020 has been prepared in line with the PTR Regulations to provide an overview of the 2019/2020 position in terms of how the Health Board has managed concerns during this time. It provides an overview of themes and trends emerging from Concerns including some of the lessons learned

Copies of all these documents and other public reports can be downloaded from the Health Board's website at https://bcuhb.nhs.wales/about-us/governance-and-assurance1/.

Thank you for taking the time to read this report. If you have any queries, would like to request further information in relation to this report, or of you would like to keep up to date with news in relation to our services, please visit our website. Details of how to contact our services can be found at the 'Contact Us' page: https://bcuhb.nhs.wales/

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 28th August 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Primary Care Update
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Chris Stockport Executive Director Primary Care & Community Services
Awdur yr Adroddiad Report Author:	Clare Darlington Assistant Director Primary Care & Community Services
Craffu blaenorol: Prior Scrutiny:	The information has been provided by primary care leads for each of the contractor professions
Atodiadau Appendices:	No appendices are included with this report

Argymhelliad / Recommendation:

The Committee is asked to note:
1. the confirmed delivery of essential services across primary care and significant work undertaken by all contractors to ensure access for patients requiring urgent care during the pandemic;
2. the ongoing implementation of the 'amber phase' of the primary care recovery plans;
3. the risks and challenges in the delivery of services across primary care

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

Sefyllfa / Situation:

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 and start to scale up normal business in an environment that still needs to respond to COVID-19.

Primary Care services have continued to be delivered across the four contractor services (General Medical Services (GMS)/GP Practices, Community Pharmacies, General Dental Services and Optometrists) throughout the Covid-19 pandemic. But to do this, considerable changes had to be made to the usual operational delivery, with a focus on ongoing access to essential services, which were adapted to meet the necessary infection control requirements.

During quarter 2 of the year, the services have moved into an 'amber' stage of delivery; with recovery plans for each contractor published by WG reflecting a cautious approach to restoring services in a phased manner over the coming months.

The following report provides an overview of access to primary care essential services in North Wales and the implementation of WG recovery plans, noting any significant risks to delivery.

Cefndir / Background:

The response to the COVID-19 pandemic has meant implementing considerable changes to the usual operation of Primary Care services. Whilst the pandemic has placed unprecedented pressures on the healthcare system it has also brought about innovative and valuable new ways of working, with many changes introduced at significant pace. We recognise the opportunity to take the learning from the COVID-19 response, capitalising on positive system changes to support the vision of *"A Healthier Wales"* and the implementation of our Primary Care Model for Wales.

There is a continuing need to maintain essential services as well as begin to open up access to additional and enhanced services. This requires an integrated approach across the whole healthcare system and must be in line with the traffic light system announced by the First Minister on 15th May in *"Unlocking our Society and Economy: continuing the conversation."*

As noted above, WG has published four recovery plans across General Medical Services (GMS), community pharmacy, dentistry and optometry. These plans align with the traffic light system and provide the overarching phased approach to restarting components of the Primary Care contracts which were relaxed in mid-March.

Alongside other Health Board primary care teams, BCUHB have actively contributed to the 'Primary Care Operating Framework for Recovery – quarter 2 and beyond' and have applied the Framework in the Health Board's plan, with work ongoing in the preparation of primary care plans for further recovery in quarters 3 and 4. This includes actions that allow the return of primary care services 'amber' towards a 'green' status, recognising the need to be able to respond to any Covid-19 outbreaks or second wave, as well as the usual demands that the Winter months bring.

Asesiad / Assessment & Analysis

Primary care contractors responded rapidly in quarter 1 to minimise the spread of COVID-19 infection, continue to provide essential services and allow the sector to cope during a surge of cases. Change was implemented at pace, enabled by workforce and digital technology innovation.

Our contractor services adapted to ensure business continuity including separation of COVID-19 and non COVID-19 patient flows with the establishment of hubs for urgent and emergency care, for GP practices, optometry and dental service provision. All services were supported to put in place arrangements to adhere to social distancing and infection control requirements through both physical measures and rapid roll-out of remote consultation working.

During this period there has been an ongoing provision of essential services, albeit with reduced capacity and alternative ways of working. In addition all services are implementing recovery plan requirements and opening up further services recognising the ongoing challenges and balancing of risk in the continued pandemic environment.

1   GMS/GP Practices

On March 17th, Welsh Government issued a letter to GMS practices with a list of temporary changes to reduce their contractual burden during Covid-19 which included the relaxation of contract and monitoring arrangements. The priority was and remains the continued delivery of GMS across Wales; essential services have been delivered throughout the pandemic period.

In quarter 1, the GP clusters led the development of the Local Assessment Centres (red hubs). In quarter 2 the continued segregation of patients are being managed via these hubs where there is an ongoing or resumed need, alongside ensuring that practices can safely manage Covid-19 related activity where clusters have stepped down their LAC.

The Health Board's Primary Care Contracting team implemented the contractual changes as required. Enhanced Services in the main were suspended, however, it was noted that patients who are poorly controlled should have their condition maximised as far as is possible, but that would be part of the ongoing professional responsibility.

All end of financial year reporting requirements were delayed to 30 September, with the exception of the Access Standards and post payment verification was suspended for 3 months initially, with a review at that point to consider extending.

The deadline for completion of Quality Improvement (QI) projects within the Quality Assurance and Improvement Framework have been extended until 30th September 2021; an extension of one year to allow practices to refocus efforts during this time

WG also advised on measures to be taken by general practices to minimise attendance and stated their support for changes that practices needed to make.

Practices were encouraged to put in place arrangements to ensure no patient arrives at a surgery without having had an appropriate triage. Practices put in place remote triage and consultation solutions, supported by the Health Board. These included *e-Consult* and video consultation such as *Attend Anywhere.* NHS Wales Informatics Service (NWIS) provided additional text messaging capacity for all GP practices with an extra two text messages per patient (based on list sizes) allocated to practices in addition to their normal practice allocation.

Practices have put in place changes to physically separate patients attending the surgeries. Appointments can be staggered to minimise waiting area congestion, which could also result in variation to current surgery times.

GPs and community pharmacies were asked to ensure robust systems were put in place for repeat prescribing which minimise patients attending the practice to order or collect prescriptions. This included maximising the use of repeat dispensing (batch prescribing) arrangements rather than extending prescription intervals.

Whilst GMS activity in early weeks of the pandemic saw a clear reduction in contacts, later weeks have seen demand upon GMS contractors increase, with greater consultation frequency occurring. It is anticipated that this will continue, with individuals presenting who have delayed contacting their GP practices. This will need careful support. Recent weeks have seen stable practice 'escalation' returns with all of our practices reporting being at Level 1 or 2, and work continues with practices during to maintain this through the continued use of (appropriate) alternative working methods.

On 21st May, WG shared Covid-19 Recovery Plans for Primary Care Contractors with Health Boards. The GMS Recovery Plan was shared with contractors on 5th June, through a joint letter from WG and BMA Wales.

In line with this plan, enhanced services are being re-introduced through a phased approach between 1 July 2020 and 1 October 2020; with normal reporting structures and Post Payment Verification in place by the end of this transition. This does not set up an expectation that services will function as they did pre-Covid-19 and assumes a continuation of the innovation and collaboration that has been seen during the pandemic response.

Directed Enhanced Services were required to be reinstated using clinical judgement, with the use of telephone or video consultation as a default position, using face to face only when necessary. Patients who have known poor compliance or control should be prioritised. All reporting requirements will be reinstated from 1st October.

Two new Directed Enhanced Services have been developed by WG in negotiation with GPC (Wales) in response to the pandemic. The Easter Bank Holiday Enhanced Service was commissioned which allowed Practices to open over the Easter weekend to reduce pressure on out of hours services and Emergency Departments. Approximately 40% practices participated in North Wales.

An Interim Care Homes Enhanced Service has replaced the previous Care Homes DES on a temporary basis for the period for 1st July 2020 to 31st March 2021. It was intended to increase support to Care Homes, and amongst its requirements is a weekly "ward round" (physical or virtual to be agreed between the practice and the care home). 94% (96/102) practices across North Wales are participating in this DES or do not have any care homes patients. Discussions are ongoing within clusters to provide a solution for the care home residents covered by the 6 practices that do not want to provide the services.

It was recognised that practices have shown agility and rapidly adapted to delivery during the pandemic with increased use of telephone first models and care navigation. GPs and their teams have also continued to work to ensure that patients have access to timely care whether through telephone consultations, video consultation or face to face where needed through COVID 19 or non-COVID 19 hubs to protect staff and patients.

WG stated that it would encourage practices to maintain this system, particularly through the use of Consultant Connect, Attend Anywhere or other local solutions to ensure those that need discussion can be seen, supporting self-monitoring mechanisms where appropriate.

The Health Board arranged a protected time session for GP practices on 2nd July to prepare their recovery plans and identify any potential service gaps. The Out of Hours service provided cover for the afternoon and practices were supported by the provision of a recovery toolkit to aid their discussions.

The Primary Care Contracting Team (PCCT) has summarised the practice responses in relation to their provision of Enhanced Services from 1st October and specific issues in relation communication, access to services, PPE, Infection Control to share with Area teams.

Key issues in relation to returning to pre-COVID-19 activity include the social distancing and infection prevention & control measures required to keep patients and staff safe within practices. Appointments have to be longer, or gaps inserted between patient appointments to reduce numbers attending at the same time, as well as physical changes to buildings to accommodate the new requirements.

WG and the Health Board continue to provide PPE for practices, although patients are being asked to provide their own face coverings where possible.

The use of remote triage by telephone and/or video, plus video consulting has become embedded in practice and patients are getting used to this new way of accessing GMS services.

A small number of practices either reduced provision from their branch surgeries or temporarily closed their branch surgeries during the last few months, but these are gradually reopening. The Health Board introduced a temporary process to allow such closures for a maximum of 12 weeks, which has now been reduced to 6 weeks.

A daily brief was introduced by the Health Board in the early days of COVID-19 to provide the most up to date advice to practices. This has now reduced to a less frequent brief, but the facility remains to be able to disseminate key messages and can return to daily briefings should the need arise.

Practices are expressing concerns regarding the impact of shielding, self-isolation or quarantine on staff numbers and capacity, particularly if there is a second wave of COVID-19 in North Wales. Furthermore, the demand for services is expected to increase with the required reintroduction of enhanced services, as well as the imminent flu immunisation campaign, and potential need to support any Covid-19 vaccination programme. Escalation levels reported continue to be monitored and Area teams are working with practices and GP clusters in addressing ongoing concerns.

2   Community Pharmacy
The majority of community pharmacies have reverted to pre COVID-19 opening hours and demand for enhanced services is increasing. All pharmacies are delivering essential services for their normal contracted hours.

Supply chain disruption has returned to pre-COVID levels. There remain ongoing transient shortages and supply issues with individual products, which are being managed by community pharmacy and the GP practices as previously. Further, demand has returned to normal levels and there are no COVID-19 specific concerns at present.

There remains a possibility of shortages in the future arising from additional disruption to supply chains as a consequence of COVID-19 outbreaks globally, or the impact of EU Transition Exit on imports. Further, surges in COVID-19 cases in North Wales, and other parts of the UK, could lead to peaks in demand for key medicines that cannot be met.

WG and regional medicine procurement leads at Health Board level are working in partnership to review and have a mitigation plan in place for potential delays in the medicines supply chain over the period of the EU exit transition period.

In addition, a service specification and fee structure has been agreed with Community Pharmacy Wales for the introduction of End of Life Care Medicines Hubs to ensure rapid access to palliative care medicines in and out of hours.

This service provision is currently being considered by the Area Teams and has been approved for funding in West and Centre, with confirmation from the East anticipated shortly. Sufficient expressions of interest have been received from community pharmacies for the service to be viable. An IT support request has been submitted for a stock notification and monitoring system; prior to this being developed, a manual system will be used.

Across North Wales good progress has been made in the delivery of the WG Recovery plan priorities, as detailed below:

- *To ensure community pharmacies continue to be available to dispense and supply repeat and acute prescriptions, with if necessary a reduction in hours pharmacies are open to the public*

   WG have limited pharmacy working behind closed doors to the first hour of each day and up to 1 hour in the middle of the day; very few pharmacies in North Wales are now using this flexibility.

   The Health Board has recently written to Pharmacy contractors recommending that, where they do not currently do so, they should review their contracted hours to include a minimum 30 minute break in the middle of the day to enable the Responsible Pharmacist to take a wellbeing break to assure the safe and effective provision of pharmaceutical services. Early discussions with contractors indicate that there are a number that are looking at amending hours in response to this.

- *To support a move away from demand-led to more planned ways of working particularly in respect of repeat prescriptions;*

   The Primary Care pharmacy teams are working with GP Practices to embed the Repeat Dispensing scheme where possible. This includes ongoing work with the GP clusters (initially in the West Area), to change the culture in respect to routine medicines supply, moving this to a planned care model, where prescriptions are issued in sufficient time to allow the pharmacy to undertake necessary checks, source medicines, deal with any queries, and dispense the prescription before the patient expects to collect. This will support pharmacy resilience in the face of future surges in COVID-19 and facilitate the provision of urgent and unscheduled services. Early discussions indicate that this is beginning to gain traction and further communications are planned in the coming months to manage patient expectations.

- *To reduce footfall in community pharmacies both to support social-distancing and reduce pressure on pharmacy teams & To support the public to self-care, through improved access to online information or through telephone advice and medicines from their community pharmacist*

  All services are now permitted to be delivered remotely by the pharmacies, with training available via Health Education & Improvement Wales (HEIW), along with hints and tips for remote consultations to support pharmacists in delivering services this way.

  A pilot of the video consultation platform 'Attend Anywhere' is currently ongoing in the Cwm Taff Morgannwg University Health Board, with a timetable for rollout in BCUHB by the end of September.

  A national group are developing a COVID-19 care pathway for sore throat management that will be piloted across approximately 30 pharmacies that participated in the original Sore Throat Test and Treat pilot in 2018/19.

- *To protect the health and wellbeing of pharmacy staff*

  Advice on wellbeing resources has been issued to contractors. As described above, a move towards a planned work model will reduce pressure and enable better organised workflows within the pharmacy. Furthermore, the encouragement of a wellbeing break being included in all pharmacies' contracted hours will facilitate proper rest breaks.

  The Health Board has supported the development of a national escalation tool for pharmacies. Monitoring of pressure levels within pharmacies is being undertaken, with 133 out of 152 in North Wales now engaged with using this tool.

  PPE continues to be provided to all community pharmacies as required, with support from the Shared Services Partnership.

- *Progress in shift to amber status*

  Service levels are approaching normal levels of provision. After a significant spike in prescription numbers in March, prescription levels have returned to more normal levels (in some cases below normal levels).   As tourist numbers increase, services designed to support this population (Emergency Medicines Service / Common Ailments Scheme / Emergency Contraception) are now seeing increases in service provision to levels closer to those normally expected.

  The Sore Throat Test and Treat service remains suspended, but as described above, work is ongoing to re-establish this provision with an anticipated re-launch in September/October 2020.

However, there are ongoing challenges and risks for the service. Concerns continue in relation to the financial viability of some pharmacies as reduced footfall has impacted on sales of 'over the counter' medicines and opportunity to provide NHS services, impacting on income.

Historic workforce shortages in professionally registered staff in community pharmacies (Pharmacists and Pharmacy Technicians) are likely to be exacerbated due to the Track, Trace, Protect system and self-isolation, as well as people taking annual leave that has been delayed in the early phase of the COVID-19 pandemic. This may impact on resilience going forward.

3   General Dental Services

Work is underway to progress the implementation of the WG dental recovery plan, which has seen the de-escalation from red phase activity during quarter 2. Alongside this there is a steady resumption of longer-term priorities, with continued encouragement to practices to adopt the principles of the contract reform programme where possible and plans to progress the development of a dental training unit in Bangor.

In line with guidance from the Chief Dental Officer, the Contract Reform Programme is currently on hold and being reviewed. Further direction is awaited and it is assumed this will align with dental services reaching 'green status'.

Restoring dental services is a complex process and there is a particular need to take into consideration the risk of Aerosol Generating Procedures (AGPs) on COVID-19 transmission, and the associated requirements for availability of recommended PPE. There is a need to balance the oral health needs of patients with the requirement to reduce the risk of community transmission of Covid-19 to protect patients, dental teams and communities in North Wales.

At the forefront of the dental recovery plan, is the need to maintain the viability of practices, whilst sustaining and improving the oral health in Wales. COVID-19 will continue to affect the practice of both NHS and private dentistry for some months to come. The need to avoid AGPs will remain necessary for some time.

In line with WG guidance, amber status for dental services has been achieved in North Wales from 1st July. Systems and processes are in place to actively monitor adherence to the guidance and subsequent dental provision by practices, including telephone advice and triaging, and delivery of non-AGPs. Some patients are receiving an Assessment of Clinical Oral Risk and Need (ACORN) as part of urgent and planning course of treatment.

From 1st July to 30th September 2020, practices with NHS contracts are receiving 90% of their Annual Contract Value (ACV); set by WG. This is an uplift from the level set at 80%, but continues to reflect the reduced material and laboratory expenses, whilst acknowledges that PPE could also present an additional cost.

To manage the ongoing Covid-19 transmission risk, the Urgent Dental Centres (UDC) established in North Wales are continuing to operate and provide access to essential services requiring AGPs. There are also an additional ten Emergency Designated Dental Centres (EDDC) provided by dental practices, operating with similar pathways to the UDC sites. Furthermore, support for out of hours (emergency) care has been commissioned temporarily through a number of GDS practices across the region.

Community Dental Services have developed a comprehensive restart plan which will encompass the reintroduction of traditional services within the confines of the clinical AGP restrictions.

Across Wales, the uncertainty around the safety of providing AGPs in dentistry and the need to maintain social distancing, means that dental treatment, activity and patient throughput, at pre-COVID levels is not be possible. It is clear that 'normal' routine dental activity, as we understand it, cannot resume in the short to even medium term. The level of patient throughput will continue to reduce the level of Patient Charge Revenue (PCR) and this risk needs to be managed.

Notwithstanding the impact on the population's oral health and backlog for treatment, the impact on budgets due to reduced activity and associated PCR is significant. For North Wales this is estimated to be between £4-7million and all dental budgets have been reviewed to manage this reduction, with WG currently considering further options.

4   Optometry Services

In line with WG guidance, in quarter 1 essential services were delivered via 15 Optometry Practice Hubs, replacing the 80 practices normally open. The WG optometry recovery plan is now being implemented with the recent move from a red to amber phase which has resulted in Practices across the region reopening.

Practices are ensuring social distancing can be maintained including restricting the number of patients in a practice at any one time, ensuring social distancing and reducing face-to-face consultation time with patients.

Furthermore WG has recently issued further guidance which confirms that capacity is available for practices to recall routine patients for their due sight test; noting the ongoing need for prioritisation and scheduling of appointments during the amber phase.

Prioritisation and scheduling of appointments must continue to consider the clinical needs and presenting symptoms relative to the risk of sight loss and harm to the patient. Routine appointments can only be scheduled, in line with prioritisation, if there is the appropriate capacity to do so, once all urgent and essential appointments have been managed. The active recall of routine patients is encouraged from 3 August.

Following analysis of domiciliary provision in other health areas, criteria has recently been agreed and guidance is being developed for the resumption of domiciliary eye care. The guidance includes Standard Operating Procedures and additional action required to deliver domiciliary provision during the amber phase.

Access to hospital eye services is not yet at to pre-covid levels. However, community Optometric Diagnostic and Treatment Centres are operational with monthly monitoring of activity and financial spend.

There are a number of factors limiting the number of glaucoma patients being seen in the ODTCs. Namely, patients are likely to be shielding and are reluctant to attend, limited tests are currently available and the ability to identify which patients are suitable for the service is affected by *some* difficulties in accessing notes. All these challenges are currently being addressed.

Work continues on the transformation eye care pathways to deliver more care closer to home delivered in partnership with local optometrists. Demand management initiatives have been delivered in quarter 1, with the Wales Eye Care Service stratification of surgical pathway numbers completed.

Referral refinements are fully implemented for the cataract pathway with a one stop service in place and post-operative reviews undertaken by Optometrists.

Work has been completed with the communications team to explain pathway changes to the public who need to access our services.

Strategy Implications

The current focus for primary care is that patients have access to essential services, whilst additional services are opened up during this amber phase. Where possible, in progressing this, consideration is given to the all Wales Primary Care model and strategic programme, as well as the Health Board's strategic priority of care closer to home.

Options considered
Options for service delivery have been considered in line with WG guidance and primary care recovery plans.

Financial Implications
Related financial implications are outlined in the body of the report.

Risk Analysis
Risks associated with the delivery of essential services and the implementation of the recovery plans are detail in the report.

Legal and Compliance
The Health Board must support contractors in the implementation of the recovery plans and any associated contractual requirements as outlined.

Impact Assessment
An impact assessment has not been undertaken as this is a report relating to progress in the delivery of national guidance and contracts.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 28th August 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Care Home Update
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Chris Stockport, Executive Director Primary and Community services
Awdur yr Adroddiad Report Author:	Mrs Clare Darlington, Assistant Director Primary and Community services
Craffu blaenorol: Prior Scrutiny:	This report draws together information from a number of sources many previously reported to Welsh Government
Atodiadau Appendices:	1. Rapid Review of Care Homes

Argymhelliad / Recommendation:

The Committee is asked to note the progress made with regards to
1. The actions taken to date to support care homes, their residents and staff during Covid 19
2. The requirement to develop a regional care home action plan
3. The measures being taken to help mitigate risks that may exacerbate the fragility of the sector.

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

Sefyllfa / Situation:

Care home providers and their staff have faced unprecedented challenges and have responded with commitment and determination to reduce the risk of harm to residents in enclosed settings who are known to be highly susceptible to the rapid spread of Covid 19.

Throughout the pandemic the Health Board has been working with partners to

- Reduce transmission by ensuring infection prevention and control (IPC) requirements are understood and applied
- Provide information for action by gathering and reporting robust data.
- Ensure proactive support to care homes

This paper provides a summary of the action taken by the Health Board, with its partners, to prioritise the protection of some of the most vulnerable people in our community. It also sets out the key actions we are taking to address the issues and risks identified, to support care homes and those who live and work, in them in preparation for the autumn and a potential further wave of infection.

Cefndir / Background:

The care home sector in North Wales is diverse with 345 homes registered with Care Inspectorate Wales (CIW) including the independent / private sector, charitable / not for profit sector, and local authorities. Together they provide approximately 7000 beds for residents. The sector includes residential care homes and care homes with nursing, for adults and children.

The appropriate care home for any individual is determined based upon an assessment of their needs. Social services assess wellbeing and personal care needs whilst the NHS determines whether needs indicate a requirement for nursing care and eligibility for continuing health care funding. These decisions determine the arrangements for communication, support and oversight of individuals and care homes.

At the outset of the pandemic a range of multiagency governance and reporting arrangements were put in place as part of the overall emergency response. They have been highly effective in providing strategic and tactical coordination to inform operational responses. Under initial command arrangements, the Health Board established a Care Home Cell reporting to the Primary Community and Public Health work stream led by the Executive Director of Public Health. Alongside specialists from primary care, palliative care, medicines management, corporate nursing and continuing health care staff, the Care Home Cell had significant and valued input from Public Health Wales, the Regional Partnership Board, Care Forum Wales and Care Inspectorate Wales. A regional health and social care emergency planning group was also established as part of the Local Resilience Forum command structure. Operational delivery and response arrangements were then discharged at a Local Authority and Area Team level to support the sector.

Oversight of the care home sector has now moved back to the Executive Director of Primary and Community services and revised governance and reporting arrangements are being developed to ensure that the work is prioritised and progressed in line with the expectations of the Board and Welsh Government. The strategic oversight of care homes continues to be supported by a nominated Area Nurse Director and Area Medical Director to ensure the work is then embedded in operational practice at a local level.

On 1st July the Deputy Director General wrote to Health Boards and Local Authorities informing them of a nationally commissioned rapid review of care homes (appendix 1). As required, a summary response has been submitted to Welsh Government setting out the key actions undertaken by the Health Board during the period. Senior officers have also participated in interviews prior to the regional workshops planned for late August. A regional care home action plan will now be coordinated on behalf of the Regional Partnership Board. Given that the

Health Board already has a single care home action plan arising from previous reports, the new regional care home action plan will need to be considered alongside this work and clarity provided on any revised monitoring and reporting arrangements.

Asesiad / Assessment & Analysis

Strategy Implications

Data collection and early warning systems

We worked with partners to reduce the burden placed on care homes from multiple contacts. A new system making "one contact a day" calls to all care homes has been implemented. This ensures a minimum data set is collected and shared so that appropriate support is offered in a timely way. This system is still in place for homes where there is an active outbreak but has been stepped down to two calls a week for other homes. The information also informs the North Wales care home escalation tool. This dynamic reporting provides early indicators of pressures and issues and allows early intervention and support from the Health Board with its partners. This is a dynamic reporting system. The position as at 12th August is that we are supporting nine homes in escalating concerns.

Testing and results

The national testing requirements for care home residents and staff has been rolled out. This is a dynamic situation and the Health Board has been responsive the regular updates to the guidance issued by Welsh Government and Public Health Wales during the period.

The Health Board launched a new care home testing hub to make it easier for care homes to request tests and receive results. This was developed so that information could also be shared in real time with named officers in local authorities and this in turn allows a more integrated response to care homes. An automated results system was also established so individual staff members and Responsible Individuals for care homes receive results as soon as they became available. Care homes can also contact the Health Board via a dedicated email and phone line to request tests and results for residents and staff as well as access clinical advice and support. The service is operational 7 days a week and we are now working to merge this function within the regional track trace and protect (TTP) team so it is sustainable and robust in the longer term.

Over 61,000 tests have been undertaken to date and the workload will continue following the Ministerial announcement that weekly testing of care home staff will be maintained in North Wales before the testing cycle is reviewed again in eight weeks .

Outbreaks

Having an outbreak in the case of COVID-19 means we consider there is transmission or spread of the infection associated with that setting and actions need to be taken to bring it under control.

During any outbreak actions are taken which are designed to protect the residents and staff and those who may have to visit the setting. Recommendations will include further testing, infection control including use of PPE, social distancing and isolation. When testing in care homes increased and more robust data collection was in place we have been monitoring the status of all care homes.

Care homes where there has been a single confirmed case in either a resident or member of staff are identified as having an outbreak. Following national guidance issued on 2nd June the setting will then be closed to admissions for 28 days following the last confirmed positive case.

In exceptional circumstances, care homes can accept a resident into a 'red home' but only following a detailed individual risk assessment, multi-disciplinary discussion and final agreement of Public Health and the care home.

When the new guidance was implemented 77 care homes within BCU were closed to admissions due to an outbreak. A number of homes have had more than one outbreak. The position as at 12th August is:

• 16 Care homes are currently closed to admissions
• 98 Care homes have had at least one outbreak (28%)
• 247 Care homes have not had an outbreak (72%)

In most cases when a home is unable to accept the resident due to an outbreak, the patient continues to be cared for by the NHS in a hospital setting until it is safe and appropriate to transfer them.

Clinical support

Since July 2020 we have participated in a daily call with environmental health officers from across North Wales, the regional TTP team and the National Public Health Wales team to discuss the application of existing and new guidance in the context of specific cases. This multidisciplinary approach is maturing and ensures that advice and support is clear, responsive and consistent, reducing risk and potential harm.

Area Teams have been working with primary care colleagues to implement a revised Direct Enhanced Service (DES) for care homes from 1st July, resulting in weekly primary care input, strengthened access to urgent clinical advice, reduction in unnecessary face-to-face visits, and structured mortality reviews.

Continuing Health Care

Recent contact with Welsh Government has confirmed that it is their expectation that assessments for any long-term care should not take place in an acute hospital environment and that Health Boards and their partners should continue to implement the Discharge to Recover then Assess (D2RA) model as set out in the guidance, the Covid-19 Discharge Arrangements (Wales).

As we are now moving towards recovery, with restrictions easing and more routine services being reinstated, we need to take stock of the current CHC position. This information will assist us in planning to deal with backlogs built up during the emergency period and reinstating assessments and reviews, alongside revised plans for introducing the new national CHC framework. We have been asked to complete an assessment of the current situation and return to welsh government by 31st August

Communication and engagement

Developing good communication with the care home sector and partners has been pivotal. To complement the individual daily calls to homes we have produced regular written briefings for care homes and domiciliary providers, and established weekly calls with the testing leads in all local authorities. In addition local authorities and area teams have established various forum to engage with care providers at a local level which have been well received. These arrangements now need to be formalised and embedded to underpin the support to care homes and their residents and staff.

Options considered

The paper is provided for information and assurance. Any proposals developed as part of the regional care home action plan will be subject to scrutiny by the Regional Partnership Board.

Financial Implications

The new range of support and reporting mechanisms put in place to support the sector are currently being managed through the core staffing of the Executive Director of Primary and Community services, and realignment of duties of a senior member of staff from the planning team alongside specific Covid-19 funding to run the testing and results hub. This situation is being kept under review and the longer term impact of any staffing changes will be monitored.

An announcement is expected imminently with regards to additional retrospective funding from WG to support care homes during Covid-19.

In 2019/20 the Health Board engaged with the National Collaborative Commissioning Unit (NCCU) to establish a new pricing methodology in collaboration with Care Forum Wales. Whilst the work with the NCCU was beginning to give the Health Board a framework for price setting

going forward, it was accepted that this work would not be completed before 2021/22. It was therefore agreed by the Board that for 2020/21 the Health Board would apply an uplift to weekly CHC rate per patient of £40. This was enacted from 1st April 2020. Clearly the impact of Covid-19 has meant that the work on the pricing methodology has stalled. The next phase of work now needs to be progressed so that any proposals for a new pricing methodology are built into the planning assumptions of the Health Board's overall financial plan.

Risk Analysis

CRR 29 on the corporate risk register summarises the risks in relation to care homes in North Wales

CRR 03 on the corporate risk register summarises the risks in relation to continuing health care

These risks are overseen by QSE Committee.

Key areas relate to

- *Infection prevention and control.*
  We want to ensure that care homes are supported so that all staff understand and apply the current advice to reduce harm. This includes the ongoing arrangements for testing care home staff and residents and supporting care homes in the appropriate use of PPE.

- *General and clinical support for care homes*
  We recognise the importance of local support for care homes and are working with partners to develop a regional care home action plan building on the emerging themes of the independent rapid review. This will include implementation of the primary care Direct Enhanced Service for care homes and arrangements for safe hospital discharge building on the learning from the three home first bureaux.

- *Financial sustainability*
  As commissioners of care we have continued to highlight the financial pressures of operating care homes services both before Covid-19 and during the pandemic. National consideration is being given to the specific additional costs incurred during Covid-19 and an announcement is expected imminently. The work on the local fees methodology for continuing health care placements in North Wales will be reinstated and proposals brought forward to the Board as part of next year's financial plan.

Legal and Compliance

The paper is provided for information and assurance. Any wider proposals developed as part of the regional care home action plan will be subject to scrutiny by the Regional Partnership Board

Impact Assessment

The paper is provided for information and assurance. Any wider proposals developed as part of the regional care home action plan will be subject to scrutiny by the Regional Partnership Board.

Albert Heaney
Dirprwy Gyfarwyddwr Cyffredinol
Deputy Director General
Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA/JM/2058/20

Local Authority Chief Executives
Directors of Social Services
NHS Chief Executives

1st July 2020

Dear Colleagues

Rapid review of care homes

The protection of the most vulnerable people in our communities has been a significant priority during the Covid-19 virus outbreak. Care home providers and their staff have faced unprecedented challenges, impacted by the nature of the vulnerable people they care for, and have responded with commitment and resolve to support their residents.

Local authorities and health boards have responded rapidly to a pandemic that moved quickly through our communities bringing changes to the way services are delivered and support provided by staff who swiftly adapted to refined roles. We have seen a determination to both maintain that pace of work and to support care providers to collaboratively secure the best protection for people living in care homes.

We are aware that organisations have continually reviewed their support for care homes during the pandemic and that reflection and evaluation has rightly started to take place in some parts of Wales. We now need to increase our local, regional and national understanding of these challenging experiences and the way in which local authorities and health boards responded.

Nationally we want to be assured that we have the information to identify and respond to outstanding issues reinforcing support required for any future wave of Covid-19 and put in place measures to help mitigate the risk of exacerbating stress on already fragile services. We want to understand the good practice that worked well and why, and how it can be scaled and expanded across Wales. We have therefore commissioned Professor John Bolton to undertake a rapid review.

Local authority and health board colleagues should reflect on their experiences and consider their response to supporting care homes during the pandemic and -

- Provide a summary letter **on or before Thursday 16 July** setting out the key actions led by the authority or health board and the issues undertaken in partnership with one another identifying successful achievements and actions that they wish to fulfil in the forward look towards the autumn. Further detail on the required response is included at **Annex A;**
- Participate in an individual discussion with Professor Bolton about the summary letter;
- Join a regional workshop to reflect on the partnership actions required; and
- Produce a regional action plan (based on the regional partnership board footprint) for care homes by early September 2020. Further details will be provided.

Professor Bolton will be in contact about the arrangements.

Yours sincerely

ALBERT HEANEY
Deputy Director General

Annex A

The summary of the organisation's experience, strengths and weaknesses, and gaps that require support from other organisations to assist regarding:

- Effective personal and nursing care for residents, including care planning to meet need, rehabilitation and prevention of harms, the resident's wishes, preferences and end of life plans
- Effective psychological care, support and stimulation to aid resident well-being such as arrangements to maintain contact between residents and family/friends including physical visits and technology for virtual contact
- Multi-professional and clinical support via technology to support communication with professionals or safe visits from GP's, mental health, dementia, OT/allied health professions
- Arrangements for safe hospital discharge and admission to step-down and care home facilities, including use of the digital care and support capacity tool
- Effective information and guidance disseminated, understood and embedded
- Infection, prevention and control arrangements including workforce management arrangements such as compartmentalisation, team approach
- Workforce well-being and support available
- Workforce capacity and advice available for care homes to self-support in the first instance proactively - internal flexibility, increased hours, redeployment and via agency, and, reactively - in emergency, from other care homes, or LA and HB commissioners staff resource
- Arrangements for continuity of supplies - clinical consumables, PPE, food
- Identify any existing gaps

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 28th August 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Essential services and re-start update
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Gill Harris, Executive Director of Nursing / Deputy Chief Executive
Awdur yr Adroddiad Report Author:	Mr Andrew Kent, Interim Head of Planned Care
Craffu blaenorol: Prior Scrutiny:	none
Atodiadau Appendices:	1. Essential Services

Argymhelliad / Recommendation:

The Committee is asked to note the content of this paper and the progress being made.

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	

Sefyllfa / Situation:

The Committee has previously requested an update against the delivery of essential services and a progress update against the safe recovery of services.

Cefndir / Background:

Planned care continues to deliver essential services and stratified patients requiring operations in the next 3 months (Q2 activity) it is also planning an approach to re-starting elective work across the organisation. This is being undertaken whilst remaining committed to treating those patients in the greatest need based on the four principles below.

Harm from COVID itself	Harm from overwhelmed NHS and social care system
Harm from reduction in non-COVID activity	Harm from wider societal actions/lockdown

Asesiad / Assessment & Analysis

Essential services were continued during the pandemic period but notably at a lower capacity level than pre-covid. These services are monitored monthly to ensure that they are maintained. The essential services are in appendix 1 and cover many services across the Health board. The Health Board have reviewed compliance with the Essential Service Framework on a monthly basis. The August review is underway, the latest report (July) demonstrates the majority of essential services are being maintained and actions have been implemented to address shortfalls. However, delays were present in diagnostic pathways and phlebotomy service, which were affecting essential services. Additional phlebotomists have been recruited to increase service capacity and diagnostic priorities re-aligned with the second Cath lab re-opening and additional endoscopy sessions established. We continued to use the facilities at Spire Yale for diagnostics and essential surgery procedures.

Cancer services

Referrals for urgent suspected cancer have increased in July, returning to their near pre-covid levels. These have been maintained throughout the Covid-19 period in line with national guidance. However, this does not mean that the services have been able to work as normal or that activity levels reflect previous pre-Covid levels. Initially referrals for Urgent Suspected Cancer fell significantly. These have recovered during July to closer to pre-Covid levels, however concern continues that some patients may not have presented. Early analysis suggests this may be the case with those currently being diagnosed being generally at later stages in their disease. Initially advice resulted in a number of treatment regimes being altered for reasons of staff and patient safety. This has resulted in a higher proportion of patients proceeding to radiotherapy or chemotherapy for their first definitive treatment and fewer patients being directed to surgery. Guidance has continually been refreshed and therefore some patients, who were initially not able to proceed to surgery, have been re-reviewed and progressed to surgery. The patients over 62 days from referral increased during the first quarter because of the above factors. July has seen improvement in the numbers over 62 days, largely due to improvements in diagnostic access. However with screening services recommencing and referrals returning to pre-Covid levels it is highly likely that the demand on cancer services will continue to increase. This will require creation of additional capacity to enable this improving position to continue and to eliminate the backlog of patients that currently exists. BCU continued to use Spire Yale for elective surgery during July as well as schedule patients in accordance with their clinically determined priority.

Stroke Care

The volume of confirmed strokes has also seen a return to pre-covid volumes. However, we have seen a deterioration in performance. This deterioration, particularly in therapy and rehabilitation continued during Covid 19. Some therapy staff were redeployed to support Covid 19 areas and the rehabilitation service in Central has now been re-established. However, the recent national mapping of therapy resource confirms the shortfall in provision of therapists for rehabilitation. This shortfall is reflected in the stroke business case, findings from the mapping exercise are being developed into an action plan by the end of August.

Ophthalmology

During Covid, the clinicians have further risk-stratified patients through a table top process and conducted telephone consultations. A high proportion of patient's virtual appointments are not suitable, as the diagnostics are required to be able to detect changes in the eye overtime. Unfortunately, some eye diseases such as glaucoma can progress unknown to the patient and therefore regular clinical

monitoring is required. New pathways were introduced to support both emergency and urgent eye care to be delivered. The emergency pathway has been effective with 2911 episodes recorded through the work of the primary care hubs. Only 13% of these patients needed onward referral to the Hospital Eye Service. The urgent care pathway has not been fully utilised and reasons for this are being further investigated. The cataract pathway has been redesigned for patients who are classified as Risk 2 and sites have tested this and will be implementing the restart of surgery from August. Overall, the risk to R1 patients remains high, with the volume overdue the target increased to 17,277 and only 41.6% now within the national target. Work is continuing to re-establish community ODTCs to provide additional capacity.

Diagnostics

Diagnostic capacity has been reduced, priority has been given to suspected cancer patients and work undertaken to equalise cancer access times between sites for services such as endoscopy. This has entailed patients being offered appointments based on service capacity as opposed to clinical location. Diagnostic capacity remains constrained in terms of both workforce availability, and equipment time. Many of our diagnostic departments are not designed to easily accommodate 2 metre social distancing and so appointment scheduling has needed to be revised to support patients and staff well-being. Additional cleaning of all equipment between patients has added to the length of procedures further reducing imaging time available for patients.

Plans to increase capacity include the appointment of our regular diagnostic agency to increase imaging capacity for CT and MRI to seven days throughout BCU. We have secured an additional CT scanner via the national programme and this will be on site during August and expected to be operational in September.

MRI mobile capacity will be required to replace the estimated 35% loss of internal activity
Work is taking place to determine the value of creating a diagnostic and treatment centre in North Wales. Once this is completed, the outcome of the analysis will be reported and any potential business case developed.

Cardiology services

Both East and West have commenced OPP activity, centre is commencing on the 20th of August, in a limited form, Other Cardiac services are part of the essential service and therefore have been maintained.

Urology services

These services are part of the Essential services and option 5 work stream, a number of pathway re-design are on-going including new ways of undertaking urology investigations, will reduce waiting times and the sharing of capacity. The move to robotic surgery is also being presented at the planned care group in august.

The Committee is reminded that Essential Services are those services that need to continue throughout Covid 19 to avoid the risk of harm arising from life threatening and life changing treatments. The framework applies to services across the whole of the healthcare system. Appendix 1, lists the essential services.

To ensure the safe delivery of these services and ensuring the right patient is treated at the right time, a risk stratification process is being implemented at stage 4 and in diagnostics and we are awaiting formal guidance from the Welsh government regarding Outpatients. This moves the organisation away from the 36-week target approach seen previously for the near future. The broad risk stratification guidelines are listed below:

- Priority Level 1a   Emergency – operation needed within 24hours
- Priority level 1b   Urgent – operation needed with 72 hours
- Priority level 2   Surgery that can be deferred for up to 4 weeks
- Priority level 3   Surgery that can be delayed for up to 3 months
- Priority level 4   Surgery that can be delayed for more than 3 months

This new measurement is still time based but clinicians undertake it and the approach starts to become a personal target date (PTD) for the patient. By following this approach, the organisation will be able to pull all patients with a target date of xx and be able to select which patients will have the better outcome, whilst capacity remains constrained. This work is still in progress as the organisation has over 100,000 on its waiting list. It is also understood that over 30,000 of those patients are waiting over 36 weeks. This is leading to a different approach for specialties on how best to educate, communicate and deliver non-surgical care. Including the exploration of digital and health apps approach. However, many patients will still be awaiting treatments for a considerable time, as in the latest audit in Q2 for In-patient and day case surgery the organisation treated 37% of its previous years activity. At best, we are forecasting a possible return of 60-70% of previous activity for the rest of the year.

As well as maintaining essential services, it is imperative that we safely re-start other services. A standard operating procedure is in place, including a checklist, which is completed, this then goes through the clinical advisory group for a quality assessment, area or hospital management teams and then signed off by the Chief operating officer. This provides a governance framework to ensure services can be safely started and that any unintended consequences do not occur. The table below illustrates the current services that are or have re-started.

Number	Service	Specific Areas included in documentation	CAG review	Approval date
1	Therapies	Routine therapy services in HMP Berwyn	15/07/20	28/07/20
2	Therapies	Strategy for the resumption of BCU Dietetic Outpatient services	22/07/20	24/07/20
3	Radiology	Radiology Pathway For Imaging Cardiac Patients - V4 July 2020	22/07/20	24/07/20
4	SALT (Speech & Language Therapy)	Clinical Pathway Proposal SALT Phase 2 COVID v2	22/07/20	28/07/20
5	YGC	Overview and recommendations for recovery YGC 29072020 (Main document and Restart-checklists embedded for the following services)	05/08/20	10/08/20

		1. Relocation of surgical ED back to ED 2. Relocation of Paediatric assessment back to ED 3. Return of GIM on call rota to pre COVID 4. Re-start of cardiac physiology 5. Re-start of medical day cases, including cardioversions 6. Angiograms and PCI 7. Restart of Orthodontic treatments (CAG approved) 8. Re-start of Oxygen Assessment Clinics in community 9. Pacemaker and TOE service 10. Drive through pulse oximetry service 11. Increase in MOPS for Maxillo Facial – 1 additional theatre list a week 12. Re-start of face to face Cardiology clinics at YGC – 15 a week 13. Re-start of face to face Cardiology clinics in community – 2 per week 14. Re-start of Dermatology face to face clinics at YGC and community 15. Re-start of Dermatology MOPs at YGC 16. Re-start of COTE face to face clinics in YGC and community 17. BCU Ophthalmology service 18. Diabetes face to face outpatient clinics – acute and community 19. Rheumatology face to face outpatient clinics – acute and community 20. Rheumatology medical day cases 21. Home visits for oxygen assessment			
6	Ophthalmology	Coronavirus Elective Cataract Pathway V1.6	05/08/20	07/08/20	
7	MaxFax	North Wales Restorative Patient COVID-19 Pathway - Transitional Phase - V1.0 10 July 2020Re-set Checklist restorative	07/08/20	10/08/20	
8	Radiology	BCU Covid Recovery GP Plain Film V2	07/08/20	07/08/20	
9	Children's	Children's Medical Day Cases Re-start	07/08/20	07/08/20	
10	Children's	Children's Drive through HbA1c testing	07/08/20	07/08/20	
11	Obstetrics & Gynaecology	Planned care switch on v12	07/08/20	07/08/20	

The risk to patient safety due to the increased backlog and reduce capacity is obvious, the over 36 week waits has increased to over 30,000 and has the potential to keep on rising at a significant rate. With over 52 week waiters now reaching over 10,000.
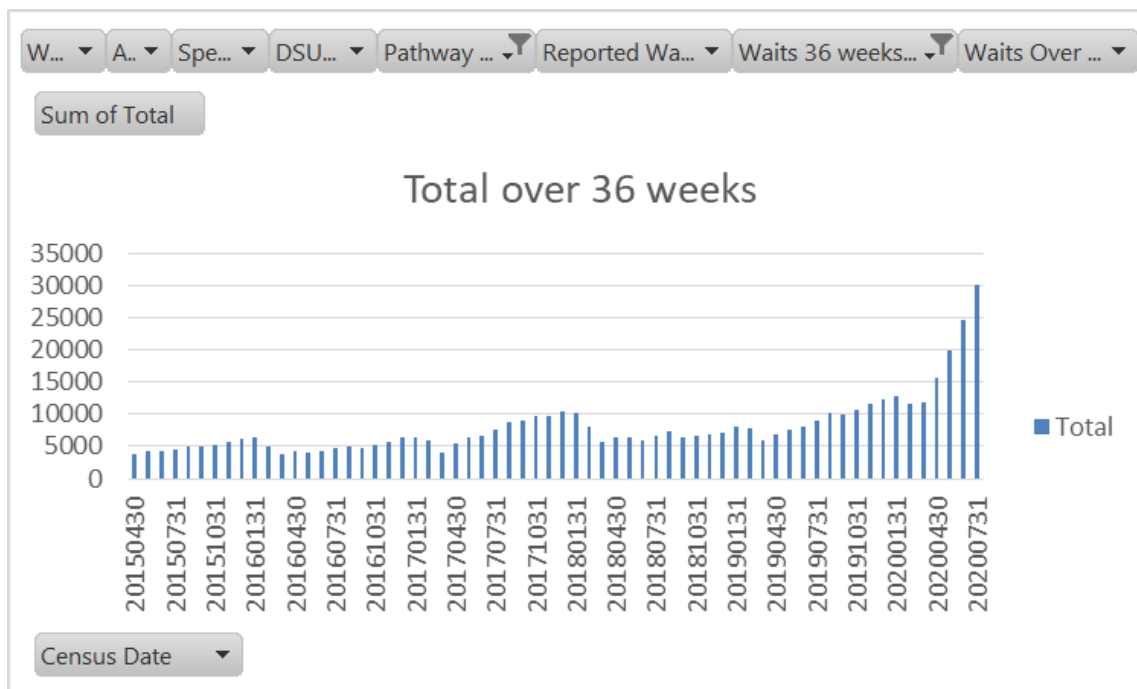
There is on-going work to develop a strategy for a long-term recovery programme and other programmes such as pre-habilitation and PROMS as alternatives, to keep patients informed and healthy during the extended waiting period. This work is being developed with urgency, so that we can reduce any potential harm as far as possible.

The risk register and mitigations are also being reviewed to reflect these new risks over the coming weeks.

Patient administration system

The significant risk to the organisation is the rapid change and the inability for the PAS system to change at the same pace. As described earlier, we are now measuring under the risk stratification system. Unfortunately, the current PAS system cannot recognise this. Therefore a work around is that it is entered under free text. This can be altered by any member of staff or removed, leaving the organisation vulnerable to losing patients. Operational teams have been asked to enter this risk onto their risk register and mitigate by communicating widely to all staff re this this risk, operational teams are holding their own spreadsheets, that are reconciled weekly. An IT patch is due out on the 7th of September, but further work will be required and reconciliation and validation will need to undertaken towards the end of September. QSE, need to note however this still remains a high risk

Conclusion

Essential services are being maintained and supported where possible. There is a growing quality and safety risk as patients wait longer for their procedures due to the covid pandemic. Steps are

being introduced at each specialty level to understand how we can support patients whilst they are waiting. Re-start of activity is increasing. However, the growing backlog is of concern and planned care are reviewing the strategy of extra capacity over the coming weeks.

Appendix 1

- Access to primary care services (providing *essential*, *additional* and a limited range of *enhanced* services that fulfil the WHO high priority categories)
- Urgent surgery including access to urgent diagnostics
- Urgent cancer treatments including access to urgent diagnostics
- Life-saving or life impacting medical services including access to urgent diagnostics
- Life-saving or life impacting paediatric services including time critical vaccinations, screening, diagnostic and safeguarding services

- Maternity Services including antenatal screening

- Neonatal Services including transport
- Mental health crisis services including perinatal care
- Mental health in-patient services at varying levels of acuity
- Community MH services that maintain a patient's condition stability (to prevent deterioration, e.g. administration of Depot injections)
- Substance Misuse services that maintain a patient's condition stability (e.g. prescription and dispensing of opiate substitution therapies)
- Urgent eye care
- Termination of Pregnancy Services
- Other infectious conditions (sexual and non-sexual)
- Renal care- dialysis
- Transplant patients
- Urgent supply of medicines
- Blood services, products and collection
- Palliative Care in all hospital & community settings

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 28th August 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Vascular Services Update
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr David Fearnley, Executive Medical Director
Awdur yr Adroddiad Report Author:	Joanne Garzoni, Vascular Network Manager Kate Clark, Secondary Care Medical Director
Craffu blaenorol: Prior Scrutiny:	Vascular Task and Finish Group
Atodiadau Appendices:	Appendix 1 – Application to the Royal College of Surgeons for an external invited review Appendix 2 – Action tracker

Argymhelliad / Recommendation:
The Committee is asked to note the progress made by the Vascular Task and Finish Group

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	X	Er gwybodaeth For Information	

Sefyllfa / Situation:
This report provides an update to the Quality, Safety and Experience Committee on the work undertaken to date by the Vascular Task and Finish Group. The third meeting of the group was held on 13 August 2020.

Cefndir / Background:
In July 2019, following the centralisation of the major arterial vascular service in April 2019, it was agreed that a review would be prepared with the principle objective of assessing the impact of the vascular services provided across the North Wales Vascular Network in the post implementation period. The presentation of the report was delayed due to the COVID19 pandemic. This review was presented to the Health Board on 22nd May 2020 with recommendations to address areas for improvement. The Health Board approved the establishment of a Task and Finish Group, chaired by the Executive Medical Director, to oversee the implementation of the vascular services review recommendations. This group would consider the draft action plan to identify any further required actions and

recommend key performance indicators. It was agreed that progress reporting arrangements would be via the Quality, Safety and Experience Committee.

Asesiad / Assessment & Analysis

Strategy Implications

This report examines the progress of the Vascular Task and Finish Group in implementing the vascular services review recommendations.

Updates to the Quality, Safety and Experience Committee

Vascular Task and Finish Group

Three meetings of the Vascular Task and Finish Group have taken place since June 2020. There is a good range of representation from multidisciplinary team members as well as patient and CHC presence. Terms of reference have been reviewed and amended following feedback from QSE and shared with the group. The action plan is being tracked by the group with regular updates provided to QSE and Welsh Government.

External invited review of the vascular service

The Royal College of Surgeons will be invited to undertake an external, independent multi-disciplinary assessment of the service. The terms of reference for this review have been prepared by the Secondary Care Medical Director in collaboration with the Community Health Council (CHC) and patient and carer representatives. The terms of reference have been shared with the Chair of QSE and are attached (Appendix 1). The application for an invited review has been sent to the Royal College of Surgeons.

North Wales Vascular Network Action Plan - Progress against actions within the Vascular Network Action Plan is good (appendix 2), and all actions were reviewed at the last meeting of the Vascular Task and Finish Group on 13 August 2020.

Key points include:

Pathways:
A pathway action plan was presented to the Vascular Task and Finish group meeting on 13th August 2020 detailing the key actions and progress to date for the pathways identified by the review.
The timeline for progress of the vascular pathways and submission to the Clinical Advisory Group for ratification is to be approved at the next Vascular Task and Finish Group meeting on 17th September 2020. Programme Management Office resource has been secured to support the development of a non-arterial diabetic foot pathway consistent with the National Diabetic Foot Pathway and NICE guidelines.

Engagement and communication:

There has been significant work undertaken by the corporate patient safety and experience department and the vascular service to review the incidents, complaints and feedback and identify themes and learning. Review of PROM/PREM measures to improve patient experience, in conjunction with existing patient experience data has been undertaken. Patient experience feedback is actively has being collected across outpatient and inpatient settings and analysis of the first 6 weeks of this outpatient data has been completed and will be shared with the service. A review of the vascular patient information led by the patient experience team is currently underway. We are working collaboratively with the Community Health Council.

Quality and Safety:
The Patient Safety and Experience department has undertaken a benchmarking exercise of incidents and there is now work to implement You Said / We Did using the patient experience proforma. The group were given an update on the development of a quality and safety E-Dashboard for the vascular service. This is aligned to corporate dashboards that aids the service in triangulating complaints, incidents, compliments and lessons learnt trends to provide assurance. A review of the safety culture across the service is being implemented. The results will be available by the end of October 2020.

Access:
The COVID recovery plan for the service was discussed and it was agreed this would be circulated to the group once ratified by the Clinical Advisory Group in September 2020. A report on the vascular waiting times and the impact of the pandemic will be provided to the next meeting on 17th September 2020.

The next meeting of the Vascular Task and Finish Group will be held on 17 September 2020.

Financial Implications

The scope of this report does not include financial implications. Additional PMO support is being sought from September 2020.

Risk Analysis

Risk assessments will be undertaken as part of the governance of the Task and Finish Group.

Legal and Compliance

There are no legal implications associated with this proposal. The Task and Finish Group will report by exception and the action plan will be tracked through QSE.

Royal College of Surgeons
ADVANCING SURGICAL CARE

Invited Review Request Form

For completion by the Chief Executive or Medical Director of the healthcare organisation.

1. Name of the healthcare organisation requesting the review

Betsi Cadwaladr University Health Board

2. Surgical specialties to be reviewed

Vascular

3. Relevant surgical sub-specialties to be reviewed

4. What has prompted this request?

☐ Concerns raised by staff	☐ Patient complaint(s)	☐ Internal/external review	☐ Changes to service delivery
☐ Serious incident(s)	☐ Audits/outcomes data	☐ Seeking assurance of quality of care	☐ Looking for ways to improve care

Please give the background to the review request with all relevant details

In January 2013, following public consultation, the Health Board announced that major and complex in-patient arterial surgery and emergency vascular surgery would move onto a single site at Ysbyty Glan Clwyd (YGC). The implementation was delayed due to renovation of the YGC site and concerns raised by some clinicians and external stakeholders. To address this, an external review was commissioned in 2015.

The Royal College of Surgeons (2015) refused to approve any further consultant appointments and the review stated 'The review team was of the strong opinion that patient safety was being compromised with a two site model and that the Board could not afford to delay the decision to move to a one site model any longer.' The service model was informed and supported by the Vascular Society for Great Britain and Ireland, The Royal College of Surgeons, Public Health Wales through the Welsh Abdominal Aortic Aneurysm Screening Programme (WAAASP) and Welsh Government. The service model was supported by the North Wales Local Medical Committee (LMC), the majority of clinicians and the North Wales Community Health Council (CHC).

The formation of the new vascular network is designed to make the service safe and sustainable, reducing the

5. What steps have already been taken locally?

☐ Discussions with staff	☐ Restrictions on practice imposed	☐ Clinical record reviews
☐ Speciality Association contacted	☐ Internal audit/investigation	☐ Discussion with GMC ELA
☐ Contact with the CQC/HIS/HIW	☐ External peer review	☐ Advice sought from PPA

Steps taken

As described above an internal review has been completed which has been reviewed by the Royal Vascular Society (report & letter from RVS attached). A task and finish group has been created to address the recommendations from the internal review (ToR and action plan attached). This is chaired by the Executive Medical Director.

6. Focus of the review

Please indicate if the principle focus of the review is the care provided by a surgical service or a specific individual surgeon:
☐ Service focused ☐ Individual focused

7. Clinical records

If you would like for this review to include an analysis of a number of clinical records please provide details below:

☐ Review of specific clinical records
☐ Review of a representative sample
☐ Review of clinical records only (without any interviews of staff)

Approximately how many clinical records would this include? Maximum of 50

8. What are the areas to be reviewed?

☐ Quality and safety of surgical care	☐ Theatre safety practices	☐ Clinical governance
☐ Behaviours or teamworking	☐ Service/network design	☐ Communication with patients
☐ Introduction of new techniques	☐ Quality of clinical leadership	☐ Multi-disciplinary work

Please provide further, specific information about the areas to be reviewed, including any specific questions to be answered.

• Quality and safety of surgical care
Concerns have been raised through Community Health Council patient engagement events (report attached as referenced above) about several aspects of the service; in particular relating to the number of amputations being performed and the decision-making process relating to this. This review would need to include a review of the decision-making process and a sample of clinical records.
• Behaviours and team working

9. Your organisation's contact for media enquiries

Contact name: Aaron Haley

Position held: Communications Manager

Direct dial telephone number: 01745 586463   Work mobile telephone number:

Email address: Aaron.Haley@wales.nns.uk

10. Healthcare organisation lead for managing review arrangements

Contact name: Joanne Garzoni

Position held (preferably a service manager or equivalent): Vascular Network manager

Direct dial telephone number: 01745 583910 ext6326   Work mobile telephone number: 07717154453

Email address: joanne.garzoni@wales.nns.uk

11. Declaration and contact details

Contact name: Dr Kate Clark

Position held, ie Medical Director or Chief Executive: Medical Director for secondary care

Direct dial telephone number: 03000 858460   Work mobile telephone number:

Email address: kate.clark3@wales.nhs.uk

**I declare that I agree to the review conditions set
out in the Invited Review Handbook. Please either insert
an electronic signature or print and sign this form.**

Please return this form to us by email. Alternatively you can print a copy and post it to:

Professor Timothy Rockall,
Chair of the Invited Review Mechanism, care of:
Ms Marilyn How
Invited Review Coordinator
Professional and Clinical Standards
The Royal College of Surgeons of England
35–43 Lincoln's Inn Fields
London WC2A 3PE

irm@rcseng.ac.uk | 020 7869 6222

Appendix 1 – Details of individual under review

If this review is focused on an individual surgeon, please complete appendix 1 – details of surgeon under review

1. Name of surgeon to be reviewed _____

2. Job title _____

3. Surgical sub-specialties and sub-specialist interests _____

4. Date of appointment to current post _____

5. Current working status _____

Please provide any additional, relevant information about the individual, such as their current scope of practice and their current level of engagement with the review process.

When submitting a request for a review of an individual, we would encourage you to discuss the review with the individual. They will be asked to provide their written confirmation of their willingness to participate in the review as part of the preparation for any review agreed.

We also encourage you to consider what support you are providing to the individual. You may wish to seek advice on this either from your occupational health department or from Practitioner Performance Advice.

CONTENTS

Vascular Task and Finish Group (commenced June 2020)

Vascular Review Action Plan - Presented to the Health Board on 21/05/20

Vascular Action Plan Recommendations:

Vascular Beds

Pathways of Care

Communication and Engagement

Quality and Safety

Access to Service

Risk Register

Vascular Task and Finish Group Action log

Version 0.4

PROJECT PLAN - MILESTONES AND TASKS

This template is to record the actions required to progress the project to its conclusion.
The milestones replicate those included with the final PID.
Please insert the tasks required to deliver the milestones.
Please use the BRAG rating information on the next tab

Ref	Recommendation	Actions	Action by	Owner	Start Date as per PID (for tasks only) DD/MM/YYYY	End Date for milestones (as per PID) and tasks DD/MM/YYYY	Revised Start Date DD/MM/YYYY*	Revised End Date DD/MM/YYYY*	Actual Start Date DD/MM/YYYY*	Actual End Date DD/MM/YYYY*	Task Status - *this will autopopulate once the start/end dates are inserted*	If overdue, task status	*Notes - include reasons in here for revised start or end date, and impact this will have on the overall deliver of the milestone
1.0	Alignment of vascular bed base	Milestone 1											
1.1	.	Review of the capacity and demand for inpatient beds across the service.	Jo Garzoni	Kate Clark	22 May 2020	16/06/2020		01/01/2021			Not yet due OR In Progress	Completed	Review undertaken and presented 16/06/20. Agreed by T&F group to rerview as part of the development of clinical pathways.
1.2		Continued delivery of the lower limb service across all sites with local access to consultant and MDT review.	Jo Garzoni	Kate Clark	22 May 2020	16/06/2020		01/01/2021			Not yet due OR In Progress	In progress and on track	Agreed by T&F group to rerview as part of the development of clinical pathways. Criteria for patient admission to spoke sites to be developed for 17/09/20.
2.0	Pathways of care	Milestone 2											
2.1		Develop the non-arterial diabetic foot pathway consistent with National Diabetic Foot Pathway and NICE guidelines	Kate Clark	Clinical Advisory Group	22 May 2020			30/04/2021			Not yet due OR In Progress	In progress and on track	The Clinical Advisory Group has produced a plan for developing the pathways for the August meeting of the T&F group. Discussions already underway to develop pathways. See Pathways of care for detailed update.
2.2		Review and refine angioplasty pathway	Jo Garzoni	Clinical Advisory Group	22 May 2020			09/10/2020			Not yet due OR In Progress	In progress and on track	The Clinical Advisory Group has produced a plan for developing the pathways for the August meeting of the T&F group. Discussions already underway to develop pathways. See Pathways of care for detailed update.
2.3		Review and refine pathways for patients that use drugs intravenously presenting with groin abscesses	Jo Garzoni	Clinical Advisory Group	22 May 2020			02/10/2020			Not yet due OR In Progress	In progress and on track	The Clinical Advisory Group has produced a plan for developing the pathways for the August meeting of the T&F group. Discussions already underway to develop pathways. See Pathways of care for detailed update.
2.4		Review and refine pathway for patients post major arterial surgery requiring rehabilitation	Jo Garzoni	Clinical Advisory Group	22 May 2020			02/10/2020			Not yet due OR In Progress	In progress and on track	The Clinical Advisory Group has produced a plan for developing the pathways for the August meeting of the T&F group. Discussions already underway to develop pathways. See Pathways of care for detailed update.
2.5		Refine and review pathway for non-surgical arterial condition for 'palliative' patients, in conjunction with palliative care team	Jo Garzoni	Clinical Advisory Group	22 May 2020			23/10/2020			Not yet due OR In Progress	In progress and on track	The Clinical Advisory Group has produced a plan for developing the pathways for the August meeting of the T&F group. Discussions already underway to develop pathways. See Pathways of care for detailed update.
3.0	Communication and Engagement	Milestone 3											
3.1		Communication Plan to be drafted with input from staff, CHC, service user representatives for presentation at the Vascular Task and Finish Group	Aaron Haley	Katie Sargent	22 May 2020	16/06/2020		01/09/2020			Not yet due OR In Progress	In progress and on track	Draft communication plan shared 13/08/20 Please see Communication plan.
3.2		Ensure any service change includes service user and carer involvement, and utilise patient feedback to inform improvement	Carolyn Owen	Carolyn Owen	22 May 2020	Ongoing		01/09/2020			Not yet due OR In Progress	In progress and on track	Action plan updated for 13/08/20 meeting and plan detail in the Communication & Engagement section

3.3		Review opportunities for staff to speak and feel able to raise concerns, including Safe Haven arrangements	David Fearnley	David Fearnley	22/05/2020	15/10/2020		01/11/2020			Not yet due OR In Progress	In progress and on track	Meeting with Safehaven team and IM 4/8/20
3.4		Development of a stakeholder engagement plan to maximize opportunities to listen and learn from feedback, to include patient and carer engagement with the development of a virtual vascular patient and carer network which will link to the Health Board's Listening and learning group	Carolyn Owen	Carolyn Owen	22/05/2020	16/06/2020				16/06/2020	Completed on time	Completed	Sent out by CO 23/06/20
3.5		Review of PROM/PREM measures to improve patient experience alongside existing patient experience data	Jo Garzoni	Carolyn Owen	22/05/2020	16/06/2020				16/06/2020	Completed on time	Completed	Review undertaken. Further action required to identify and implement PROMs within the service
3.6		Review of patient information and accessibility (including travel) with the support of the patient experience team	Carolyn Owen	Carolyn Owen	22/05/2020	16/06/2020				16/06/2020	Completed on time	Completed	Review undertaken. Further action required to identify patient need in conjunction with the CHC
4.0	Quality and Safety	Milestone 4											
4.1		Baseline Safety culture survey to be undertaken to inform areas for improvement	Carolyn Owen	Matt Joyes	22/05/2020	17/07/2020		30/10/2020			Not yet due OR In Progress	In progress and on track	Update at August T&F group.
4.2		Benchmarking of service incident reporting to improve safety via an open incident reporting culture and improve learning	Carolyn Owen	Matt Joyes	22/05/2020	17/07/2020		20/08/2020			Not yet due OR In Progress	In progress and on track	Action plan updated for 13/08/20 meeting and plan detail in the Communication and Engagement section
4.3		Explore the potential to work with a high reporting service to share good practice	Carolyn Owen	Matt Joyes	22/05/2020			01/09/2020			Not yet due OR In Progress	In progress and on track	Action plan updated for 13/08/20 meeting and plan detail in the Communication and Engagement section
4.4		Development of quality and safety E-Dashboard, aligned to corporate dashboards, triangulation of complaints, incidents, compliments and lessons learnt trends to provide assurance from ward to board	Carolyn Owen	Matt Joyes	22/05/2020	17/07/2020		17/09/2020			Not yet due OR In Progress	In progress and on track	Patient experience data to be incorporated. Further workforce metrics to be reviewed and included as data available. Update for September meeting.
4.5		Develop key workforce indicators to provide assurance on the safety of the workforce, including escalation measures		Jo Garzoni	22/05/2020	17/07/2020		17/09/2020			Not yet due OR In Progress	In progress and on track	Workforce indicators identified and discussion with Information whether these can be incorporated on the dashboard.
4.6		Training Needs Analysis to be undertaken to support the emerging clinical pathways and future workforce model		Service Clinical Leads	22/05/2020	13/08/2020		27/11/2020			Not yet due OR In Progress	In progress and on track	Update at September T&F group.
4.7		Issues of significance report from vascular Task and Finish group to Quality, Safety and Experience Committee	Kate Clark Jo Garzoni	David Fearnley	22/05/2020	Ongoing		01/09/2020			Not yet due OR In Progress	Completed	Regular reports to QSE and Welsh Government on progresss.

4.8		Consider all opportunities for national/international benchmarking including the National Vascular Registry and national audits to assess, evaluate and review opportunities and improve the service		Arpan Guhu	22/05/2020	16/06/2020		17/09/2020			Not yet due OR In Progress	In progress and on track	Presentation at July T&F group on data bases to develop benchmarking information. This included antibiotic resistance presentation. Update 13/08/20 - Further discussion on the use of the NVR data and audits across the department to be held on 09/09/20. Update to be provided 17/09/20 T&F meeting.
5.0	**Access to Service**	Milestone 5											
5.1		Evaluate and report to Quality, Safety and Experience Committee compliance with agreed service implementation plans	Kate Clark Jo Garzoni	David Fearnley	22/05/2020	Ongoing		01/03/2021			Not yet due OR In Progress	Completed	Regular reports to QSE and Welsh Government on progresss.
5.2		Monitor vascular waiting times		Head of Planned Care	22/05/2020	Ongoing		17/09/2020			Not yet due OR In Progress	In progress and on track	Report for September meeting
5.3		Reporting template and submission to be drafted by the Secondary Care leadership team and to be ratified	Jo Garzoni	Kate Clark	22/05/2020	16/06/2020				16/06/2020	Completed on time	Completed	Kate Clark to re-criculate reporting template. Action closed.
5.4													
5.5													
5.6													
5.7													
5.8													
5.9													
6.0													
6.1													

Task/Action required	How Task will be achieved & Outcome	Responsible to	Current Status	
			By When	**Progress update and notes**
		VASCULAR BEDS		
Review of the capacity and demand for inpatient beds across the service	Presentation to the Vascular Task and Finish Group	Vascular Network Manager	Jun-20	Bed numbers for VTF 16.06.20 v2.ppt
Continued delivery of the lower limb service across all sites with local access to consultant and MDT review.	Agreed by T&F group to rerview as part of the development of clinical pathways. Criteria for patient admission to spoke sites to be developed for 17/09/20.	Vascular Network Manager	17/09/2020	

Vascular Task and Finish Group – actions and preparation for 13th August meeting

Pathways of care

REVIEW	ACTIONS			DRIVERS	MONITORING & REPORTING	
OBJECTIVES	ACTIONS	By Whom	By When	Strategic Drivers	Progress against action criteria	
					Red Amber Green	Update
Development of a non-arterial diabetic foot pathway consistent with the National Diabetic Foot Pathway and NICE guidelines	To fully comply with project governance in line with BCUHB policies working under the umbrella of the Vascular Task and Finish Group. Reporting structure as per Terms of Reference of the Vascular T&F Group.	Project Lead	Ongoing		🟩	
	Identify project resource including: o Clinical lead o Project lead	Secondary Care Director	28/08/2020		🟧	PMO resource confirmed 14/08/20. Meeting held with project lead and Vascular Network Manager 14/08/20.
	Project initiation document – what is the problem?	Project Lead	18/09/2020		🟧	
	Define and scope: • Identify stakeholders • Process mapping • National benchmarking	Project Lead	18/09/2020	NICE Guidance National Diabetic Foot Pathway		

	To agree a communication and engagement strategy for the pathway development. Continue to update and comply with communication strategy for engaging with key internal and external stakeholders	Project Lead	Ongoing (see strategy)		
	Measure and understand: To collate and measure key baseline outcome measures and to use these as indicators to assess progress i. Identify and agree key metrics which reflect process, outcome and balancing measures	Project lead	To be agreed		
	Design and plan – agreed action plan to be developed Establishment of an operational steering group	Project lead	To be agreed		
	To ensure effective communication between all stakeholders i. Meet and engage with key stakeholders through communication strategy. iii. Liaise with strategic and operational management groups	Clinical Lead Project Lead	To be agreed		
	Identify all issues and risks associated with the project. i. Development of an ongoing risk log. ii. Review and discussion with the operational steering group meeting. ii. Provide clear roles and responsibilities and methods for data collection, input and monitoring iii. Continue data collection	Project Lead	To be agreed		

	iv. Review data collected through operational group					
	Establishment of referral pathway for the patient. i. Referral pathways to be reviewed by operational steering group and Vascular T&F strategic group for agreement.	Project Lead	To be agreed			
	i. Continued collaboration with Clinical Effectiveness and Audit Department to evaluate key deliverables. ii. Continued collection of data assessing clinical outcomes pre and post intervention. iii. Continued collection of qualitative and quantitative data related to patient experience and attendance. iv. Facilitate patient focus groups. vi. Collation and interpretation of results	Project Lead	To be agreed			

REVIEW	ACTIONS				DRIVERS	MONITORING & REPORTING	
OBJECTIVES	ACTIONS		By Whom	By When	Strategic Drivers	Progress against action criteria	
						Red Amber Green	Update
Review and refine angioplasty pathway	i. Engagement with stakeholders		Vascular Network Manager	31/08/2020		Ongoing	Protocol For Day-Case Angioplas
	ii. Draft Pathway development and national bench marking		Clinical Leads	25/09/2020			
	iii. Pathway discussion pan-BCUHB			25/09/2020			

	iv. Ratification at the Clinical Advisory Group		09/10/2020			
Review and refine pathways for patients that use drugs intravenously presenting with groin abscesses	i. Engagement with stakeholders	Vascular Network Manager	Dec-19		Complete	Responses received Still to be incorporated
	ii. Draft Pathway development and national bench marking		Mar-20		Complete	Vascular - IVDU Groin Infection Path
	iii. Pathway discussion pan-BCUHB		21/09/2020		Outstanding	
	iv. Ratification at the Clinical Advisory Group		02/10/2020		Outstanding	
Review and refine pathway for patients post major arterial surgery requiring rehabilitation	i. Engagement with stakeholders	Vascular Network Manager	Dec-20		Complete	DRAFT Pathway for the Management of
	ii. Draft Pathway development and national bench marking		Jan-20		Complete	
	iii. Pathway discussion pan-BCUHB		21/09/2020		Outstanding	
	iv. Ratification at the Clinical Advisory Group		02/10/2020		Outstanding	
Refine and review pathway for non-surgical arterial condition for 'palliative' patients, in conjunction with palliative care team	i. Engagement with stakeholders	Vascular Network Manager	End of August 2020		Outstanding	Contact with palliative care CD 20/07/20
	ii. Draft Pathway development and national bench marking		18/09/2020			
	iii. Pathway discussion pan-BCUHB		05/10/2020			
	iv. Ratification at the Clinical Advisory Group		23/10/2020			

Vascular Task and Finish Group – actions and preparation for 13th August meeting

Aims: Engagement and communication:

Communication Plan

Task/Action required	How Task will be achieved & Outcome	Responsible to	Current Status	
			By When	**Progress update and notes**
COMMUNICATION				
Communication Plan to be drafted with input from staff, CHC, service user representatives for presentation at the Vascular Task and Finish Group	Attached vascular communication plan to detail the key objectives to support this development.	Aaron Haley	Jul-20	

Review of PROM/PREM measures to improve patient experience, in conjunction with existing patient experience data
Review of patient information and accessibility (including travel) with the support of the patient experience team

Task/Action required	How Task will be achieved & Outcome	Responsible to	Current Status	
			By When	**Progress update and notes**
PREMS				
1. Review secondary data relating to complaints, real-time feedback, care2shares and patient comments.	Exploratory Data Analysis to include, where possible, statistical comparison of Q1&Q2 2019/2020, compared with Q3&Q4 2019/2020. To include thematic comparison of qualitative feedback to identify any trends or inferences post and pre reconfiguration of vascular services. The methodology will use 'vascular speciality' to scope patients and location exact = Dulas YG and Ward 3 YGC.	PM and AD	2nd June	Completed. There is limited evidence that patient experience has been adversely impacted by the reconfiguration of vascular services. Review of secondary care comp

2. Identify active outpatient clinics for the next 6 weeks.	Table of OPD clinics and contacts in order that Patient Experience Coordinators are able to approach staff to hand out questionnaires and/or use smart devices to collect the data.	JO	5th July	Outpatient clinics across all sites identified. Data collection was staggered and commenced for YG and YGC from 15/06/20. Data collection commenced for WMH from July 2020. Clinics: YG: Wed AM YGC: Wed PM WMH: Wed AM, Thursday AM, Friday AM
3. Review and if necessary amendment of patient feedback (PREMS) questionnaire. To include any additional items related to access to and coordination of the service identified as reported issues within the CHC report.	Validation of patient experience questionnaire. At the vascular task and finish group meeting meeting the request was discussed, requesting CHC and patient/carer representaion from the group to review our form. There was agreement from patient and carer representation present that it was of benefit to request via CHC.	PM	2nd June	Completed. Patient feedback questionnaire was reliable and did not require amendment as the content met the needs of the feedback.
4. Utilise amended questionnaire in real time within active OPD and within Vascular Wards (3)	Real/Near Time from OPD clinics and vascular ward – where activity exists and access is possible[1] (*Data collection to commence 15th June – and coded and analysed 'manually' using coded template for weekly reporting*).	JO PALS Officers/AD/EY	31/07/2020	Data Collection completed for YG and YGC. Please see attached report for further details. Analysis of data for OPD in YGC and YG Analysis of data collected from WMH will be completed by 28/09/20

5. Develop a sampling frame for retrospective audit of Vascular patients. Register as Tier III audit.	Agreed that Ward 3 YGC would be utilised in the first instance, and consent obtained to participate within Care2Share interview prior to discharge and Datix PALS utilised to store and code the interviews.	JG/PM with support from IM&T		Participant information and consent form developed and shared with PALS officers and Patient Experience Managers. Commencing 10th August until the 31/08/20
6. Develop question stems for Care2Share in order to collect primary feedback in relation to the reported issues within the CHC report.	Tested Care2Share interview pro-forma	JO/EA/PALS Officers	15th June	Participant Information Sheet developed by Summer Intern – AD to validate. Share approach with CHC and patient representative Care2Share_Vascular&General_Welsh.d(Shared with CHC again on 06/08/2020
6a. Share Approach with CHC	Share approach with CHC and patient representation and explore options for a collaborative approach	PM/CO	5th June	CHC aware of the proposed approach and collaborative approach offered and explored operationally.
7.Utilise sampling frame to invite patients to take part in retrospective audit. (5, 6 & 6a)	Agree dates and time for care2share telephone interviews. Utilise mailing list for patient experience survey. Additionally ensure that the survey is available on the internet.	PALS Officers	20th September	Documentation to be delivered to the Wards by 10th August 2020, and first interview to be undertaken by 15th August 2020. Request if CHC can support exploration. – information sent to CHC 06/08/20 To commence on the 10/08/20. Fay Taylor to liase with Llinos Roberts. Questionnaires delivered.

8.Utilise a combination of care2share and/or amended patient experience survey to collect data. (7)	Retrospective review of patient experience for vascular patients using NHS Inpatients Questionnaire – complete audit report and recommendations.	PM/PALS Officers	20th July	Request for sampling frame forwarded to IM&T – based on the same procedure as for INPATS

PROMS				
Task/Action required	**How Task will be achieved & Outcome**	**Responsible to**	**Current Status**	
			By When	**Progress update and notes**
1.Determine if PROMS data set exist	Undertake analysis of PROMS data set for AAA pre and post surgery questionnaire. Incorporate into version 0.2 of patient experience report – see 1 above	PM	5th June	There are no PROMS data sets currently in existence within BCUHB.
2.If PROMS data set does not exist – decide at what points in the pathway the ED5 questionnaire can be utilised (1)	Identify patient groups, and 2 points in the pathway or determine if it can be utilised post recovery for retrospective patients.	JG and nominated clinical leads	24/06/2020	Meeting with the chair of the clinical effectiveness group, secondary care medical director, vascular manager and clinical director on 24/06/20 to ensure effective collaboration. Following this meeting introductions will be made with the Head of Value based healthcare in South Wales with regards to developing a infrastructure for administering and introducing vascular PROMS across the service.

Task/Action required	How Task will be achieved & Outcme	Responsible to	Current Status	
				14/07/20 – Meeting held with Head of Value Based Healthcare in Swansea Bay to discuss sustainable implementation of PROMS. Meeting with Deputy Medical Director 12/08/20.
3. Develop protocol for administering PROMS Questionnaire (1 & 2)	Establish PROMs Data set for identified Vascular Patient Groups	JG and nominated clinical leads	TBC	Link with chair of the clinical effectiveness group to ensure effective collaboration. Meeting on 24/06/20. JG emailed AG on 17/07/20 and 11/08/20. Meeting with Deputy Medical Director 12/08/20.
PATIENT INFORMATION				
Task/Action required	**How Task will be achieved & Outcme**	**Responsible to**	**Current Status**	
			By When	**Progress update and notes**
1. Website and leaflets	Scope information available on the internet/intranet to ascertain what information is presently available to patients in relation to their vascular procedures, literature etc. Contact the vascular clinics on sites to scope and identify all written information given to clinic attenders, and those discharged from the vascular wards. Scope what information is given to vascular patients following rehabilitation therapy (physio/ OT).	CO/JO	12th July	Initial review undertaken, 12th June. 2nd stage required to identify what information patients want and feel is required. Seek CHC support to engage with patients and service user. See action below. Patient information provided to patients pre and post op.

Task/Action required	How Task will be achieved & Outcome	Responsible to		Current Status
1a. Reviewing Written Information & create Validated Library of Vascular Patient Information in line with ISUE01 policy guidlines.	Ensure that CHC representation is mandated within the readers/review panel for Written Patient Information Guidance Policy ISUE01 explicitly states this.	JG	21.9.20	Request CHC engagement to review revised guidance and review vascular health information samples. Delay in response to activate CHC advocacy therefore action date changed. JO Patient Information procedure. Share with CHC members *& CNS x3 Information sent to the CNS, and JG copied in.06/08/20
2. Review complaints from November 2019 to March 2020 to ascertain whether any significant points of concern resulting from the change in arrangements for vascular services, which may or may not have triggered an increase in complaints.	Repeat query used to compile information informing the Vascular report, for the period November 2019 to March 2020.	YW	25th June	Summary of themes of Complaints.docx **Summary:** Out of 28 complaints during this period, the majority of complaints related to access to service as demonstrated in the first three headings, 17 of the total number. Continuing with the theme of delays, arrangements for ongoing management and follow up were also highlighted by complainants. 3 Complaints related to conflicting advice where there was a difference in opinion, again resulting in a delay in progress for care and treatment. In conclusion there were no significant themes or trends suggesting the change in vascular services had an adverse impact

DASHBOARD			
Task/Action required	**How Task will be achieved & Outcome**	**Responsible to**	**Current Status**

			By When	Progress update and notes
3. Development of a Vascular Dashboard	The group discussed dashboards and shared information. JG had a meeting on 5th June and will forward any useful information after that.	JG	5th August	Full draft dashboard shared with Medical Director, Sec Care Medical Director, Patient Experience Lead and Clinical Director for comment. Presented to T&F on 16/06/20. Further developments in progress for presentation at July meeting. Development progressing JG will update Task and Finish group 17th July. Action completed
3a Agree the Dashboard and Performance Metrics	Agree Minimum Data set for Vascular dashboard and ensure that Patient Experience Data (legacy and prospective) is linked.	JG/CO	25th August 2020	Vascular Network Manager Awaiting response from the Information team re: inclusion of available Patient Experience viewpoint data. Update to be provided18/08/20.

IMPROVEMENT PLAN – ENGAGEMENT & COMMUNICATION				
Task/Action required	How Task will be achieved & Outomce	Responsible to	Current Status	
			By When	Progress update and notes
1. Support service change and assure this includes service user and carer involvement, and utilise patient feedback to inform improvement	Ensure that change framework includes a baseline evaluation of patient experience, a 'Voice of the Customer' type matrix and a post implementation evaluation of patient experience. PM to develop potential framework by the next Vascular Task & Finish Group	CO/JO	31st October	Initial discussion in relation to proposed methodology, the utilisation of PREMs measures identified above pre and post change cited as essential.

2. Development of a patient and carer stakeholder engagement plan to maximize opportunities to listen and learn from feedback, to include patient and carer engagement .	See 1 & 2 above. Progress towards archivement of the aims and objectives of the engagement plan to monitored by the Listening and Learning Group (Patient Carer Group).	CO/JO	31st October	Whole action plan supports and underpins the improvement plan
3. Development of a virtual vascular patient and carer network which will link to the Health Board's Patient & Carers Group (QSE).	Attached vascular communication plan to detail the key objectives to support this development.	Communications team AH	Jun-21	Monitor progress against

Vascular Task and Finish Group – actions and preparation for 13th August meeting

Quality and Safety

IMPROVEMENT PLAN – QUALITY & SAFETY				
Task/Action required	**How Task will be achieved & Outomce**	**Respon sible to**	**Current Status**	
			By When	**Progress update and notes**
1. Baseline Safety culture survey to be undertaken to inform areas for improvement	Ensure that BCUHB has permission to utilise the Manchester Univesrity Pt Safety Evaluation framewok – although this should be open source as developed by the NPSA, and develop a framework for its application within BCUHB – to be reviewed at next Vascular Task & Finish Group Meeting.	JWJ	31st October	Organisational scoping exercise commenced July 2020 Culture safety tool developed and being tested. Plan to distribute to vascular and inter dependent staff. Scoping meeting arranged for week commencing 17th August.
2. Benchmarking of service incident reporting to improve safety via an open incident reporting culture and improve learning	Secondary data analysis of Complaints and Incidents in relation to lessons learnt for speciality='Vascular' and identify any trends in relation to training and/or service improvement.	CO/YW	20th August	Complaints aspect completed YW completing incident review YW collected data and providing incidents analysis
	Plan for introducing You Said/We Did to Incidents & Complaints – development of SOP, using PALS You Said/We Did Pro-forma	CO/JO	20TH August	SOP formulated, and shared with the Heads of Services

3. Review Service Risk Register	Complete review of risks and controls, determine if controls are adequate, identify any further service developments or training which is required to reduce the mitigated risk score further and/or to remove the risk from the register.	MJ and CO to work with JG	5.8.20	The risk register has been reviewed by JG & David Tita on 11/06/20. Currently with Dr Kate Clark Secondary Care Medical Director clinical review for additional. Review of the risk register with Emma Hosking, Soroush Sohrabi and Jo Garzoni on 07/08/20. Updated risk register included in the Vascular T&F action tracker. Risk register managed and reviewed monthly Secondary Care QS reporting structure.

DASHBOARD				
Task/Action required	**How Task will be achieved & Outcome**	**Respon sible to**	**Current Status**	
			By When	**Progress update and notes**
3. Development of a Vascular Dashboard	The group discussed dashboards and shared information. JG had a meeting on 5th June and will forward any useful information after that.	JG	5th August	Full draft dashboard shared with Medical Director, Sec Care Medical Director, Patient Experience Lead and Clinical Director for comment. Presented to T&F on 16/06/20. Further developments in progress for presentation at July meeting. Development progressing JG will update Task and Finish group 17th July. Action completed
3a Agree the Dashboard and Performance Metrics	Agree Minimum Data set for Vascular dashboard and ensure that Patient Experience Data (legacy and prospective) is linked.	JG/CO	17/09/2020	Vascular Network Manager Awaiting response from the Information team re: inclusion of available Patient Experience viewpoint data. Update to be provided18/08/20.

WORKFORCE INDICATORS			
Task/Action required	**How Task will be achieved &**	**Respon**	**Current Status**

	Outcome	sible to	By When	Progress update and notes
Develop key workforce indicators to provide assurance on the safety of the workforce, including escalation measures	Liaise with workforce to identify indicators. Intergration of metrics to the Dashboard	Vascular Network Manager	13/08/20 17/09/20	Indicators identified

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 28th August 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Internal Audit Report Deprivation of Liberty Safeguards – update paper to support the internal audit report findings and to evidence progress
Cyfarwyddwr Cyfrifol: Responsible Director:	Michelle Denwood Associate Director of Safeguarding Gill Harris. Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Chris Walker Head of Safeguarding Adults and Chris Pearson DoLS Manager, supported by Michelle Denwood Associate Director of Safeguarding
Craffu blaenorol: Prior Scrutiny:	Corporate Safeguarding Team
Atodiadau Appendices:	1. Internal Audit Report Deprivation of Liberty Safeguards

Argymhelliad / Recommendation:

The Committee is asked to note the findings of the internal Deprivation of Liberty Safeguards (DoLS) audit and recognise the significant improvement to achieve and implement into practice all five (5) recommendations, as well as the continued work and development within the Deprivation of Liberty Safeguards (DoLS),Mental Capacity Act (MCA) and Liberty Protection Safeguards (LPS) arena.

Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	☞	**Ar gyfer sicrwydd For Assurance**	☞	**Er gwybodaeth For Information**	☞

Sefyllfa / Situation:

The Mental Capacity Act Deprivation of Liberty Safeguards provides protection for vulnerable people in NHS hospitals (including registered independent hospitals and hospices) who lack capacity to agree to be accommodated for their care or treatment.

The current situation with regard to the findings and implementation of the recommendations are recorded below with outcomes and evidence of mitigation and actions taken.

A number of reports have been produced and shared at the following key forums evidencing activity, demands and strategic activities; QSG, QSE, Mental Health Act Committee - Deprivation of Liberty Safeguards (DoLS), Internal Audit Report Committee, HASCAS Improvement Group and the Safeguarding Governance and Performance Group. This reporting is in line with the Safeguarding Reporting Framework.

Cefndir / Background:

In accordance with the 2019/20 Internal Audit Plan a review of the Deprivation of Liberty Safeguards (DoLS) process has been undertaken. The Mental Capacity Act Deprivation of Liberty Safeguards

provides protection for vulnerable people in NHS hospitals (includes registered independent hospitals and hospices) who lack capacity to agree to be accommodated for their care or treatment.
Governance

The governance of the Deprivation of Liberty Safeguards (DoLS) within the Health Board has been the subject of recommendations in response to the investigation of the Tawel Fan Ward. DoLS was previously managed within the portfolio of the Office of the Medical Director (OMD) but was transferred into the portfolio of the Executive Director of Nursing and Midwifery during 2017/2018 and forms part of the Corporate Safeguarding portfolio.

Both the HASCAS and Donna Ockenden reviews identified the DoLS work plan as a high-risk area, which required a full review.

DoLS has two key frameworks, the Supervisory Body, which is the Corporate Safeguarding Team and the Managing Authority, which is the responsibility of the care giver, namely the ward manager, or those who are responsible for the care of patients.

Activity

A DoLS Code of Practice, issued by the Lord Chancellor in 2008, outlines key requirements. Since 2014 the number of DoLS applications has increased significantly due to the Supreme Court creating a new case law test (the 'acid test') which has resulted in a higher number of patients being subject to a deprivation of liberty in a registered hospital.

The total number of BCUHB DoLS applications have increased annually as evidenced below, this impacts upon service provision.

Year	Total DoLS Applications	
2014/15	414	
2015/16	787	
2016/17	854	
2017/18	792	
2018/19	744	
2019/20	1014	
2020/21 Q1	256 (projection 1024)	

Court of Protection (CoP)

Additional responsibilities which impact upon the work of the DoLS Team include attending Court of Protection hearings. Court of Protection cases are referred for two key reasons;

Firstly, because the patient's advocate is stating that the individual is objecting to their detention under DoLS and has a right in law to appeal (Article 5(4) ECHR). Secondly, it is referred because there is a need for a welfare decision to be made, relating to the patient's care in hospital or elsewhere which is in their best interests.

The number of cases referred by the DoLS service through Legal and Risk services has increased significantly from one (1) case in 2018/19 to sixteen (16) cases in 2019/20. Cases may take months for the Court to finalise proceedings due to the amount of evidence, often cases are dealt with over a number of hearings. All cases incur legal costs for which there is no indicative Safeguarding/DoLS budget, resulting in a cost pressure within the Corporate Safeguarding service.

Case Law

In September 2019, the Supreme Court held that in the case of *D v Birmingham,* where a 16 or 17 year old child cannot (or does not) give their own consent to circumstances satisfying the 'acid test', a revised process is required.

This means previously parents could consent to a deprivation of a young person aged 16 or 17 years, who lacked capacity, to agree to circumstances of a deprivation, from September 2019 lawful authority is required from the Court of Protection to agree to deprive that person. This increases the number of cases referred to the Court of Protection.   Several actions by the team have been put in place to implement this case law, which include alerting all relevant children's services of the impact of this case law, updating DoLS mandatory training to embrace the impact of this court judgement; direct training offered to Children's Services, Paediatrics and CAMHS which commenced in February 2020.

Asesiad / Assessment & Analysis

Audit Outcome

The 2019-2020 audit of the DoLS service provision by BCUHB was the first ever internal audit of the service. It was recognised that progress had been made during 2019-2020 and the overall outcome was positive; however, the outcome was recorded as Limited Assurance and five (5) key findings and recommendations were identified.

It should be recognised that the findings from the review have highlighted no issues that are classified as weakness in the system control or design for Deprivation of Liberty Safeguards.

The audit highlighted key findings and recommendations, these have been acknowledged, actioned and implemented into practice by the DoLS Corporate Safeguarding team.

Findings / Recommendations

1. Policies and Procedures (Supervisory Body)

Recorded that there is no published up-to date operational procedure clarifying expectations of departments/wards in their capacity as Managing Authorities. Staff would also benefit from further

guidance on timescales / escalation and reporting breaches to ensure ward staff are taking appropriate action.

Update Position

The Corporate Safeguarding team (Supervisory Body) produced a BCUHB Standard Operating Procedure (SOP) which provides additional guidance for staff across the Health Board, which is in addition to the National Guidance.
The SOP includes actions, timescales and a rationale for responding to an actual or potential deprivation of a patient. Ratification of the SOP took place through the Safeguarding Governance and Reporting Framework; which is the, Safeguarding Performance and Governance Group; and Quality Safety Group (QSG). **Completed - Ratified QSG 12.06.20**

2. Vacant Best Interest Assessor (BIA)

Found there was a lack of BIAs which is impacting upon the timescales for DoLS applications. Although an establishment figure of six BIAs was identified with two in each of the three area teams across North Wales, a post remained vacant.

Update Position

The initial challenge was a cost pressure due to a banding review. However, the Health Board could be exposed to financial penalties from non-compliance with the requirements of DoLS legislation and that these costs could significantly exceed the costs currently being saved by having a reduced establishment.

Monies have been secured, recognising a cost pressure and the outstanding post is now currently advertised. However, due to the continued demands upon the team the submission of a further paper to QSG highlight the current demands and organisational risks within the DoLS service provision remains and the potential impact of LPS across the Health Board was presented.

After a period of delay as a result of the COViD pandemic, further discussions have taken place and it was agreed that a business case highlighting the need for a proposed enhanced structure with recognised financial implications is to be presented at the Executive Management Group; Oct 2020. **Remains in progress – BIA post currently advertised**

3. Completeness of Documentation (Managing Authority)

The need for all wards to be reminded of the need to complete DoLS paperwork in an accurate and comprehensive manner, in keeping with the stipulated requirements.

Update Position

Challenges and issues currently faced by the DoLS team (Supervisory Body) are in relation to the completion of DoLS paperwork by wards (Managing Authority) these include; Insufficient clinical information, no name of Consultant, no Mental Capacity form, old or out of date Mental Capacity Form, no care plan, incorrect dates, no relevant details of Mental Health Act (MH Act) 1983 application details, missing signatures.

In response the DoLS team (Supervisory Body) have produced a Safeguarding Bulletin specifically assigned to DoLS that has be disseminated across BCUHB. The Safeguarding Ambassadors have also ensured the bulletin has been shared within their areas and teams.

With support the Managing Authority have developed an audit and assurance process by using Datix to ensure all DoLS applications are completed accurately and correctly. The development of the SOP for DoLS further strengthens the process, supports staff by enhancing their awareness of their responsibilities and the actions to be taken to safeguard patients when a deprivation is occurring. All of which is supported by training and clear and accessible guidance on the Safeguarding Webpage.
Completed – 30.04.20

 4. Monitoring and Authorisation (Managing Authority)

The report found whilst there has been significant progress on the part of the DoLS Team (Supervisory Body) with a clear increase in the number of Authorisers (signatories) with the provision of specialist training, it noted issues in respect of engagement on the part of those nominated who are yet to be trained and that the majority of DoLS applications authorised in the current year were signed off by a small number of the pool of potential Authorisers (signatories).

Update Position

In response the Managing Authority ensure that Authorisers (Signatories) are reminded of their role and responsibilities through the PADR and supervision processes available to them. The DoLS Manager (Supervisory Body) has included guidance reinforcing their role and responsibilities as Authorisers within the Safeguarding Bulletin. A SOP document has been devised setting out the responsibilities for those who have been approved to authorise a DoLS. This has been ratified through the Corporate Safeguarding Governance and Reporting Group. In addition, a leading barrister, who is an expert in DoLS has led training for Authorisers (Signatories) which was completed in 2020, to further enhance and support this important role.
The average time is two (2) days to obtain authorisation.
Completed – 01/05/20

 5. DoLS Monitoring (Managing Authority)

The audit found that within the reports produced from Datix the auditors were unable to identify any specific reporting of breaches by individual wards/departments, specific to DoLS, within the period under review. From the information and findings reported within safeguarding reports produced by the DoLS Manager (Supervisory Body) this was believed to an omission of Datix reporting by the ward (Managing Authority).

Update Position

With support, the Managing Authority have undertaken a random sample of Datix incidents within their responsibility to determine if breaches have been reported. The Managing Authority have developed an audit of DoLS paperwork and DoLS activities within the current Audit of records and have developed a process to cross reference Datix incidents to determine whether breeches have been reported promptly.

It should be noted that the development of a Standard Operating Procedure (SOP) identified in findings 1 and 3 demonstrate that the Managing Authority have clear guidance relating to their responsibilities and the consequences of any breach relating to Article 5 (a Deprivation of Liberty,

Human Rights Act '98) and the expectation of non-compliance reporting through Datix. This enables a notification to the DoLS Team (Supervisory Body) enabling education, support and guidance to remind the Managing Authority that a Datix must be actioned. **Completed 15.04.20**

Continued Improvements

Review of National DoLS Forms

The Safeguarding Team (Supervisory Body) continue to undertake activities to enhanced monitoring and as a result a review of the DoLS National Forms has taken place to support the development of a gold standard documentation, supported by bespoke training packages. The DoLS Forms used in Wales have not been reviewed since 2015. This was recognised by Corporate Safeguarding and following a successful bid to Welsh Government for funding, a review of the Welsh DoLS Forms used and adapted by BCUHB has been agreed.

Although the Forms do not carry a statutory status like those used for detention under the Mental Health Act 1983, they do form the basis upon which people are detained under the Mental Capacity Act 2005.

DoLS/MCA Flowchart

The development of a DoLS/MCA Flowchart to support applications during the COVID-19 pandemic has been completed and endorsed by QSG. This provides clear guidelines to ensure patient and staff safety and offers assurance with regard to the legal process, which must continue.

Training

During 2019/20 there has been a concerted effort to increase awareness of the rights based approach to depriving individuals lawfully of their liberty. This has been created by increasing the range of training provision across BCUHB to internal and external health and social care professionals. In 2019-2020, 620 BCUHB staff completed the DoLS/MCA training provided by Corporate Safeguarding.

Corporate Safeguarding already anticipated that face to face training will not be possible for all training during the current lockdown. DoLS and MCA Level 3 mandatory training is being delivered through on-line access and through peer led voice-over and video recordings, specifically in relation to training focused on 16-17 year old's as required by case law. This includes learning assessments which can be accessed by managers of staff using e-learning to ensure learning objectives are being met.

Impact Risk Assessments – Liberty Protection Safeguards (LPS)

Work-stream Task and Finish groups are being implemented during 2020/21 to develop a strategic impact risk assessment, which are supported by the identification of actions to mitigate against the risks for the Health Board. These are in preparation for the implementation of LPS, and are aimed to facilitate implementation, understanding and knowledge of this case law.

Following the successful bid to Welsh Government for time and issue specific funding. An introductory E-learning training package to be used by Betsi Cadwaladr Health Board in preparation for the new liberty protection safeguards ('LPS') in hospital and NHS registered facilities has been commissioned. The introductory LPS E-learning training package will enable staff to have a working

knowledge and understanding of their role and responsibilities within the assessment for LPS through downloadable content.

Corporate Safeguarding have been leading on innovative methods to deliver training to large cohorts of health professionals who will be involved in assessments under LPS. In addition to online and video based training documentation Corporate Safeguarding are producing text documents, a folding pocket size leaflet, slides, and self-assessment quizzes to improve and retain knowledge of LPS. The folding pocket sized leaflet will support staff by setting out key messages and processes of the new LPS arrangements.

Financial Implications

The demand upon the DoLS team extends not just to BIAs but to all members of the Safeguarding Team, and the implication of LPS will mean a substantial change and responsibility for BCUHB. It is estimated that in excess of 55% of residents across North Wales within Nursing Homes are in receipt of 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 overall objective identified by Corporate Safeguarding is to ensure that DoLS applications are managed in accordance with the Deprivation of Liberty Safeguards Code of Practice, Welsh Government guidance and Health Board procedures. Noting the recommendations of the HASCAS and Ockenden reports, Corporate Safeguarding (Supervisory Body) have identified progress where this directly relates to those areas and the issues which are identified as a result of the internal audit. In addition, we have identified further areas of improvement and progress to provide a level of assurance that BCUHB adhere to current practice and law.

There are financial implications for the health board in relation to the implementation of the Liberty Protection Safeguards (LPS) that formulate part of the Mental Capacity (Amendment) Act 2019. The anticipated Code of Practice will set out in detail practical guidance and the changes that will come into effect in April 2022. The financial impact for LPS is wide ranging with a change of roles and responsibilities across the Health Board. Health Boards will retain ownership of LPS for all commissioned patients wherever they reside and this will see an increase in assessment requests, with an approximate additional application figure of 1200.

The review and effectiveness of the Corporate Safeguarding Team /DoLS Team (Supervisory Body) and the need to strengthen the current structure will remain to be a key focus, with greater consideration given by the Executive Management Team in October 2020.

Legal and Compliance

Safeguarding is underpinned by legislation, policy and procedure. The role of Corporate Safeguarding (Supervisory Body) within BCUHB is to ensure that the Health Board execute their responsibilities and comply with the Safeguarding legislation, providing assurance that the strategic measures are implemented, audited and reviewed. The Managing Authority must implement and act in accordance to the legal framework.

Conclusion

Corporate Safeguarding have actively progressed and engaged in the DoLS, MCA and LPS national agenda. It is evident progress has been made to address the Five recommendations/findings with all activities evidenced within an internal audit plan to ensure ongoing implementation.

Work undertaken over the last 18 months to ensure that patients are supported under the correct legal framework has been evident but has not been without challenge. Risk has been identified and communicated within BCUHB, with mitigation recorded. Corporate Safeguarding proactively engage in development, however continued improvements are limited and challenging, resulting in a reactive rather than proactive service and a recognised delay in the implementation of the strategic agenda. This is a result of increased demand and capacity and the need to provide continued support to the Managing Authority to ensure they are working in line with the Deprivation of Liberty Safeguards (DoLS) legal process.

Betsi Cadwaladr University Health Board

Deprivation of Liberty Safeguards (DoLS)

Final Internal Audit Report

March 2020

BCU-1920-20

NHS Wales Shared Services Partnership

Contents

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Head of Internal Audit
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Distribution: Associate Director of Safeguarding
Safeguarding Specialist Practitioner/DoLS Manager
Acting Board Secretary
Statutory Compliance, Governance and Policy Manager
Committee: Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

ACKNOWLEDGEMENT
NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - Please note:

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Betsi Cadwaladr University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1.   Introduction and Background

In accordance with the 2019/20 Internal Audit Plan a review of the Deprivation of Liberty Safeguards (DoLS) process has been undertaken.

The Mental Capacity Act Deprivation of Liberty Safeguards provides protection for vulnerable people in NHS hospitals (includes registered independent hospitals and hospices) who lack capacity to agree to be accommodated for their care or treatment.

A DoLS Code of Practice, issued by the Lord Chancellor in 2008, outlines key requirements. Since 2014 the number of DoLS applications has increased significantly due to a the Supreme Court creating a new case law test (the 'acid test') which has resulted in a higher number of patients being subject to a deprivation of liberty in a registered hospital.

The governance of DoLS within the Health Board has been the subject of recommendations made as part of two reviews undertaken in response to the investigation of the Tawel Fan Ward.

"Both the HASCAS and Donna Ockenden reviews identified the DoLS work plan as a high-risk area, which required a full review. This remains a high priority in the Corporate Safeguarding work plan for 2019-20 as the demand, complexity and challenging nature of this specialist area requires a sound infrastructure to meet the needs of the client group and organisation. Consultation on the revised DoLS Structure is due to commence in June 2019" (Source: BCUHB Corporate Safeguarding Team-Safeguarding and Protection of People at Risk of Harm Annual Report 2018-19).

The law has changed with an amended Mental Capacity Act (MCA) 2019 which received Royal Assent in May 2019. The MC(amendment) Act 2019 also puts in place new legislation, the publication of a new statutory Code of Practice and statutory Regulations under Liberty Protection Safeguards (LPS) which will replace DoLS legislation and procedures from an expected date of 1st October 2020. While DoLS is to be replaced by LPS, there will be a period of transition for those individuals who are granted a DoLS and the expiry date will occur after the implementation date. This means until the expiry date existing DoLS authorizations will continue until their expiry date. Any new authorisations for LPS will be under that legal regime. Any policy and procedures will therefore need to be updated prior to the implementation of LPS. Existing DoLS policy and procedures need to be updated to reflect its continuation for individuals subject to DoLS after the implementation date prior to its expiry and also other related policies and procedures which take account of DoLS or MCA 2005.

DoLS has two key frameworks, the Supervisory Body, which is the Corporate Safeguarding Team and the Managing Authority, which is the responsibility of the ward manager who is responsible for the care of patients.

A number of report have been produced and shared at key forums evidencing activity and demands and strategic activities, QSG, QSE, Mental Health Act

Committee, HASCAS Improvement Group and the Safeguarding Governance and Performance Group.

2.   Scope and Objectives

The overall objective of this audit was to review the process for DoLS applications to ensure that these are managed in accordance with the Deprivation of Liberty Safeguards Code of Practice, Welsh Government guidance and Health Board procedures. Additionally noting the recommendations of the HASCAS and Ockenden reports we reviewed progress where this directly relates to those areas that are the subject of our testing.

The review has evaluated arrangements in place to ensure that:

- There are clear policies, procedures and responsibilities for the process of the management of DoLS;

- DoLS applications are logged and actioned in a timely manner;

- Information maintained to monitor DoLS is up to date, accurate and complete;

- Documentation is completed fully by appropriate people;

- Issues identified are being actively managed as reported within the Quality & Safety Dashboard.

3.   Associated Risks

The potential risks considered at the outset of the review were:

- Policies, procedures and responsibilities relating to DoLS are not clear;

- DoLS applications are not logged and actioned promptly;

- Information used for monitoring DoLS applications is not up to date, accurate and complete;

- Documentation is not completed by appropriate persons; or

- Issues identified with the process are not being actively managed.

OPINION AND KEY FINDINGS

4.   Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the Deprivation of Liberty Safeguards (DoLS) process is **Limited** Assurance.

RATING	INDICATOR	DEFINITION
Limited assurance	 -　　　　+ Amber	The Board can take **limited** assurance that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention **with moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

5.　Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Policies, Procedures and Responsibilities			✓	
2	DoLS Applications and completeness of documentation		✓		
3	DoLS Monitoring			✓	
4	Issues and actions identified			✓	

* The above ratings are not necessarily given equal weighting when generating the audit opinion.

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weakness in the system control/design for Deprivation of Liberty Safeguards.

Operation of System/Controls

The findings from the review have highlighted 5 issues that are classified as weakness in the operation of the designed system/control for Deprivation of Liberty Safeguards.

Please note: We have not reviewed records held on wards focusing instead on the process followed once a DoLS application has been submitted; similarly the review has sought to test new applications and we have not reviewed submissions for extensions to existing DoLS.

Policies, Procedures and Responsibilities

There is a DoLS Code of Practice, published by the Ministry of Justice, which details the DoLS process that must be followed. This code supplements the Mental Capacity Act 2005 Code of Practice. The statutory responsibilities of Managing Authorities [MA] and Supervisory Bodies [SB] is detailed within the Code, and there is also separate guidance for each.

Wards within the Health Board acute and Community Hospitals along with Mental Health acute facilities are Managing Authorities. The DoLS Team co-ordinate and manage the DoLS assessments, undertaking the statutory function of Supervisory Body for the Health Board, processing the DoLS applications (receipt, arrangement of assessors and authorisation).

We were sighted on a locally produced policy document (SCH018) that was produced in 2014, however we understand that this is not published online for staff to refer to [as it contains a range of appendices which are no longer applicable]. The Welsh Government (WG) revised all the forms in 2015 and whilst the Health Board have since put in place revised forms, the policy document has not been revised to reflect this.

The Safeguarding Specialist Practitioner/DoLS Manager advised us that this is currently under review, with a revised version to be submitted to the Safeguarding Governance and Performance Group for approval, but with changes under Liberty Protection Safeguards (LPS) due in 2020, this had been placed on hold and is to be developed from a LPS perspective.

There is a flow chart showing the DoLS process and standard forms; however as noted earlier there is no current local Health Board policy or operational procedure detailing the process and responsibilities for staff.

Information relating to DoLS is available to staff via the intranet and included and reiterated during both the DoLS and Safeguarding mandatory Training. Within the Safeguarding Web page there is a specific section for Mental Capacity Act (MCA)/DoLS. This provides members of staff with:

❖ A flowchart showing the process.
❖ MCA code of practice and guidance for MA & SBs.
❖ Relevant forms.
❖ Contact information.
❖ Training information.
❖ Care plan templates.
❖ Reports.
❖ Guidance for families.

DoLS applications and completeness of documentation

The joint Care Inspectorate Wales (CSSIW) and Healthcare Inspectorate Wales (HIW) Deprivation of Liberty Safeguards Annual Monitoring Report for 2017-18 noted that there was a continuing annual increase in DoLS applications across Wales [up by 8% from 2016/17] and that resource required to manage the DoLS

process often exceeds the resource available. It reported that the average number of applications for Health Boards in Wales was 201 per 100,000 population. The Health Board fell below this with 153 applications per 100,000.

However, the Deprivation of Liberty Safeguards Update report as presented to the Mental Health Act Committee meeting of the 27th September 2019 records that for Quarter 1 of 2019/20 *"there has been a significantly high level of applications from all areas across the Health Board. In the West a 77% increase; the East 53% increase and Central remains the same trend"*.

The logging and processing of DoLS applications is undertaken by the DoLS Team based at Preswylfa. The database is managed by two staff.

We have reviewed a sample of records to determine where/if any delays may be occurring within the current process for DoLS applications and if this is captured for review by management. We confirmed that the date an application is received by email is recorded.

For each DoLS application, two assessors need to be commissioned and appointed:

- Section 12(2) assessor (mental health and eligibility criteria).

- Best Interest Assessors (best interests, mental capacity, No refusals and age assessments).

The Section 12(2) assessors are doctors, who get paid a fee for each assessment, (the exception being those who work within a Health Board Mental Health setting) Accountability for this function sits within the Office of the Medical Director however, the DoLS Team manager provides guidance and support and the administration team manages the process and data collection. The Best Interest Assessors (BIA) are nurses or social workers, employed by the Health Board in the BIA role with specific approved qualifications/training appropriate to the post. The Health Board does however on occasions utilise an external BIA Assessor where work load dictates.

We reviewed a sample of ten DoLS applications for each of the three respective acute sites (Managing Authority). The sample was selected from submissions made between April and the end of June 2019 (Qtr1). Whilst we were able to identify and choose a sample of ten DoLS applications for the East (Wrexham Maelor), we were only able to choose seven submitted from the West Area (Ysbyty Gwynedd) with only five to choose from Central Area (Ysbyty Glan Clwyd).

To assist with our testing we were provided with access to the database maintained by the DoLS Team and the folders in which all copies of forms and correspondence were held. The testing focused solely on the completeness of information submitted and the process followed once a DoLS application had been submitted to the Supervisory Body.

Completeness of documentation

- 9/22 of the DoLS applications submitted did not appear to have been accompanied by a copy of the MCA

- Only 1/22 DoLS applications submitted appeared to have included a copy of the care plan. Form 1 (P2) specifies that "*A RELEVANT CARE PLAN SHOULD BE ATTACHED*".

These findings echo those reported by the Safeguarding Specialist Practitioner/DoLS Manager in the September 2019 (Qtr1) Deprivation of Liberty Safeguards (DoLS) update report where issues with individual applications varied between 35-50% depending on the area submitting them. It is noted that the DoLS Team are challenging the respective services when these occur, however the issue remains relevant and in need of further mitigation.

<u>Process for submission of applications</u>

The document 'Guidance for Managing Authorities working within the Mental Capacity Act Deprivation of Liberty Safeguards' notes the following:

"Wherever there is the possibility that a relevant person may need to be detained the managing authority should plan ahead. If the detention is likely to be unavoidable, then, if possible, the managing authority should make a request for a standard authorisation in advance so that the standard authorisation is in place at the beginning of the detention. If this is not possible and the relevant person needs to be detained as a matter of urgency then the managing authority can give itself an urgent authorisation for up to 7 days which will enable it to lawfully detain the person while the standard authorisation is pending".

The DoLS applications that made up our sample were exclusively classified as Urgent, it is understood that the majority of DoLS applications within BCUHB take this form.

The first element of the process we analysed was the appointment of Best Interest Assessors, to determine the timescale between the application being received and the booking of a BIA assessment and following this the time period before the findings of the assessment have been formally recorded (please see Table 1).

The second part of the process we reviewed surrounds the request for a Section 12 (S12) assessment to be completed. Again we sought to identify the timescale between the application being received, the booking of the S12 assessment and following this the time period before the findings of the assessment have been formally recorded (please see Table 2).

The third part of the process we focused on is where following a review of completed assessments and where authorisation is granted, "Form 5" should be fully completed and signed by the Supervisory Body (to confirm that assessments have been considered as part of the review process), then sent to the Managing Authority. We reviewed the timescale between completed assessments and authorisation by the Supervisory Board signatory. It should be noted that the sample had been reduced by half at this stage due to a number of factors, including applications being withdrawn or being declined following assessment by the BIAs (please see Table 3).

Table 1: Best Interest assessments

Days	<8	8-14	15-21	22-28	>28
Timescale between DoLS application and booking of assessor **Average = 16 days**	4	8	4	1	3
Timescale between booking of assessor and completed assessment **Average = 8 days**	13	2	3	0	0

Table 2: Section 12 assessments

Days	<8	8-14	15-21	22-28	>28
Timescale between DoLS application and booking of assessor **Average = 10 days**	12	4	1	1	1
Timescale between booking of assessor and completed assessment **Average = 6 days**	13	4	1		

Table 3: Authorisation of application

Days	<8	8-14	15-21	22-28	>28
Timescale between completed assessments and authorisation by SB (10 applications tested as above) **Average = 11 days**	2	6	2	0	0

In the final table (Table 4) we sought to identify the overall timescale between a DoLS application being submitted and authorisation being granted. The sample was reduced for this element by virtue of the fact that half of the sample as selected did not reach this stage for a number of reasons, alluded to earlier.

Table 4: Overall period of time elapsed between applications being initially received and authorisation being granted.

Days	<8	8-14	15-21	22-28	>28
Timescale between application being made and authorisation by SB (10 applications tested as above) **Average = 29 days**	**1**	**0**	**0**	**4**	**5**

Analysis of delays & risks

The findings as detailed in tables 1 to 4 above highlight delays in all elements of the process that combined mean that the average Urgent DoLS application [as per our sample] took twenty nine (29) days to be authorised which is in breach of the Code of Practice.

Our testing revealed a variety of compounding factors that contribute to this.

Firstly, DoLS application documents are not being completed correctly which means that the DoLS Team have to go back to the originating Ward/Department to request that the forms, as submitted, be completed fully/signed. 30% of our initial sample were found to have been initially submitted in an incomplete manner. This will be detailed further under completeness of documentation.

The figures show a high average number of days between the booking of the Best Interest Assessments and the eventual completion and reporting of the assessment. The figures above also show the majority of applications being authorised over seven days following receipt of the last assessment. This adds to the delay already experienced in booking and receiving assessments.

The DoLS update report provided to the Mental Health Act Committee Meeting of the 29th March 2019 noted under 3.4 (P4) that "*In order to continue to meet capacity demands the DoLS team will retain the services of a Sessional BIA to undertake assessments until the full integration of qualified BIA staff is complete*".

We understand that although an establishment figure of six BIAs was identified with two in each of the three areas across North Wales, the West area still relies on one BIA. We were advised that the lack of recruitment to this post is attributed to budgetary constraints, although we have not corroborated this assertion. However noting this, we requested the cost of paid additional sessions utilising bank and External Assessors for January to October 2019 and the figure came to £10,880. We understand that the bank assessors are largely Health Board BIA team members who are paid a sessional fee of £360 per assessment, but that they are limited on how many they are allowed to undertake in any given month.

With the delays identified in getting the BIA assessments, there is a risk to the Health Board that they could be exposed to financial penalties from non-compliance with the requirements of DoLS legislation and that these costs could significantly exceed the costs currently being saved by having a reduced establishment of BIAs. We acknowledge however that the impending introduction of LPS should be factored in and future workforce requirements take account of potential changes in working practices.

The majority of S12(2) assessments were undertaken in less than six days from

the point of being booked to the assessment being conducted and reported back to the DoLS Team, however for an urgent seven day DoLS application this still leaves little time to complete the process and comply with the requirements of the Act. In addition the average time taken from a DoLS application being submitted and a Doctor being contacted to undertake the S12(2) assessment was found to be 10 days. It is not immediately clear why this is the case, but when this is factored in with the average six day lead time, before an assessment can be undertaken, the delays are added to.

The DoLS Team have made great strides in increasing the number of authorised signatories over the course of the past twelve months with the Health Board having a total number of forty four signatories at the time of this review, with a further thirty two nominated as signatories by their line managers but still to complete training.

We noted that the DoLS Manager reported in the DoLS update report to the Mental Health Act Committee meeting of the 27th September 2019 under s4.1 (P6) that, *"A concern remains regarding a delayed response to requests to complete the task of agreeing a standard authorisation with some signatories not responding to emails"*.

We sought to quantify the level of engagement by the signatories and requested a list of all the applications authorised since April 2019 and noted the following:

* 137 DoLS applications were authorised between April and October 2019.

* 19 different signatories were found to have authorised these 137 applications, these 19 represent 43% of the total signatories who could have potentially provided authorisation.

* However, we further identified that of the 137 of the DoLS applications authorised since April 2019, 108 (79%) were signed/authorised by 7 individuals. The remaining 12 individuals authorised an average of 2.4 each.

DoLS Monitoring & Reporting

The coversheet that accompanies the quarterly Deprivation of Liberty Safeguards (DoLS) update report notes that *"DoLS activity and issue of risks and mitigating factors are addressed within the Safeguarding Governance Framework which includes the Safeguarding Governance and Performance Group, Area/Secondary Care Safeguarding Forums: MH/LD Safeguarding Forum: Consent, Capacity Strategic Working Group; Safeguarding Performance and Governance Group; Quality, Safety and Experience (QSE) and Quality Safety Group(QSG) .*

It adds that the *"Mental Health Act Committee Report on DoLS is shared with these groups".* It is this report that we have focused on when reviewing DoLS Monitoring and Reporting. In conjunction with this, we also reviewed update reports provided to the Quality, Safety and Experience Committee in relation to HASCAS/Ockenden recommendations, where these pertained to areas covered by this review and were presented by the Associate Director of Safeguarding.

The quarterly report produced by the Safeguarding Specialist Practioner/DoLS Manager is comprehensive with details both on DoLS applications received but

also on challenges to Health Board in meeting its obligations.

The Health Board reports data for DoLS applications to the Care Inspectorate Wales (CIW) on an annual basis. We have had sight of the correspondence demonstrating that the return was made in line with the expected due date.

Issues and actions taken

As noted earlier a comprehensive quarterly report is produced by the Safeguarding Specialist Practitioner/DoLS Manager and is presented at the Mental Health Act Committee (MHAC).

We also had sight of an update report which is produced quarterly and presented at the four individual Safeguarding Forums, these being: East, Central, West and Mental Health & Learning Disabilities. We note minutes of these meetings along with that of the MHAC demonstrate discussions arising from the content of the reports presented which reflect the performance and challenges being faced by the DoLS Team.

Whilst conducting the review we also observed that the Health Board Corporate Safeguarding Team produce a quarterly report which is presented at the Quality Safety Group and to the Quality, Safety and Experience Committee (QSE) on a bi-annual basis. This report includes a section dedicated to DoLS and includes details of the number of applications, along with details of cases referred to Court of Protection; further details are provided about work undertaken by the DoLS Team in their capacity representing the Supervisory Body. The significant increase in Court of Protection activity both referencing complexity and demand place a greater demand upon the Supervisory Body. The requirement for legal advice and attendance also places a cost pressure to the service.

The latest copy of this report as presented to the QSE meeting held on the 19th November 2019 also includes a section detailing the monitoring undertaken by the HASCAS Improvement Group. In particular we note the progress against HASCAS12/Ockenden 9, which relates to DoLS are detailed, this includes narrative showing that the implementation date for the recommended actions has been moved back from 2018/19 to March 2020.

We noted that an overarching Safeguarding risk (CRR16) is included in the Corporate Risk Register and that this does detail a list of actions which include a number in relation to DoLS; this includes narrative which records that "*A review of the DoLS Structure and service provision is a priority activity for 2019-20 and a key requirement from HASCAS. An options paper which sets out options for the DoLS team will be presented to QSG in December 2019*". This references risk no 2548 which is included at tier 2 – Directorate risk within the Executive Director of Nursing and Midwifery portfolio.

We were able to review the tier 2 risk in relation to DoLS as included in Datix and note risk 2548 which is specific to DoLS and in addition risk 2780 which has been raised in relation to the impending introduction of LPS and the transition from DoLS and the risks surrounding this.

Whilst acknowledging that these risks have been identified and included in the associated risk registers, it is apparent that there is no mention of the ongoing

compliance risk concerning the submission and processing of DoLS applications within the required timeframe. In addition, it is our understanding that where breaches are occurring these are not being recorded in Datix or subject to reporting.

6.   Summary of Audit Findings

The key findings are reported in the Management Action Plan.

7.   Summary of Recommendations

The audit findings, recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	3	2	-	5

Finding 1 - Lack of local Policy in respect of DoLS (Operating effectiveness)	Risk
There is no published up-to date operational procedure clarifying expectations of departments/wards in their capacity as Managing Authorities. Staff would also benefit from further guidance on timescales / escalation and reporting breaches to ensure ward staff are taking appropriate action.	Staff may be unclear on their responsibilities.
Recommendation	**Priority level**
Supervisory Body. An up to date procedure should be produced and consideration given to short guidance for staff on wards that identifies action they should be taking and clarifies timescales. Staff should then be made aware of new policies / guidance and all published on intranet.	**Medium**
Management Response	**Responsible Officer/ Deadline**
The DoLS Manager will lead and be supported to produce a Standard Operating Procedure (SOP) which will provide additional guidance for staff across the Health Board. Actions, timescales and a rationale for responding to an actual or potential deprivation of a patient. Ratification will take place through the Safeguarding Governance and Reporting Framework; which is the, Safeguarding Performance and Governance Group; Quality, Safety and Experience (QSE) and Quality Safety Group (QSG).	DoLS Team Manager 30th April 2020. Associate Director of safeguarding Full ratification 31st May 2020

Finding 2- Shortage of Best Interest Assessors (BIAs) (Operating effectiveness)	Risk
The lack of BIAs is impacting upon the timescales for DoLS applications. We understand that although an establishment figure of six BIAs was identified with two in each of the three areas across North Wales, the West area still relies on one BIA. With the delays identified from our testing in relation to getting the BIA assessments completed there is a risk to the Health Board that they could be exposed to financial penalties from non-compliance with the requirements of DoLS legislation and that these costs could significantly exceed the costs currently being saved by having a reduced establishment. We do acknowledge however that the impending introduction of LPS should be factored in and future workforce requirements take account of potential changes in working practices.	Health Board could face financial penalties due to DoLS assessments breaching timescales
Recommendation	**Priority level**
Supervisory Body. The funded establishment of BIA is reviewed as a matter of urgency to address the current delay in undertaking DoLS assessments and the pending introduction of the Liberty Protection Safeguards (LPS). The risk of financial penalties arising due to the delays in undertaking DoLS assessments be included, with action planned, in the corporate risk register.	**High**
Management Response	**Responsible Officer/ Deadline**
In the immediate, the DoLS Manager will complete an Establishment Control Form to process the vacant post to be advertised. The post is currently on hold due to the Health Board's budget pressures, however as a result of the recent papers to QSG additional consideration must be given, as all current and new	DoLS Manager 31ST March 2020.

post holders will require new LPS training which has yet to be developed by the universities. The pending development of LPS being implemented in England and Wales has delayed some progress relating to the development of procedures and additional guidance due to the uncertainty and the delay of the publication of guidance. However after receiving training and information in February the DoLS Manager with support has produced a further report to the Quality Safety Group (QSG) to highlight the current demands and organisational risks with current DoLS service provision and the potential impact of LPS cross the Health Board and impact of LPS for the whole workforce and organisation. A further business case highlighting the financial requirements to support the service delivery will be developed as a result of the report and presented to the Finance and Performance Group.	Associate Director, Corporate Safeguarding. 13th March 2020. Associate Director of Safeguarding 31st May 2020

Finding 3 Completion of DoLS paperwork (Operating effectiveness)	Risk
We were provided with access to the database maintained by the DoLS Team and the folders in which all copies of forms and correspondence were held. From our testing we noted the following: • 9/22 of the DoLS applications submitted did not appear to have been accompanied by a copy of the Mental Capacity Assessment.	Issues with completion of DoLS application by wards leading to delays in the DoLS process.

• Only 1/22 DoLS applications submitted appeared to have included a copy of the care plan. Form 1 (P2) specifies that *"A RELEVANT CARE PLAN SHOULD BE ATTACHED".* These findings echo those reported by the Safeguarding Specialist Practitioner/DoLS Manager in the September 2019 (Qtr1) Deprivation of Liberty Safeguards (DoLS) update report where issues with individual applications varied between 35-50% depending on the area submitting them. It is noted that the DoLS Team are challenging the respective services when these occur, however the issue remains relevant and in need of further mitigation.	
Recommendation	**Priority level**
Managing Authority. All wards are reminded of the need to complete DoLS paperwork in an accurate and comprehensive manner in keeping with the stipulated requirements.	**High**
Management Response	**Responsible Officer/ Deadline**
A Safeguarding Bulletin specifically assigned to DoLS will be produced and disseminated. The Safeguarding Ambassadors will also ensure the bulletin is disseminated within their areas and teams. The Managing Authority will develop an audit and assurance process to ensure all DoLS applications are completed accurately and correctly.	DoLS Manager 30th April 2020. Safeguarding Business Unit/ Safeguarding Team Managers May 2020 Directors of Nursing 31st May 2020

The development of a SOP for DoLS should further strengthen the process and to support staff and enhance their awareness of their responsibilities and the actions to be taken to safeguard patients when a deprivation is occurring. (Finding 1) The SOP will be agreed through the existing Safeguarding Governance Framework. The dissemination will include all relevant communication processes used by the Corporate Safeguarding Team. This action directly links to Finding 1 management response above.	DoLS Manager 30th April 2020 Associate Director of Safeguarding 30th April 2020

Finding 4 Lack of engagement from DoLS signatories (Operating effectiveness)	Risk
Whilst there has been significant progress on the part of the DoLS Team in increasing the number of signatories and providing training to these, we noted issues in respect of engagement on the part of those nominated who are yet to be trained and that the majority of DoLS applications authorised in the current year have been signed off by a small number of the pool of potential signatories.	Health Board increasingly reliant on a small number of signatories with the risk that delays will occur.
Recommendation	**Priority level**
Managing Authority. Management should ensure that all nominated signatories attend training and are reminded of their obligations in respect of the DoLS	**Medium**

process.	
Management Response	**Responsible Officer/ Deadline**
The Managing Authority will ensure Authorisers (Signatories) are reminded of their role and responsibilities through the PADR and supervision processes available to them.

The DoLS Manager will include guidance reinforcing their role and responsibilities as authorisers within the Safeguarding Bulletin which is to focus specifically upon DoLS, (as above).

A SOP document will be devised setting out the responsibilities for those who have been approved to authorise a DoLS. This will be signed off through Corporate Safeguarding Governance and Reporting arrangements.(linked to Finding 1) | Directors of Nursing 31st May 2020

DoLS Manager
30th April 2020

DoLS Manager
30th April 2020
Ratified May 2020 |

Finding 5 – Reporting of Breaches through Datix (Operating effectiveness)	**Risk**
We were provided with reports produced from Datix but were unable to identify any specific reporting of breaches by individual wards/departments, within the period under review.	Under reporting of breaches within individual wards/departments.
Recommendation	**Priority level**

Managing Authority. Wards/Departments should undertake a check of DoLS cases and monitoring records within their areas to establish whether breaches are being reported promptly. Managing Authority. Staff should be reminded that all breaches are to be reported via Datix (with appropriate CCS code.)	**High**
Management Response	**Responsible Officer/ Deadline**
The Managing Authority will undertake a random sample of Datix incidents within their responsibility to determine if breeches have been reported. The Managing Authority are to develop and to include an audit of DoLS paperwork and DoLS activities within the current Audit of records and develop a process to cross reference Datix incidents to determine whether breeches have been reported promptly. The management response of developing a SOP identified in Finding 1 and 3 authority are fully aware of their responsibilities and the consequences of breaches of Article 5 (a deprivation of liberty, Human Rights Act '98) and expectations to have in place Datix reporting and notification to the DoLS Team.	Directors of Nursing 30st April 2020 Directors of Nursing 31th May 2020 DoLS Manager, Associate Director of Safeguarding 30th April 2020

Appendix B - Assurance opinion and action plan risk rating
Audit Assurance Ratings

Substantial assurance - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

Reasonable assurance - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

Limited assurance - The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

No assurance - The Board can take **no assurance** that arrangements in place to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Assurance not applicable is given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are **not appropriate** but which are relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

Cyfarfod a dyddiad: Meeting and date:	Quality Safety and Experience Committee 28th August 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Occupational Health and Safety Annual Report 1st April 2019 to 31st March 2020 and Quarter 1 Report.
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Green Executive Director of Workforce and Organisational Development.
Awdur yr Adroddiad Report Author:	Peter Bohan Associate Director of Health Safety and Equality.
Craffu blaenorol: Prior Scrutiny:	N/A
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Committee is asked to:

1. Approve the Occupational Health and Safety (OHS) Annual Report 2019-2020 and Q1 Report
2. Note the position outlined in the report and support the recommendations therein that the OHS team:

- Implement the 3 year OHS Strategy.
- Ensure adequate staffing is available to provide an appropriate H&S security function to BCUHB.
- Develop further policies and safe systems of work to provide evidence of practice.
- Establish monitoring systems to measure performance including clear KPIs.
- Train senior leaders and develop further competence in the workforce at all levels
- Learn lessons from incidents and develop further the risk profile

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

Sefyllfa / Situation:

The report provides information regarding the legal and moral responsibilities in relation to OHS, which requires considerable work and additional steps to progress the shortfalls identified. The 3-year strategy described in last year's report provides BCUHB with the framework to ensure, so far as is reasonably practicable, the working environment is safe for its employees and any other persons who may be affected by its work activities. The overall responsibility for OHS and for the successful implementation of the Occupational Health and Safety Management system and associated policy and guidelines rests with the Chief Executive acting through the respective Executive Directors, Area Directors, Assistant Directors, Managing Directors, Managers and Heads of Service. The report identifies issues to be addressed and provides recommendations on its findings.

The annual report has identified that the BCUHB Health and Safety (H&S) Strategic approach requires considerable work. The 3-year strategy produced last year embraces the concepts of sensible OHS by ensuring control measures are proportionate to risk. Awareness will be key to ensuring that staff can deliver on their service priorities whilst ensuring risks are managed in a sensible, proportionate and legally compliant way. BCUHB is committed to take all practicable steps, consistent with the provision of health care services, to safeguard its patients, visitors and staff from injury or ill health whilst on the premises. The H&S Policy has been developed to provide healthy and safe working conditions for all staff and to abide by and satisfy the requirements of the Health and Safety at Work etc. Act 1974 and the Corporate Manslaughter and Corporate Homicide Act 2007. The Policy stipulates the objectives of the Board will be to:

- Observe in full the legislation relating to the H&S of employees at work
- Cause this to be observed by its employees at all levels
- Ensure adequate education and training for this purpose
- Ensure that any accidents occurring, however minor, are fully recorded, investigated, and where necessary, reported to the Health and Safety Executive (HSE)

To achieve the provision of the proper facilities for patients, whilst ensuring that personal injuries and hazards to the health of staff and others are reduced to the minimum, management and staff must work together with a view to achieving a safe working environment. BCUHB will therefore, expect all staff to exercise responsibilities to maintain healthy and safe working conditions by:

- Taking reasonable care for their own H&S and that of others who may be affected by their acts or omissions.
- Co-operating as far as is necessary with their employer to enable BCUHB to carry out its duties laid down under the Health and Safety at Work etc. Act 1974
- Fully using all the safety equipment, devices and protective clothing provided
- Helping in the formulation of and adherence to safety procedures and safety policies

Cefndir / Background:

The gap analysis undertaken in September 2019 identified significant areas of concern in the management of OHS within BCUHB. The OHS Team have developed a comprehensive action plan to identify and mitigate the risks identified. The action plan includes key areas of risk including, contractor management and control, work at height, vibration and noise, asbestos, legionella water safety, driver safety, security, violence and aggression (V&A), fire, electrical safety, manual handling and incident reporting procedures to ensure when things do go wrong we learn lessons. The OH&S Policy is a key element of implementing a safety management system.

Asesiad / Assessment & Analysis

Successful implementation of the OHS Policy will lead to a range of benefits. These include improved infrastructure, compliance with the law, staff support systems for recording and tracking contractors, physical security of buildings and assets. In addition, this leads to an improvement in morale and the perception of investment in the safety and security of the workforce, which with appropriate relevant training and acknowledgment, would result in reduction of risks and subsequent reduction in staff ill health conditions arising as a result of their work activity. Benefits and improvements will be measured via the improvement governance structure underpinning the gap analysis work.

Strategy Implications
BCUHB will be required to implement the OHS 3-year Strategy that focussed on identifying and wherever practicable eliminating or minimising hazards based on the HSE Safety Management System HSG65 and principles of Plan, Do, Check, Act. The process described in the Policy will not only help to reduce the likelihood of accidents and ill health. It will also help to improve time for staff to give care to patients, help to reduce financial waste and will help to improve the quality of care and quality outcomes given to clinical services and non-clinical support services. The 3-year plan is based upon credible data from a variety of sources to identify the need for change. Similarly, quality improvement methodology will be utilised to enable change.

Financial Implications
There are significant budgetary implications, which are currently not funded. A business case has been produced and shared with the relevant Executive Directors. The major financial implications include staffing for Security and Health and Safety Training packages include the Institute of Occupational Health (IOSH) Director and Managing Safely programmes. Estates related software includes MiCad for schematic drawings of the estate and Sypol for Control of Substances Hazardous to Health, re-surveys of premises for asbestos, implementation of risk assessment findings for fire and compartmentation and health surveillance systems for staff.

Risk Analysis
The significant risks have been escalated to Tier 1 on the risk register and were previously agreed by QSE. These include Leadership of OHS, Security, Contractor Management and Control, Asbestos, Legionella and Fire Safety. All risks have mitigation plans, but require investment. A business compliance case has been produced to support the implementation of the control measures. The risks are scored as 20. Additional risks identified since COVID-19 pandemic include:-
- Gap analysis action plan work required has been delayed due to COVID-19
- Security compliance limited with staffing available within the Team
- Social distancing may not be compliant in all service areas
- HSE take legal action as a result of failure in compliance

1. Executive Summary

The Annual Health & Safety (H&S) report aims to give an overview of the key areas of concern and progress made in compliance with H&S legislation across BCUHB during the period 1st April 2019 to the 31st March 2020. In addition, it includes the significant amount of work undertaken by the Health and Safety Team during the Covid-19 Pandemic (Quarter 1), which has resulted in the action plan for H&S being deferred. This is due to the volume of reactive work required in response to COVID-19 as well as changes to HSE criteria for reporting RIDDORs. The Board is now better informed in relation to legal compliance, setting clear goals, risk identification/management and further developing a pro-active occupational health and safety culture. The report outlines considerable work required for improvement to ensure and maintaining the occupational health, safety and wellbeing of its employees, the public, visitors, patients, contractors and volunteers who use our services.

2. Introduction

This report is produced to inform the QSE Committee and Health Board of the previous year's progress and Q1 report. Considerable work and progress has been made during the year on the gap analysis work undertaken by the H&S Team and development made towards meeting the Health Board's statutory obligations for H&S. However, due to the COVID-19 pandemic, the gains

made have been halted and the information provides limited assurance on safety management systems that have pro-actively controlled all risks identified. A focus on security and H&S is required to establish further the three year improvement strategy along with an appraisal of achievements to date and future priorities.

3. Background

All organisations have statutory duties to ensure suitable arrangements are put in place to manage H&S effectively that should form an integral part of workplace behaviours and attitudes. This report identifies the additional work and evaluation required to ensure the planning, organising and monitoring of the organisation's compliance with statutory health and safety obligations and duties can be clearly evidenced.

Over the past year the gap analysis, undertaken over a 6 week period from 17th June to 31st July 2019 by the H&S Team, OH, V&A Case Manager and Manual Handling Manager, analysed 31 pieces of Occupational Health and Safety (OHS) legislation. This included undertaking 117 site specific inspections including Acute, Mental Health Community Services GP and Wrexham HMP. The OHS team had significant support from our trade union partners, who visited a significant number of gap analysis reviews with the Team. The process has been further evaluated by Internal Audit who will provide a report on its findings to ensure that the systematic and fair evaluation had taken place. There was significant support from a number of key staff, with good practice being evidenced in Wards and Departments that had taken on the advice of the OHS Team, or had developed their own safety systems.

The audits identified that 15 pieces of legislation are deemed to be non-compliant, 13 partially compliant and 3 fully compliant. The overall impression of safety management systems was that OHS performance had become fragmented, with central control taking responsibility from sites, and limited overall evidence of training, good quality risk assessments and safety management systems being implemented. Clear lines of responsibility and accountability are not being evidenced in a number of service areas. There is serious concern over the management of key areas of the business including H&S training and level of competence, asbestos management, legionella, contractor management and control, stress management, permits to work systems, work at height, manual handling and control of substances hazardous to health.

The lack of structure and systems poses risk of serious harm to individuals who work for the Health Board and others who may be affected by its work activities. The risk leaves the Health Board open to enforcement action, prosecution and fines for the most serious offences. A fundamental shift in the safety culture is needed to improve safety outcomes for staff, visitors, patients, contractors and volunteers. This report provides a clear plan and framework for action to firstly identify hazards and place suitable controls in place; this will require appropriate funding and a determined effort to focus on the changes required.

4. Key issues to note

- The information provided below is a summary of the range of incidents reported; this includes a large number of slips, trips and falls, 38 reported through RIDDOR which correlate with the number of reported incidents of 307. The number of sharps incidents reported on all incidents was 383. The 2 RIDDOR sharps incidents occurred when staff were exposed to HIV, Hep B or Hep C. 20 RIDDOR incidents relate to abuse by patients, which were attributable to a major injury or staff member being off work for over 7 days. A root cause analysis has been

undertaken to identify the range and type of RIDDOR incidents to ensure lessons are learned across the organisation. Compared to 2018-2019 the number of RIDDORs have increased slightly from 97 to 110. There has been an increase in abuse of staff from patients from 15 to 20 and injury caused by physical or mental strain increased from 9 to 19. There were 2 other incidents recorded in 2019 involving environmental factors that do not appear in 2019-2020.

- Effective security provision within BCUHB remains a significant challenge as reflected by its recording within the risk register. Roles and responsibilities for service providers as well as individual job roles require clarification, however progress has been made with the development of a Business Case, which identifies those areas of concern and proposes new roles and strategies to address those concerns. Progress was made by the increase of security guard hours within District General Hospitals, supplied by external contract arrangements during the COVID-19 pandemic.

- During the period 2019 - 2020 there were 3,983 incidents of violence & aggression recorded on the Datix system; there were 3,752 incidents the previous year, an increase of 231 cases. In the period 1st April 2019 - 31st March 2020 there were 2,257 incidents classed as "affecting staff", this appears to be an increasing trend as there were 2,175 incidents the previous year and 1,776 incidents during 2017/18. Of these, 1,114 resulted in a personal injury (992 previous year) with 719 injuries affecting staff (655 previous year) and 20 RIDDORs were reported compared to 18 in the previous year. Communicating a patient's past behaviour in relation to violent/threatening incidents is fundamental to reducing the risk of further violence. Early identification and communication of this risk should assist in measures being taken to enhance safety. Work in this area has remained static over several years due to compatibility issues experienced with the electronic note system. There continues to be no BCUHB Violence & Aggression Alert system in place.

- Occupational Health & Wellbeing has focused on undertaking a gap analysis across areas of BCUHB, focusing on: sharps incidents, health surveillance, latex, wellbeing & flu. Following on from this all clinical examination gloves have now changed to non-latex. Hand arm vibration was reviewed and policies for health surveillance and latex were revised. Areas with high levels of musculoskeletal disorders and stress were visited and bespoke recommendations put in place to support these teams. Mindful movement sessions were trialed and introduced as part of manual handling training long term. 27 sessions on 'How to create wellbeing in the workplace' were held with 363 managers in attendance. A three pronged approach for training was implemented, focusing on stress management for staff, stress management for managers and finally mental wellbeing champions. The number of Mental Wellbeing Champions increased this year by 100 to 300 in total. On World Mental Health Day, a conference on suicide prevention and awareness was held. A partnership approach to training was adopted for the all Wales attendance management training with 64 sessions delivered at which 1,386 (76%) of managers attended. The service led a piece of work to update pre-employment questionnaires on an all Wales basis, allowing efficiencies with application of a self-declaration process. The service was part of the team who were awarded the Disability Confident Leader. In the 2019/20 flu season the Health Board administered a record number of flu jabs totaling 10,068 (57.82% in direct patient care staff) and was awarded the 'Beat Flu Team Award'. The service has commenced working towards the national accreditation for Occupational Health to attain the Safe Effective Quality Occupational Health Standards (SEQOHS). In the last quarter, seven staff wellbeing strategy workshops were conducted as part of joint conversation events to consider ways of enhanced health and wellbeing. This later quarter was also dominated by implementing advice, support and testing arrangements for staff presenting with COVID-19. A

full report will be provided describing the significant work Occupational Health have undertaken over the past 15 months.

5. Gap Analysis of legislation

During 2019-2020 an improvement plan was developed linked to a complete review of the UK Occupational Health and Safety legislative framework. The gap analysis was conducted in June 2019 for 4 weeks, using 31 pieces of legislation and over 180 questions, evaluated current performance across the organisation and evaluated 117 departments or sites for compliance. The focus was on evidence identified on site of key pieces of legislation which include asbestos, legionella, Control of Substance Hazardous to Health (COSHH), stress, sharps, work at height, RIDDOR and workplace regulations. The key areas of concern identified included:-

- Contractor management and control including recording and induction process
- Asbestos management requiring an action plan to address shortfalls in system
- Work at height permit to work system for a variety of services
- Legionella management and control systems actions on risk assessment
- COSHH risk assessment including latex management and control
- Training for all levels of staff required on H&S Management
- Union representatives and H&S Leads provision
- Stress management systems and mental health support
- Manual handling musculoskeletal disorders
- Fire safety, risk assessment and evacuation
- Vibration monitoring and control
- Noise assessment and control
- Clear lines of responsibility in relation to building management and control
- Vehicle/Driver safety
- Lone Working systems and management
- Security provision in all service areas

A comprehensive action plan is in place to address these concerns, however the COVID-19 pandemic has unfortunately paused its progress, however a workshop is planned for August to realign Occupational Health and Safety action plans. An update of progress up to the end of March 2020 is available in Section 11 of this report. The timescales for completion will be updated as part of the Business as Usual planning in Q2.

6. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

This set of regulations commonly referred to as the RIDDOR regulations require employers and other people in charge of work premises to report and keep records of work-related accidents. This includes those that lead to death, work-related accidents which cause certain serious injuries (major injuries), work related accidents resulting in over seven day absences, diagnosed cases of certain industrial diseases and certain 'dangerous occurrences' (incidents with the potential to cause harm).

The information provided below is a summary of the range of incidents reported; this has included a large number of slips, trips and falls with 38 of these being reported through RIDDOR, which correlate with the number of reported incidents of 307 across all service areas. The number of sharps incidents reported on all incidents was 383 with only 2 RIDDOR sharps incidents occurred when staff where exposed to HIV, Hep B or Hep C. 13 RIDDOR incidents relate to abuse by

patients and was attributable to a major injury or staff member being off work for over 7 days. A root cause analysis has been undertaken to identify the range and type of RIDDOR incidents to ensure lessons are learned across the Board.

Compared to 2018-2019 the number of RIDDORs have increased slightly from 97 to 110. There has been an increase in abuse of staff from patients from 15 to 20 and injury caused by physical or mental strain has increased from 9 to 19. There were 2 other incidents recorded in 2019 Environmental factors that do not appear in 2019-2020.

Annual RIDDOR Information April 1st 2019- March 31st 2020

	BCUHB Central	BCUHB East	BCUHB West	Total
Abuse etc of Staff by patients	5	7	8	20
Accident caused by some other means	7	4	2	13
Exposure to electricity, hazardous substance, infection etc	1	1	1	3
Implementation of care or ongoing monitoring - other	0	1	0	1
Infrastructure or resources - other	0	1	0	1
Injury caused by physical or mental strain	10	4	5	19
Lack of/delayed availability of facilities/equipment/supplies	0	1	0	1
Lifting accidents	7	4	1	12
Needlestick injury or other incident connected with Sharps	1	1	0	2
Slips, trips, falls and collisions	10	12	16	38
Total	41	36	33	110

Incidents by Action taken codes and Region	BCUHB Central	BCUHB East	BCUHB West	Total
Staff Awareness Raised	14	7	14	35
Risk Assessment Carried Out/Reviewed	6	9	8	23
Root Cause Analysis Carried Out	7	2	13	22
Communicated with Relevant Stakeholders	8	9	4	21
Review Undertaken	7	6	6	19
Total	42	33	45	120

The top 5 actions taken to control the risks associated with RIDDOR incidents include staff awareness raised (35), risk assessment carried out (23), root cause analysis (RCA) carried out (22). This is a significant improvement on last year, when limited risk assessments or RCAs were undertaken. There was also communication with relevant stakeholders (21) and review undertaken (19). The reason there are more actions than RIDDOR incidents is due to more than one action within one RIDDOR report. A review of RCAs was carried out by the Corporate Health and Safety team as part of the Gap Analysis work. It was identified that emphasis and investigation focused more on patient incidents and injuries within the organisation than on staff related incidents and injuries. The quality of the RCAs carried out were generally poor, which affected identification of lessons learnt. Closer scrutiny of RIDDORs is required and work continues to improve the RCA process and provide investigation training in order to improve overall safety within BCUHB.

6.1 Incidents - BCUHB staff 2019-2020

The overall incidents to staff have reduced from 1,457 to 1,410 over the past 12 months, which is encouraging. However, the number of incidents related to sharps (affecting staff) was 383

compared to 373 in 2018-2019. Compliance with sharps legislation was reviewed as part of the gap analysis review. The review identified that 18 teams had poor compliance, scoring less than 65% and indicative of high risk, which requires immediate mitigation or escalation. 6 teams had a score between 65% and 84%, with significant but lower level of risk requiring planning for mitigation or escalation. No teams had a compliance score greater than 85%

All service areas completed the self-audit tool. In addition, site visits were undertaken in the Emergency Departments and Theatres. The key outcome of the audit concluded that not all the specialist safety devices procured were in use. Support and advice has been provided, and further work is planned. The OH Department commenced an awareness campaign to look to reduce sharps incidents which involved distribution of a pack to managers and local dialogue with key service leads.

The second largest area was accidents caused by other means. This identified a reduction from 426 in 2018-2019 to 378 in 2019-2020. These types of incidents ranged from cut finger on tap whilst turning off, curtain rail fell on staff member, knocked knee on bedside handle, caught arm on boxed files which were sticking out in the filing room. Slips, trips and falls accounted for 307 compared to 317 in 2018-2019. Injury caused by physical or mental strain has also decreased from 174 in 28-2019 to 153 in 2019-2020.

Incidents by Detail and Region	BCUHB Central	BCUHB East	BCUHB West	Total
Accident caused by some other means	125	134	119	378
Exposure to electricity, hazardous substance, infection etc	47	43	35	125
Injury caused by physical or mental strain	62	51	40	153
Lifting accidents	35	21	8	64
Needlestick injury or other incident connected with Sharps	139	119	125	383
Slips, trips, falls and collisions	97	105	105	307
Total	505	473	432	1410

7. Risk Register relating to Occupational Health and Safety

The risk register has the top H&S risks at tier 1 which include Fire Safety, Security, Contractor Management and control, Electrical Safety, Legionella and asbestos management. A comprehensive action plan requires implementation with the required funding to ensure that the risks are effectively mitigated.

8. Security

Effective security provision within BCUHB remains a significant challenge as reflected by its scoring within the risk register. Roles and responsibilities for service providers as well as individual job roles are unclear, however progress has been made with the development of a Business Case, which identifies and proposed strategies to address those concerns. More progress was made by the increasing of security guard hours within District General Hospitals supplied by external contract arrangements.

8.1 Reported incidents of Violence/Aggression

During the period 1st April 2019 - 31st March 2020 there were 3,983 incidents of violence & aggression recorded on the Datix system; there were 3,752 incidents the previous year.

When separated by category there were 28 incidents of verbal abuse, 1680 incidents of aggressive behaviour, 939 incidents of assault and 225 incidents of threatening behaviour. 778 incidents were recorded as 'other and unreported'.

When incidents have been separated by result, there were 1114 incidents that resulted in personal injury, 2139 resulting in no injury or harm, 570 near miss with intervention and 106 near miss with no intervention. 49 also were reported to have led to damage to property or equipment.

In the period 1st April 2019 - 31st March 2020 there were 2,257 incidents classed as "affecting staff", this appears to be an increasing trend as there were 2,175 incidents the previous year and 1,776 incidents the year 2017/18. Of these, 1,114 resulted in a personal injury (992 previous year) with 719 injuries effecting staff (655 previous year) and 22 RIDDORs were reported compared to 18 in the previous year. 157 Incidents indicate that police were called.

8.2 Obligatory Responses to Violence in Healthcare

The Obligatory Responses to Violence in Healthcare status was due to be enhanced by the issue of a Welsh Health Circular during 2019 supported by welsh Government. This has been delayed due to Brexit & COVID-19 pandemic. The team have engaged with North Wales Police to deliver information sessions in relation to the Obligatory Responses to Violence in Healthcare process with a total of 207 police staff attending. This has had a positive effect with police staff advising ward/clinical staff of their obligations in respect to the Obligatory responses to Violence in Healthcare process.

The Obligatory Responses to Violence in Healthcare process has significant positive impact upon those incidents in which persons with mental health issues engage in violence towards staff. There are continued attempts by V&A Case Management to highlight the need for engagement within those areas which are volume generators of violent incidents where staff are victims. Information is now posted upon the Health Board's intranet system and automated links have been set up within the Datix incident reporting system in an attempt to signpost staff to support when required and it was hoped that brief information would be supplied during V&A training from April 2020. (This has been delayed due to the COVID19 pandemic)

8.3 Personal Safety Markers

Communicating a patient's past behaviour in relation to violent/threatening incidents is fundamental to reducing the risk of further violence. To this end, the aim of a personal safety marker is to assist in early alerting of individuals who pose a risk of violence towards BCUHB employees. Early identification and communication of this risk should assist in measures being taken to enhance safety. A BCUHB Working Group, chaired by Informatics Head of Clinical Systems, has been established, to explore the possibility of Personal Safety Markers (& Alerts/Allergies) being established across the Health Board using the electronic patient record systems. The Personal Safety Marker (for Violence/Aggression) is yet to be adopted, largely due to infrastructure and compatibility issues surrounding the electronic patient note system. Work in this area has remained static over several years due to the compatibility issues experienced by the electronic note system. There continues to be no BCUHB Violence & Aggression Alert system in place.

8.4 Changes in Legislation

The Welsh Government continues to review section 119 & 120 of the Criminal Justice and Immigration Act 2008, which makes causing a nuisance or disturbance on NHS property an offence and gives powers of removal using reasonable force to NHS employees. This may have training implications for BCUHB staff and potentially contracted security staff. Assaults on Emergency Workers (Offences) Bill 2017-19 has now received Royal Assent. This has effectively doubled the maximum sentencing length for common assault from 6 months to 12 months if perpetrated against emergency workers.

8.5 Policy/Procedure development/reviews

BCUHB procedure HS02 Procedure & Guidance Protecting Employees from Violence and Aggression is currently under review. The CCTV and Security policies have been drafted and were due to be presented to the Strategic Occupational Health & Safety Group. This had been delayed due to the COVID-19 pandemic.

9. Health & Safety Training 2019-2020

The Corporate Health and Safety Team undertake a variety of internal training. Within the last year the following courses ran with attendance as follows:-

Training April 2019-March 2020	East	Central	West	Number of Sessions	Number of Attendees
Managing Safely					
No of Sessions	6	6	7	**20**	
No of attendees	42	53	78		**173**
Combined Risk Assessment & COSHH					
No of Sessions	2	0	1	**3**	
No of attendees	12	0	5		**17**
RIDDOR Awareness					
No of Sessions	0	0	0	**0**	
No of attendees	0	0	0		**0**
			Total	**23**	
			Total		**190**

Course Subject	Number of sessions	Number of staff trained	Number of Cancelled Sessions
Managing Safely 2 Day Course	**20**	**173**	**8**
Risk Assessment & COSHH ½ Day	**3**	**17**	**3**
RIDDOR Awareness Training 1 ½ hrs	**0**	**0**	**6**
Total	**23**	**190**	**16**

It has become evident that registration numbers are often low and sessions are cancelled when there are 8 delegates or less. When sessions were facilitated for specified areas, the attendance has improved.

COSHH Safety Training had 17 staff attend in total, 12 staff in East and 5 from West, with 3 COSHH classes being attended, 2 in the East and 1 in the West, 8 were cancelled of which 4 were due to COVID-19 training restrictions. 5 of the 2 day Managing Safety classes were cancelled in 2020: 2 in February and 3 in March. The number of attendees in total was 173 with 20 DNAs. All RIDDOR courses were cancelled due to lack of attendance in 2019-2020. The main focus of the H&S Team was to review the gap analysis work this year plus staff were unable to be released to attend safety courses. A revised course focusing on risk assessment will be launched in 2021.

10. Manual Handling Annual Report 2019 – 2020

During this period, the Manual Handling Team has provided and supported training for both BCUHB employees and external staff, including students from the local universities (Level 1 & 2 Manual Handing, along with Modules B & C in Violence & Aggression). The following figures identify the volume of work achieved by the team, which include:-

- 1,768 in Level 2 Manual Handling Classroom Refresher
- 658 Level 2 Manual Handling Competency
- 50 sessions for orientation, offering up to 1,000 places annually
- 1,600 Students from Bangor and Glyndwr Universities
- 750 Competencies completed by Manual Handling Champions
- 74 Champions completed Level 2 Champion 2 Day Training
- 864 Level 1 Manual Handling through Mandatory Training Days
- 1,222 Modules B&C in Violence & Aggression Refresher

During 2019-2020 it was identified that a review of training for all staff for Manual Handling and Violence & Aggression training was required. The review identified that 10,358 staff require Level 2 Manual Handling every two years, which equates to 432 per month. A further 13,753 employees require Module B Violence & Aggression every two years, equating to 573 per month. The amount of training the team of 4.5 staff can deliver is 360 places for each subject every month, not accounting for Champions and their Manual Handling competencies submitted. The gap analysis identified that Violence & Aggression had the highest DNA rate of all courses offered at 30%, this results in less availability for other staff members and poor use of resources. A review of how the training can be streamlined has been undertaken with additional e-learning and videos, however this does not eliminate face to face training which is required for practical application of techniques. A review by the Manual Handling Manager raised concerns over the accreditation in the training delivered by the Team. A number of members of the Team do not have the accreditation required to deliver quality assured training. Recommendations for external training for the Team remains outstanding and placed on the Risk Register, and is within the business case raised in March 2020.

Currently there are 121 Manual Handling Champions across BCUHB, who aid in ensuring high standards are maintained in manual handling after an attendee has left the classroom. The Champions have supported manual handing in the workplace for a total of 750 staff this year. As part of the gap analysis action plan, we are looking to ensure a ratio of one Champion per 10 members of staff in each area requiring Level 2 Manual Handling. Work has been undertaken by the department to ensure Champions have an increased knowledge on legislation and how to implement the principles of Task, Individual Load and Environment in the workplace. This year we a bespoke Porters Champions course has been developed for Estates & Facilities, which we are hoping to implement in 2020.

Work continues with the Manual Handling Action Plan to update Manual Handling and Larger Patient Handling Policies. Liaison with the All Wales Manual Handling Group ensures that the Manual Handling Passport is utilised to guide the framework of these policies.

The Team have undertaken 229 Ergonomic Risk Assessments, with some rescheduled due to COVID-19 restrictions. Approximately 75% of the assessments are for staff experiencing difficulty with their workstation or requiring equipment for the sedentary work undertaken. The Advisors also provide assessments to staff returning to work following a musculoskeletal disorder or injuries. They also provide advice to patients in hospital or their own home, along with supporting bariatric patients as required.

In the reporting period, 59 Datix incidents were received relating to Manual Handling all of which were followed up to ensure training issues are dealt with and risk of reoccurrence and injury reduced.

A number of deep dives have taken place in the mortuary to reduce the risk of musculoskeletal disorders with further work being undertaken in Radiology to offer advice, along with possible changes to practice and reduce high numbers of sickness absences due to musculoskeletal injuries.

11. Progress of H&S in Service areas

The H&S Team is looking to support and address the shortfalls identified in the gap analysis, which include the review of the continued progress made in relation to BCUHB's compliance with a significant number of Policies. These include the Work at Height Policy and Procedure which addresses high risk areas such as Scaffolding, Ladders, Step Ladders, Mobile Elevated Working Platforms (MEWPs) and Trestles Procedure and the identification, management and implementation of a 'Permit to Work' system for fragile roofs. To support lower risk working at height activities, a 'working at height' risk assessment template was developed together with a guidance for the use of stepladders and kick-stools.
The current Noise at Work Regulations Procedure was revised and a draft Noise at Work Regulations Policy was developed and forwarded to services for consultation, with the aim of ratification by the Health Board in Q1 2020. The Corporate H&S Team also carried out compliance reviews to the Occupational Health (Noise) Exposure Regulations 2019, on services such as Operational Estates, Postural Mobility Engineering and Facilities. Work is underway by the Corporate H&S Team in the review of the current Provision and Use of Work Equipment Procedure and Guidance, working closely with services such as Operational Estates and EBME on the development of an effective policy.

The Corporate H&S Team supported BCUHB's Environmental Officers in their implementation and audit of IS0 14001 and their review of the current Waste Management Policy. The Team also undertook work to support the development of BCUHB's Environmental and Sustainability Strategy. The Team worked closely with Radiology on BCUHB's compliance to The Ionising Radiation Regulations 2017 (IRR17) and supports the overarching and local Radiation Protection Committees which monitor compliance to the Radiation Protection Policy (RP1). Together with Trade Union Partners, the Corporate H&S Team identified all the Safety Representatives within the organisation, and established a Safety Representatives Forum which meets bimonthly to support and ensure close partnership working on all aspects of health and safety. Research was undertaken into the development of 'health and safety champions' and of the benefit that this role may have to the health, safety and welfare of staff within the organisation.

A review of BCUHB's compliance to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) was undertaken. Recommendations to improve BCUHB's compliance to the statutory reporting timescales and the Root Cause Analysis process have been provided to the Board, to ensure timely investigations and the identification of 'lessons learnt'.

A full schedule of Asbestos re-inspection surveys was completed. The Permit to Work system has been trialled and is now in place and the updated Asbestos Registers have been delivered to all sites. The team are supporting the Asbestos Manager with the review of the Asbestos Management Policy and have attended meetings to discuss the purchasing of a Micad system where asbestos records can be held.

A list of staff / teams that are at risk from vibration related injuries has been developed, and staff referred to Occupational Health for Health Surveillance. The H&S team have worked with the Occupational Health team to agree the Health Surveillance program for exposure to vibration and this has been incorporated into the Health Surveillance policy. The Corporate H&S risk assessment template has been circulated and all managers have been supported with writing these. The team have worked closely with ASL Consultancy and HAVi to establish accurate vibration and noise measurements for relevant departments with support as well as from the Estates teams.

The H&S team supported Estates with the purchase of a COSHH management system and have attended demonstrations on the system with Estates. The lead for Infection, Prevention and Control completed an SBAR in relation to face fit testing and the COSHH policy will need to be updated to reflect the agreed procedure for this going forward.

Collaborative work is being undertaken by the H&S team with Occupational Health to review DSE procedures and a new procedure for return to work has been completed. The roles of the manual handling team, health and safety team and occupational team have been clarified in a procedure for managers to support staff with DSE issues or returning to work. A DSE newsletter was circulated in 2019 and a further Ergonomic newsletter had been completed. A flow chart for ordering new and replacement equipment has been completed and work was undertaken with the Procurement team to identify a new standard office chair to ensure safe and consistent purchasing is undertaken.

A policy has been drafted for the Construction (Design and Management) (CDM) Regulations 2015. The policy aims to raise awareness and provide guidance on correct management for all services commissioning or undertaking construction work. Awareness and procedures are varied; Capital Planning and Operational Estates have the greatest awareness and procedures which fit well with CDM, and meetings have been held with Estates, Capital Planning and Informatics to establish position and advise of requirements. CDM assurance has been reviewed for Capital Planning and built into project management in a more visible way, with active audit of sites by a third party (Lucion Services), copies of reports received by H&S and Capital Planning. Assurance and demonstration of this has been witnessed through the Enfys projects and Substance Misuse Service refurbishment projects. H&S Advisors are now included as an essential part of planning, design and construction project management.

The Corporate H&S Team have reviewed the Policy for the Management of Safe Water Systems and Procedure in line with HSE Approved Code of Practice L8 – "Legionnaire's Disease – the

control of legionella bacteria in water systems", and are also now attending the Water Safety Group. While the Policy and Procedure are robust and require only minor updates (comments have been submitted to Estates) there are risks associated with poor representation at the Water Safety Group. The Chair has written to group members to emphasise the importance of correct representation at this group. This has also been highlighted on the Corporate risk register as a concern.

The Control of Contractors (CofC) review has previously had a draft procedure presented to the Senior Estates Officers during one of the group meetings. At the time it was identified that at least 3 full time equivalent posts may be needed to administer the system. Cloud based software programmes are available, some used by other NHS trusts, that provide document control, induction information, site specific information and booking-in controls, and on site mock demonstrations of these systems have been presented to managers. If this type of system was introduced it will provide a level of assurance to the board that any current or proposed manual system could never achieve based on our topographical layout.

The Driving at Work Policy has been reviewed and a draft risk assessment relating to deliveries and unloading areas is being reviewed prior to implementation. Meetings were held with colleagues from Expenses, Lease vehicles (Shared Services) and pool car users to ensure all aspects of the policy can be implemented and to identify shortfalls. This includes enquiring if the current expenses company Selenity have the facility to control the 'Duty of Care' process (which is currently in place for expenses and lease car holders) to include pool car users as they are the risk group and account for over 5 million of our business miles each year. There is a draft All Wales Driving at Work policy and this needs to be followed up further. One large piece of work is to identify the location / owner of every pool car and the division / function responsible within BCU as this was, at the time, unknown but work has continued.

12. Health & Safety Reviews & Safety Leads.

The Safety Leads group continues to meet throughout the year. This group has been well attended and has proved to be an essential way of communicating messages as well as identifying where improvements have or need to be made across the Occupational Health and Safety system. For the 2019-2020 year, a decision was made to put the health and safety reviews on hold to allow time to concentrate on undertaking the comprehensive review of BCUHB's compliance with legislation. The Occupational Health and Safety team used time in May and June to prepare for the gap analysis work and then undertook 117 visits in June and July. These are broken down as follows:

Health and Safety East	Health and Safety Central	Health and Safety West	Manual Handling (all BCUHB)	Occupational Health (all BCUHB	Violence and Aggression (all BCUHB)	Total
14	15	16	31	24	15	117

The reports from these were then used to provide comprehensive qualitative and quantitative information for an overarching report to the Board. An action plan was then created with each of the advisors being allocated with work streams.

In January 2020, the questions for the 2020/21 health and safety reviews were updated and discussed with the Health and Safety Leads, and the guidance document was updated. The intention was to commence the 2020/21 Corporate Health and Safety Self-Assessment Reviews in April 2020. This has been deferred due to COVID-19.

13. Previous HSE regulatory input April 1st 2019- 31st March 2020

A RIDDOR report for Vibration White Finger (VWF) in the mortuary resulted in a visit by an HSE inspector in September 2019 who reviewed VWF, the inspector was happy with the arrangements and action plan implemented, and no fee for Intervention or charge was incurred. A boiler explosion resulted in a HSE investigation and action plan implemented. There have been no formal notices served by the HSE in the year 2019/2020. A Change in RIDDOR reporting to include COVID-19 as an occupational disease and dangerous occurrence has resulted in a number of clusters and individual occupational diseases being reported after April 8th. Further details will be captured in the Q1 report.

14. Quarter 1 report (1st April 2020 – 30th June 2020) COVID-19 related work

14.1 Gap Analysis Action Plan

Although this work has been put on hold during the COVID-19 pandemic, there are some updates against the action plan. The Estates team have progressed the ordering of the HAVi total system and vibration monitoring equipment to ensure staff work within safe vibration limits. Work has also started on reviewing the Control of Vibration policy and the Driving for Work policy.

14.2 Corporate Health and Safety team site visits

The intention was to commence the 2020/21 Corporate Health and Safety Reviews in April 2020. With the onset of the Coronavirus (COVID-19) pandemic in March 2020 and the subsequent government advice to 'stay at home' on the 23rd of March 2020, the Corporate H&S reviews were placed on hold. From the end of March, onsite visits were only undertaken where necessary, and generally focused on the temporary hospitals. This gradually changed with 14 BCUHB site visits undertaken in May. On the 1st of June the Welsh Government advice was changed to 'stay local' and this allowed the Corporate H&S team to start undertaking further site visits to support with the 'social distancing and staying safe' program. In June, the H&S team undertook 42 site visits and these were either at the request of departments to provide managers with support or to assist with Health and Safety investigations.

14.3 Health and Safety Frequently Asked Questions (FAQs) and supporting guidance documents

It was recognised in Mid-March that guidance documents were required to support BCUHB managers and staff. These documents were not limited to staff who were still working on site or out in the community, but also included guidance documents for staff who were now working from home. The FAQs were put together to provide a single resource for managers to obtain links to these guidance documents, risk assessments or other information. The first FAQs were published on the 27th of March and to date there have been eleven versions with updated information. Twenty short guidance documents have been written on varying subjects, including portable DSE guidance and general guidance for social distancing and staying safe.

14.4 Staff at increased health risk assessment

The first BCUHB risk assessment template for staff noted to be at an increased health risk was available from the 25th of March. This included the health conditions that the Government had advised place people at higher risk if they also then contracted COVID-19. This was slightly modified on the 20th of April following new information from the Welsh Government. The H&S team have supported all managers who have requested help with completing this risk assessment. On Friday 1st of May, the Welsh Government issued a risk assessment tool for staff from Black, Asian and Minority Ethnic (BAME) backgrounds. The Corporate Health and Safety team have played a key role in the team responsible for ensuring that this risk assessment was completed. Guidance documents have been written to support managers with controls to consider for the completion of the risk assessment and workshops were held via Skype to train the staff identified as leads for this risk assessment.

This risk assessment has been further developed and is now called the Welsh Government Workforce Assessment Tool with the intention for all staff to have completed this. The H&S team remain proactively involved with the development of additional guidance documents and the Q2 report will reflect the work undertaken to support managers for staff who are shielding when the restrictions lift on the 16th of August (1st of August for England).

14.5 Collaboration with Health and Safety Trade Union (TU) representatives

The H&S team have had daily Skype team meetings from early April and the Wednesday meeting was extended to H&S TU representatives. These meetings have been an opportunity for the communication of information between the trade unions and the H&S team. Guidance documents have been shared for comments before circulating and the FAQs were updated with questions raised to the TU representatives. During these meetings, there has been discussion on subjects such as reintroducing practical manual handling training and decisions have been made with TU agreement. The meetings are minuted, which will be a useful account for future learning.

14.6 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

The release or escape of Coronavirus (SARS-Cov-2) and a worker having a diagnosis of COVID-19, which is attributable to occupational exposure, are both reportable under RIDDOR. Early information on the requirement of when to report COVID-19 related Occupational Diseases and Dangerous Occurrences was not clear. An SBAR was completed on the 24th of April which confirms that verbal advice was sought by the Corporate Health and Safety Team on the 7th of April from the HSE to ensure accurate reporting. The HSE guidance changed during the early part of the pandemic with reporting guidelines changing on the 8th April.

A meeting was held with Sarah Baldwin-Jones HSE inspector on the 4th of May to clarify further when to report incidents under RIDDOR. A number of scenarios were discussed and clarification was given that clusters may be reported as one incident. On the 28th of May the HSE notified BCUHB that all staff from a cluster reports as a Dangerous Occurrence report now had to be reported individually. This created a significant back log of RIDDORs for the team to report, which have now been cleared and the total number of COVID-9 specific RIDDORs reported in Q1 were 274.

**14.7 COVID-19 Specific Investigations**

The daily checking of Datix and the continual requirement to follow up with managers to get information has a significant impact on time for the team. The original documentation available for managers to undertake an investigation were from the HOPE network. The investigation tool did not give the information required to allow for reporting under RIDDOR and meant that repeated follow up emails were often required. Make it Safe reports were carried out by managers for staff clusters, but these again did not follow a H&S investigation procedure and do not provide adequate information for reporting; in some cases they would not evidence an adequate H&S investigation has been carried out.

Sadly, two colleagues in BCUHB died from COVID-19 in Q1. The interim Head of Health and Safety has undertaken the H&S investigation for both staff incidents to support the overarching report required from the Patient Safety team. A further investigation is still ongoing with the HSE in relation to a facemask that slipped during a procedure with a patient in Radiology.

On the 16th of June, a new 72-hour review for staff with a positive COVID-19 test result was circulated across BCUHB. A flowchart was also developed to give clear explanation of which investigation form was required from managers. This 72-hour review form gives adequate information for the H&S team to determine whether an incident is reportable as a RIDDOR. This was primarily to reduce the number of late reports being sent, but also to ensure that managers were aware of the requirement to notify the H&S team if their staff were admitted to hospital or if there was a staff cluster so that the investigation includes a member of the H&S team.

14.8 DATIX incidents

A total of 2,097 incident were reported in Q1 under the datix category 'Accident that may result in personal injury incidents'. This is an increase from Q4 where there were 1,873 incidents reported in this category.
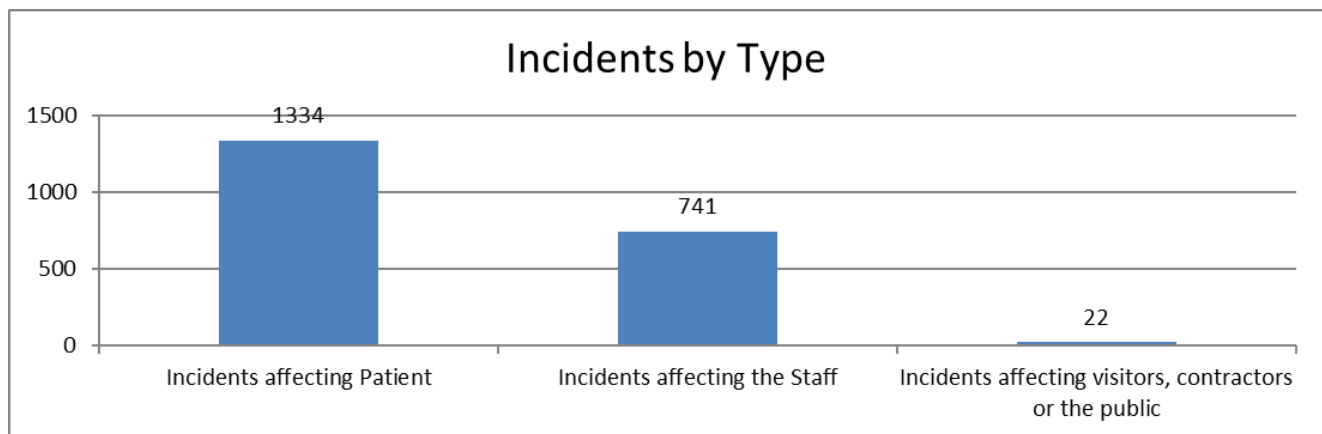
In comparison to Q4 the incidents affecting patients and incidents affecting visitors, contractors or the public are both less for Q1 with the first being 1,484 and the second being 35. The total staff incidents for Q4 were 353, which is less than half of the 741 reported in Q1.

The incidents affecting staff has been broken down and indicates the number of incidents for exposure to electricity, hazardous substance, infections etc. is 449 which are split quite evenly across the three geographical areas. In Q4 the total for this category was 33.

	BCUHB Central	BCUHB East	BCUHB West	Total

Accident caused by some other means	50	46	27	123
Exposure to electricity, hazardous substance, infection etc	140	168	141	449
Injury caused by physical or mental strain	13	8	11	32
Lifting accidents	3	2	2	7
Needlestick injury or other incident connected with Sharps	41	15	21	77
Slips, trips, falls and collisions	20	19	14	53
Total	267	258	216	741

The category exposure to electricity, hazardous substance, infections etc. has been broken down further:

Incidents by Adverse Event and Region	BCUHB Central	BCUHB East	BCUHB West	Total
Accident of some other type or cause	16	18	6	40
Exposure to biological hazard	30	4	18	52
Exposure to Chemical	1	1	0	2
Hazardous and avoidable exposure to infection	92	143	115	350
Hazardous exposure to electricity or electric shock	0	2	2	4
Unintended exposure to radiation	1	0	0	1
Total	140	168	141	449

Incidents by Location exact (Top 5)	BCUHB Central	BCUHB East	BCUHB West	Total
Dulas, YG (secondary care)	0	0	19	19
Gwanwyn Ward	0	18	0	18
Physiotherapy (area)	9	4	4	17
Padarn, Ysbyty Eryri (Area)	0	0	16	16
ITU, YGC (secondary care)	16	0	0	16
Total	25	22	39	86

The number of needle stick or sharps incidents in Q1 were less with a total of 77 where there were 100 incidents reported. Of the 77 incidents reported in Q1 61 were from 'dirty' sharps and the most common contributory factor noted was 'lapse in concentration'.

14.9 Health and Safety Ysbyty Enfys (Deeside, Bangor and Llandudno)

The Corporate H&S team supported the Ysbyty Enfys' projects from the early construction phase. The Associate Director developed a risk management strategy that dynamically looked at risks associated with CDM, legionella, site transport, security, fire safety etc. The systems developed ensured the H&S Team, who are not experts in construction health and safety, were able to look at the wider hazards relevant to construction sites. The H&S Advisors also supported with training of staff on site and were available to help with any of the health and safety queries raised.

14.10 PPE Steering Group

H&S have supported the PPE Steering Group throughout the COVID-19 crisis; advising on legal and HSE requirements, face fit testing, model types, usage protocols and communications. The team were also heavily involved in providing advice and setting assurance mechanisms for Community and BCUHB manufactured Visors, and involved in discussions around the use of face coverings in communal areas of BCUHB.

14.11 Additional documentation

Along with the FAQs, guidance documents and risk assessment templates, the H&S team have recorded, where possible, all steps taken since the COVID-19 pandemic started. A daily team action log has been kept to record key actions completed. An issues log was also kept to record

themes of queries raised to the team or issues identified by the team themselves with updates on actions taken. A decision log has also been kept so that the team can look back at what decisions were made, when and why. These documents will be essential for the lessons learnt and reflection sessions that are taking place with the team in Q2.

14.12 Future Plans

The H&S team are now looking at plans to prepare for the next steps for this team going forward. The Q2 report will confirm the work that is being undertaken to complete this.

15. Security

At the start of the pandemic, there was concern that hospital emergency departments would need additional security. The current provision was increased on each site to two guards 24/7. Security was also required for the temporary hospitals, particularly during the construction phase. The security provision for the temporary hospitals was reviewed at the end of June and reduced for all three hospitals whilst in the 'dormant' stage. This security provision can be increased with 24 hours notice. Weekly reports from the police liaison officer confirmed that there had been a reduction of reports to the police in Q1.

Security continues to be resource heavy for the H&S team with no budgeted security management resource. Progression of the case for change and investment is key and is being managed through the Executive team.

15.1 Violence and Aggression

The Violence & Aggression Case Manager has also undertaken a Security Management function during Q1 following interim arrangements with Corporate Health & Safety team. Datix reports have fallen during the Q1 2020 period possibly due to reduced "footfall" during lockdown.

All data is related to "Incidents affecting the staff/abusive, violent, disruptive or self-harming behaviour" as listed on Datix. Those listed as affecting staff were 307 during Q1 in comparison to 604 in Q4 (19/20). The incidents marked as 'police called' were 21 for Q1 and 35 for Q4 (19/20).

Incidents by Incident date (Financial quarter) and Region
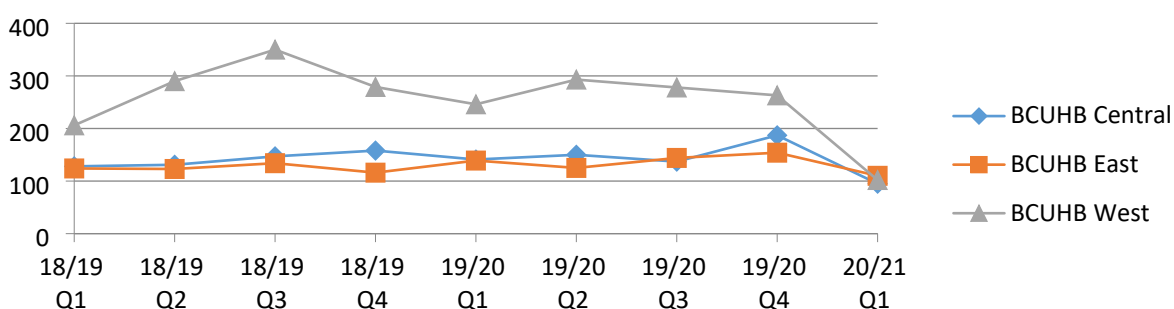
Incidents by Incident date (Financial quarter) and Which equality characteristic is the incident linked to?
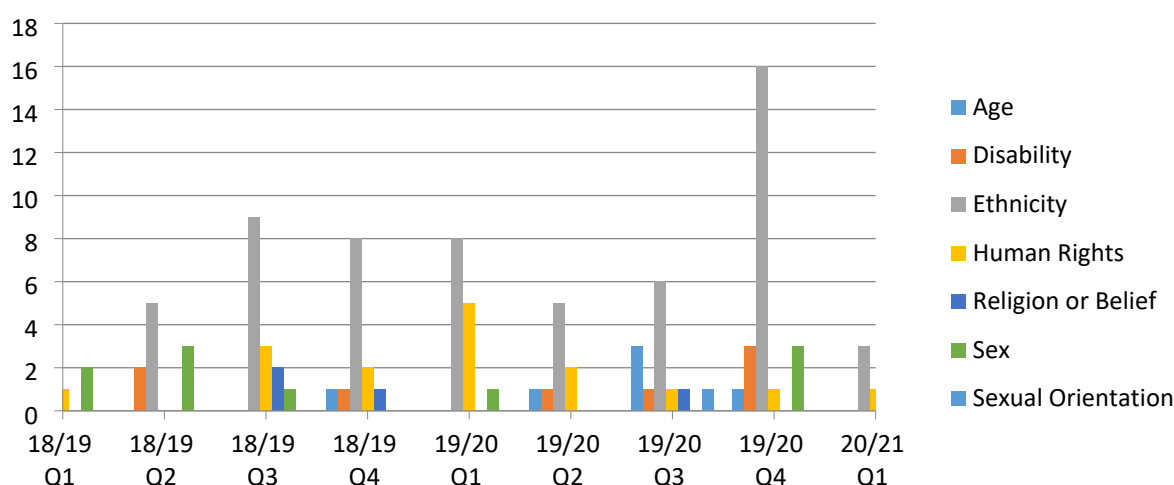
Management of Cases 2020/2021

Q1 2020	Area	division	Status	Notes
Q1/20 DB1	Central	Mental Health	Closed	No datix report. ORV process not followed. Patient made conditional threats therefore no crime.
Q1/20 DB2	Central	Mental Health	Closed	ORV process not followed. No communication with managers. No returned contact from victim. Patient relative made offensive remarks on telephone calls.
Q1/20 DB3	West	Mental Health	open	Patient made threats to staff. ORV process partial followed (case manager informed late). Awaiting return contact from victim

16. Manual Handling

16.1 Training

During this period training provision changed for the department, with face to face courses cancelled throughout BCUHB. The Manual Handling team have created videos of commonly used techniques to support new staff who were not able to access practical training courses. The trainers were redeployed to support other departments, and returned to the Team on the 17th of June 2020. It was recognised that there was a significant risk that practical training sessions and observations could not be delivered to new staff and risked them not being able to use the correct techniques. This was potentially putting both the staff members and the patients at risk. Following the completion of a risk assessment and Standard Operating Procedures for each training venue, the practical observation sessions, which are usually undertaken on the wards, were reintroduced into a classroom setting. These observation sessions commenced on the 29th of June. Training was also carried out with staff and volunteers allocated to the three temporary hospitals. 200 staff were trained over 26 sessions.

16.2 Ergonomic Assessments

Ergonomic Assessments were provided over the phone where possible. Three patient assessments were undertaken along with four DSE assessments. An assessment was also undertaken for the mortuaries on each of the District General Hospital sites. Guidance documents and risk assessments were completed to support staff during this period. It has been noted that there has been an increase in DSE assessment requests for home workers and the Manual Handling team offer their support to colleagues and developing the Agile Working Policy.

16.3 Manual Handling related Datix

There have been 21 Datix reports relating to manual handling reported in Q1, of which 17 highlighted issues relating to manual handling activities, for example an injury occurred to a staff members back whilst rolling a patient. The Manual Handling Advisor therefore observed the technique correcting as required to reduce any further MSK injury. All Datix reports are responded to by the Manual Handling Manager, with advice offered through email or telephone. Additional Training is arranged for those who may need it either in the classroom or thorough ergonomic assessments undertaken with the Manual Handling Advisor if needed.

16.4 Manual Handling support for Ysbyty Enfys (Bangor/ Deeside /Llandudno)

In addition to the training provided on site, the team supported with advice for many manual handling hazards identified. This included advice on the beds purchased, support with the movement of equipment around the sites particularly with the ramps and floor level changes. There were frequent visits to the temporary hospitals during this time and full support was provided to ensure safety for all stakeholders.

17. Conclusion

There is a need for a systematic review of the safety management system across the Health Board. The good work previously undertaken over the 6 months prior to COVID-19 requires consolidation and further work is required to develop the safety management system based on the HSE framework plan, do, check, act. The report does not give assurance of compliance with the law, significant gaps exist in all service areas. The cost to the organisation of not effectively managing work related violence, security and stress is significant in terms of human cost and sickness absence pay. The H&S Team have worked tirelessly to try to improve safety management during the period of the annual report and during the COVID-19 outbreak and should be commended on their efforts to date to protect the staff and the patients we serve. Further management commitment to safety in all service areas is being seen, but continues to be a considerable challenge. The organisation needs to work harder on developing the systems and processes that further develops a positive H&S culture.

18. Recommendations
- Implement the 3 year OHS Strategy.
- Ensure adequate staffing is available to provide an appropriate H&S security function to BCUHB.
- Develop further policies and safe systems of work to provide evidence of practice.
- Establish monitoring systems to measure performance including clear KPIs.
- Train senior leaders and develop further competence in the workforce at all levels

- Learn lessons from incidents and develop further the risk profile

The Committee is requested to note the position outlined in this report and support the recommendations.

Cyfarfod a dyddiad: **Meeting and date:**	Quality Safety and Experience Committee 28th August 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Independent Review of Fire Precautions at Ysbyty Gwynedd Stage 1 Report : Prior to Agreement of Action Plan – May 2020
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mark Wilkinson - Executive Director of Planning and Performance
Awdur yr Adroddiad **Report Author:**	Rod Taylor – Director of Estates and Facilities
Craffu blaenorol: **Prior Scrutiny:**	The Independent Review of Fire Precautions has been shared and discussed with the Senior Management Team at Ysbyty Gwynedd and Corporate Health and Safety.
Atodiadau **Appendices:**	Appendix 1 – Independent Review of Fire Precautions at Ysbyty Gwynedd, Stage 1 Report : Prior to Agreement of Action Plan – May 2020

Argymhelliad / Recommendation:

The Quality Safety and Experience Committee are asked to support the following recommendations :

1. To receive the Independent Review of Fire Precautions at Ysbyty Gwynedd
   Stage 1 Report : Prior to Agreement of Action Plan – May 2020

2. To note the contents of the report and support the action being undertaken in developing an action plan to address prioritised risks identified within Appendix B of the independent report.

3. To note commencement of the specialist compartmentation survey to inform the Health Board action plan for completion by 31st of October 2020.

4. To support the inclusion of Ysbyty Gwynedd fire precaution risks being included on the Health Board corporate risk register.

5. To support commencement of discussions with North Wales Fire and Rescue Service (NWF&RS) in regards to the contents of the independent report and actions being taken by the Health Board to reduce fire safety risks.

6. Fire Safety Management was identified as a risk within the Corporate Health and Safety Audit. The report will also be presented to the Strategic Occupational Health and Safety Group for consideration at its next meeting.

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

Sefyllfa / Situation:

The Health Board's Annual Fire Safety Reports have previously identified the ongoing findings emerging from the Grenfell enquiry and the publishing of the Dame Judith Hackett's report: Building a Safer Future - Independent Review of Building Regulations and Fire Safety, which suggests extending the recommendations beyond high-rise to include institutional buildings such as hospitals and care homes.

It is on this basis that the Health Board through an appointed Authorising Engineer – Fire Safety (a role undertaken by Welsh Government's NHS Wales Shared Services Partnership (NWSSP) – Specialist Estates Services) has commenced a programme of independent reviews of fire precautions across a number of higher risk hospital sites in accordance with the monitoring procedures outlined within Facilities Services Notification FSN12/102.

This report shares the findings of the Independent Review of Fire Precautions at Ysbyty Gwynedd, which was undertaken by NWSSP-SES May 2020; the report is attached as Appendix 1.

The Independent report provides a series of recommendations concerning Compartmentation, Ventilation, Emergency Lighting, Fire Alarm System, Fire Risk Assessments, Dry Risers, Fire Risk Assessments, Fire Drawings and Site Specific Fire Safety Policy and Management Procedures.

The purpose of this report is to confirm the Health Boards response to the prioritised recommendations as outlined in Appendix B, based on risk stratification and to confirm the actions to be taken by the Health Board to reduce fire precaution risks at Ysbyty Gwynedd.

Cefndir / Background:

During late February 2020, on behalf of the Health Board Specialist Estates Services (NWSSP-SES) completed an independent review of the fire precautions at Ysbyty Gwynedd (YG), in accordance with the monitoring procedures outlined in Facilities Services Notification FSN12/102.

The report sets out the overall findings of that review, which have been established following a combination of a desktop review, site survey and discussions with the fire management team and estates personnel.

The review primarily focuses on the standard of construction and the main passive and active fire precautions. It was not intended to be a risk assessment, however, the observations and recommendations made may support or influence the Health Board's fire risk assessment and related 'significant findings' as required by the Regulatory Reform (Fire Safety) Order (FSO). Details of signage, measured travel distances, dead end and inner room situations, etc. are not specifically addressed in this report. These elements should be considered through the fire risk assessment process.

The findings of the report undertaken by NWSSP-SES for the Health Board identify a number of measures necessary to improve fire safety standards at Ysbyty Gwynedd.

Notwithstanding the Health Board's proactive approach to fire safety management on site, the report identifies many deficiencies in the built form and associated engineering services relating to fire safety.

There are significant and numerous deficiencies in the standard of the passive and active fire precautions throughout the main building. Recommendations are made to review the fire strategy and location of designated fire walls, following which a compartmentation survey (including fire doors) should be undertaken and a remedial action plan implemented.

The report identifies that the interface between the ventilation systems and the fire strategy are far from compliant with current standards. Therefore, in conjunction with the compartmentation survey and associated remedial works, a significant number of additional fire dampers will need to be installed. The fire response procedures are influenced and instigated upon activation of the fire alarm. Therefore, recommendations are made to enhance the effectiveness of the fire alarm and detection system, particularly regarding the zoning arrangements, cause and effect and provision of additional repeater panels.

The report also makes recommendations to improve the facilities for horizontal and vertical evacuation; including escape lighting, the provision of refuge areas and reviewing the suitability of the existing evacuation equipment. Firefighting facilities are addressed with recommendations made to enhance these fire safety features. The report acknowledges the development of site-specific documentation, response procedures and fire risk assessments but recommends elements where these can be further refined.

NWSSP-SES supports the earliest possible implementation of the recommendations, prioritised according to risk. The Health Board should develop a prioritised action plan for implementing these remedial measures, in addition to addressing the significant findings identified through the Board's fire risk assessment, in an acceptable timeframe agreed with the Fire and Rescue Service (FRS).

Asesiad / Assessment & Analysis

Strategy Implications

The Health Board is currently developing a strategic infrastructure and compliance programme business case for Ysbyty Gwynedd and therefore the requirements to mitigate the fire precaution risks identified within the report will be included within the programme business case scope as the level and scale of investment required can only be supported through All Wales capital funding.

Options considered

In support of developing a robust and achievable action plan to share with Welsh Government / Specialist Estates Services (NWSSP-SES) and North Wales Fire and Rescue Service, work has commenced on commissioning a compartment survey based on a representative sample. Information gained from this survey will enable greater understanding of compartmentation breaches and therefore corrective actions required to populate a detailed action plan. This survey will also advise on potential changes required to improve the current fire management and evacuation arrangements on site.

The action plan will also incorporate any recommendations and/or interim measures identified by North Wales Fire and Rescue Service following the sharing of the Independent Review.

Following completion of the compartment survey and review of fire safety management on site a detailed action plan will be prepared by October 2020 ready for reporting to the Health Board and Welsh Government / Specialist Estates Services (NWSSP-SES).

Financial Implications

The initial compartmentation survey will be been funded through Estates and Facilities revenue compliance budget 2020-21.

Mitigation of short-term recommendations contained within the Independent Fire Precautions report will require an allocation of disc capital funding in 2020-21 and 2021-22. The value of this work will be define within the first stage action plan.

The development of a strategic infrastructure and compliance programme business case for Ysbyty Gwynedd will confirm the overall level of funding required for consideration against All Wales capital funding.

Risk Analysis

Major risks associated with this report are summarised as follows :-

1. Agreement on a defined action plan and timeline of mitigation that is acceptable to North Wales Fire and Rescue Service as enforcing authority.
2. Availability of Disc Capital in 2020-21 and 2021-22 to mitigate priorities risks.
3. Access restrictions to the hospital site during COVID19 pandemic to undertake compartmentation survey.
4. Additional activity on site due to potential surge capacity planning during COVID-19.
5. Timeline to secure All Wales capital investment through the business case planning process.

The risk score and narrative is currently being drafted for inclusion on the Corporate Risk Register. The risks associated with fire precautions have been recorded on Ysbyty Gwynedd Hospital Management Team risk register.

Legal and Compliance

There is a risk that the enforcing authority (North Wales Fire and Rescue Service) under Article 30 of the FSO could issue a site wide enforcement notice to correct the identified deficiencies within a prescribed times scale. This situation will be clarified followings discussions with the Fire Service.

Impact Assessment

At this stage, no formal impact assessments have been undertaken. This will be addressed as part of drafting the action plan.

Attachments
Appendix 1 - Independent Review of Fire Precautions at Ysbyty Gwynedd
Stage 1 Report : Prior to Agreement of Action Plan – May 2020

Independent Review of
Fire Precautions at
Ysbyty Gwynedd
Penrhosgarnedd, Bangor, Gwynedd
LL57 2PW

Stage 1 Report: Prior to
Agreement of Action Plan

May 2020

NWSSP - SPECIALIST ESTATES SERVICES

INDEPENDENT REVIEW OF

FIRE PRECAUTIONS

AT

YSBYTY GWYNEDD,
Penrhosgarnedd, Bangor,
Gwynedd LL57 2PW

Stage 1 Report:
Prior to Agreement of Action Plan

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ORIGINATOR: **A Pitcher**   (Signed)
                  Senior Fire Safety Advisor

AUTHORISED: **S Douglas**   (Signed)
                  Head of Estate Development

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1.0   INTRODUCTION

During February 2020, on behalf of the Welsh Government, NWSSP[1] – Specialist Estates Services (NWSSP-SES) completed an independent review of the fire precautions at Ysbyty Gwynedd (YG), in accordance with the monitoring procedures outlined in Facilities Services Notification FSN12/10[2].

This report sets out the overall findings of that review, which have been established following a combination of a desktop review, site survey and discussions with the fire management team and estates personnel.

The review primarily focuses on the standard of construction and the main passive and active fire precautions. It is not intended to be a risk assessment, however, the observations and recommendations made may support or influence the Board's fire risk assessment and related 'significant findings' as required by the Regulatory Reform (Fire Safety) Order (FSO). Details of signage, measured travel distances, dead end and inner room situations, etc. are not specifically addressed in this report. These are elements that should be considered through the fire risk assessment process.

Each of the chapters 4 through to 7 are set out in the form of a brief commentary setting out generic context and background information, followed by detailed observations and a series of recommendations considered necessary to further enhance fire safety.

Following examination of the review by the Health Board, it has been agreed that the Board will provide NWSSP SES with an action plan and programme for addressing each of the recommendations.

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[1] NHS Wales Shared Services Partnership
[2] Independent Reviews of Fire Safety

2.0   EXECUTIVE SUMMARY

2.1   The findings of this report undertaken by NWSSP-SES for Betsi Cadwaladr University Health Board identify a number of measures necessary to improve fire safety standards at Ysbyty Gwynedd.

2.2   Notwithstanding the Board's proactive approach to fire safety management at this site, the report identifies many deficiencies in the built form and associated engineering services relating to fire safety.

2.3   There are significant and numerous deficiencies in the standard of the passive and active fire precautions throughout the main building. Recommendations are made to review the fire strategy and location of designated fire walls, following which a compartmentation survey (including fire doors) should be undertaken and a remedial action plan implemented.

2.4   The report identifies that the interface between the ventilation systems and the fire strategy are far from compliant with current standards.   Therefore, in conjunction with the compartmentation survey and associated remedial works, a significant number of additional fire dampers will need to be installed.

2.5   The fire response procedures are influenced and instigated upon activation of the fire alarm.   Therefore, recommendations are made to enhance the effectiveness of the fire alarm and detection system, particularly regarding the zoning arrangements, C&E and provision of additional repeater panels.

2.6   The report also makes recommendations to improve the facilities for horizontal and vertical evacuation; including escape lighting, the provision of refuge areas and reviewing the suitability of the existing evacuation equipment.

2.7   Firefighting facilities are addressed with recommendations made to enhance these fire safety features.

2.8   The report acknowledges the development of site specific documentation, response procedures and fire risk assessments but recommends elements where these can be further refined.

2.9   NWSSP-SES supports the earliest possible implementation of the recommendations, prioritised according to risk. The Board should develop a prioritised action plan for implementing these remedial measures, in addition to addressing the significant findings identified through the Board's fire risk assessment, in an acceptable timeframe agreed with the Fire and Rescue Service (FRS). The agreed action plan programme will be incorporated to the final stage edition of this report.

3.0 BUILDING DESCRIPTION

3.1 Building Description

The Ysbyty Gwynedd site provides accommodation for approximately 450 inpatients and a series of outpatient services. The four storey District General Hospital was constructed in the late 1970's, however over the years there have been numerous extensions and alterations to the original building, particularly to the ground and first floor.

The main building is a concrete frame structure with flat roofs, internal partitions comprising a mixture of brick and lightweight stud form. The upper levels form an 'H' and 'T' block configuration, which accommodate the majority of inpatient beds.

A single service tunnel extends in a straight line from the detached boiler house to the 'H' block central core. This contains a multitude of services including; natural gas, oxygen, nitrous oxide, heating pipes and electrical distribution cabling.

Mechanical ventilation is typically locate in rooftop plant rooms with the distribution ducting dropping in vertical service shafts and through the ceiling voids above the suspended ceilings.

Floor plans are contained in Appendix A.

This report only addresses the main building. Within the curtilage of the site there are numerous other buildings including the Staff Residential Blocks, Hergest Mental Health Unit and Management/Finance Building, these are excluded from this report.

4.0 MANAGERIAL ARRANGEMENTS, FIRE DOCUMENTATION AND RISK ASSESSMENTS

4.1 Commentary

To comply with the mandatory requirements of Welsh Health Circular WHC(2006)74 all NHS organisations must:

- *have a clearly defined fire safety policy covering all buildings they occupy;*
- *nominate a Board Level Director accountable to the Chief Executive for fire safety;*
- *nominate a Fire Safety Manager to take the lead on all fire safety activities;*
- *have an effective fire safety management strategy.*

Firecode also recommends that site-specific fire safety manuals are developed, this is an essential tool for managing the fire safety of an occupied building.

BS 9999:2017 'Code of practice for fire safety in the design, management and use of buildings' states:

"The fire safety manual should:

- *provide a full description of the assumptions and philosophies that led to the fire safety design, including explicit assumptions regarding the management of the building, housekeeping and other management functions;*
- *explain the nature of fire safety planning, construction and systems designed into the building and their relationship to the overall safety and evacuation management;*
- *draw on documentation produced at design stage to describe the use of various protection systems in each type of potential incident;*
- *set out the responsibilities of management and staff with regards to fire safety;*
- *provide a continuously updated record of all aspects of the building and the building users that affect its fire safety."*

The fire safety manual should support the Board's overall fire strategy and form part of the information package that contributes to the fire risk assessment to support and justify the significant findings.

With regards to Fire Risk Assessments, the Regulatory Reform (Fire Safety) Order 2005 (FSO), requires the responsible person to put in place general fire precautions as deemed necessary to safeguard relevant persons in case of fire. The fire risk assessment is the mechanism for determining an acceptable level of fire safety.

Recognising the enhanced emphasis on fire risk assessments, Firecode, HTM 05-03 Part K 'Guidance on fire risk assessment in complex healthcare premises' was published replacing the former HTM 86. This has been supplemented by an online fire risk assessment module (refer to WHEN 09/08[3]), which is

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[3] Welsh Health Estates Notification 09/08 - Web-based Fire Risk Assessment Module

supported by the Chief Fire Officers Association (Wales), and provides a consistent approach to fire risk assessments across the NHS in Wales.

4.2   Observations

4.2.1   Policy Documentation and Management Structure
The following comments are based on the Board's Corporate Fire Policy 'Policy for the management of fire safety' (Ref. ES04 - Version 0.4) dated January 2019.

The fire policy documentation details management's fire safety responsibilities, including their duties, and also outlines monitoring arrangements, legislation and details regarding the training needs analysis.

The Board's fire management structure follows the exemplar outlined in Firecode WHTM 05-01, the Fire Safety Manager reports directly to the Board Level Director with responsibility for fire. In addition, the management structure also details the fire managerial roles for regional and site level control, including reference to Deputy Fire Safety Mangers and Designated Responsible Persons at specific sites.

For operational estates functions, the Board's estate is split into three regions East, Central and West. Ysbyty Gwynedd sits in the West region. The regional operational estates managers fulfil the role of Deputy Fire Safety Managers for the properties under their control. The duties are detailed in Section 4.7 of the policy.

Section 4.11 of the fire policy details the role of the Designated Responsible Person for Acute & Multi Occupancy hospitals, citing that the Local Hospital Director fulfils this role.

To support a co-ordinated approach to fire safety management, the policy references a Fire Safety Management Group. This group, which is typically chaired by the Fire Safety Manager, includes representation from those cited in the fire management structure. The forum has a standing agenda, meets on a quarterly basis and reports to the Board's Health and Safety Committee.

The Board's policy promotes the appointment of fire wardens in all wards and departments.   The fire policy details the fire warden duties which are also addressed in specific fire warden training sessions.

4.2.2   Fire Manual Documentation
Section 7 of the Board's fire policy (ES04) recognises the importance of fire manuals, stating 'A S*ite Specific Guidance & Documentation Manual will be held at each of the Health Board sites'*, which should follow the guidance promoted in WHEN 09/16[4].

Accordingly, the Board have compiled a comprehensive site specific fire folder which is retained in the fire information box adjacent to the reception desk at the

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[4] Welsh Health Estates Notification 09/16 - Guide to the production of site-specific fire safety manuals

main entrance. This also contains the Response Procedures document 'Site Operational Fire Strategy - Procedural Arrangements at Ysbyty Gwynedd' which was last reviewed in August 2019, noting the Board acknowledge that the content needs to be further refined.

The provision of accurate drawings is also an essential element of a robust fire manual as cited in the fire policy. Whilst plans are available illustrating some fire safety provisions, such as; the alarm system and schematic ventilation layouts, all of these plans require updating to accurately reflect the 'as installed' systems and layout. The Board acknowledge the need to collate and refine fire drawings and are aiming develop their MiCAD drawing database. More specific recommendations regarding the drawings are made in subsequent sections of this report.

As well as supporting the FRS, this documentation will support more robust fire management arrangements in the future.

In addition to the Site specific documentation, in accordance with WHTM05/01, the Board have also introduced department specific fire folders. Again this approach is considered best practice in supporting a proactive fire management system.

4.2.3 Fire Risk Assessments

Utilising the online format, the Board have conducted a series of seventy fire risk assessments across the site. Whilst the risk assessments generally reflect the standards evident during this review, anomalies were noted where certain aspects should be strengthened. These anomalies are discussed in later sections of this report. Accordingly, it is recommended that the risk assessments are reviewed and updated where necessary to address the anomalies and reflect the findings of this report.

It is a requirement of the FSO that fire risk assessments are periodically reviewed and maintained up-to-date. Accordingly, the Board have stipulated a review frequency of between 12 and 36 months, generally reflecting the risk profile encountered in the specific area. The Board's endeavours to adhere to the review frequencies is noted. At the time of this review the majority of risk assessments were in date.

Recent correspondence from Welsh Government to the Health Boards, stresses the importance of ensuring up-to-date, suitable and sufficient fire risk assessments are conducted for all parts of the estate and, more importantly, arrangements are implemented to address the significant findings identified.

This report reiterates that message highlighting the necessity to ensure the significant findings are prioritised for action accordingly.

4.3   Recommendations

4.3.1   The Board should ensure the roles and responsibilities and related management arrangements detailed in the Fire Policy continue to be implemented.

4.3.2   The Board should continue to refine and update the content of the fire manual to reflect the fire safety measures and procedures at this hospital.

4.3.3   The Board should ensure an accurate up-to-date set of 'as installed' drawings are available and retained with the fire manual.

4.3.4   The Board should continue to review the risk assessments to address the anomalies and reflect the findings of this report.

4.3.5   The Board should ensure the fire risk assessment recommendations are prioritised and addressed as necessary within the agreed timescale.

5.0   DETECTION AND ALARM

5.1   Commentary
In healthcare buildings, analogue addressable fire alarm and detection systems should be provided to an L1 standard (total coverage with a few exceptions) in accordance with Firecode HTM 05-03 Part B[5] which supplements BS 5839:1.

The purpose of the alarm system is to provide the earliest possible warning of an incident to enable emergency response procedures to be implemented as necessary.

Fire alarm systems are often interfaced with other 'active' fire precautions/devices to maintain fire safety through the 'cause and effect (C&E)'. As the hospital fire alarms are intended to alert staff, Firecode permits reduced audibility of sounders in patient areas.

5.2   Observations

5.2.1   General Description
Ysbyty Gwynedd has a Static addressable fire alarm system with over 3500 actuation devices. A high standard of coverage was noted, although not to an L1 standard[6].

Responsibility for the fire alarm system rests with the Operations Manager (West). Weekly tests are conducted by in-house estates staff, the system is also maintained and serviced under contract with Static Systems. It is recommended that consideration be given to the full list of the duties and responsibilities contained in the current edition of BS 5839:1 Section 7 Users responsibilities; this includes responsibility for maintaining appropriate documentation, plans, servicing records, and rectification of faults/UwFS, etc.

5.2.2   Zoning Arrangements and Addresses
Zone plans are retained on site in the fire manual, zone lists were also evident adjacent to some of the fire alarm panels. A graphical user interface is also located in the main reception area.

The current configuration of the alarm zoning arrangements is far from optimal. Zone boundaries do not reflect the existing departmental boundaries and, in several areas, are considered too large. This presents unnecessary challenges in terms of managing a response to an alarm activation. Furthermore, not all alarm zones are bounded by appropriate fire resistant construction.

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[5] Firecode HTM05-03 Part B Fire detection and alarm systems.
[6] BS5839 L1 - Category L systems are intended for the protection of life. L1 systems are installed throughout all areas of the building. The objective of a category L1 system is to offer the earliest possible warning of fire, so as to achieve the longest available time for escape.

The alarm zone boundaries should ideally follow departmental boundaries which in turn should be bounded either by compartment or sub-compartment walls.

The pending review of compartmentation and sub-compartmentation arrangements will necessitate reconfiguration of the zone boundaries.

In conjunction with the zoning reconfiguration, the device addressing should be reviewed and updated to accurately reflect the new zoning and room designation.

5.2.3 Cause and Effect (C&E)

In addition to the sounders, there are a significant number of active fire protection devices installed throughout the hospital that are triggered by the fire alarm system. This includes equipment such as; magnetic locks, détentes, fire/smoke dampers and gas valves. The lifts are also interfaced with the fire alarm. The correct sequence of operation of these devices is critical to the effectiveness of the fire response procedures.

The Board have a C&E matrix which highlights the various output groups. This is presented in the form of an extensive spread sheet which is not considered to be a user-friendly format. Furthermore, the output group descriptions are not concise enough to identify the full extent of associated devices.

The 'as-installed' drawings illustrate the location of interface units albeit not specifically what ancillary device the interface unit controls. Ideally, the CAD drawings should be enhanced to illustrate all interface units and their associated ancillary devices. It should also be noted that many more interface units will be required to control the additional fire smoke dampers referenced later in this report.

In conjunction with the reconfiguration of the zoning arrangements, it will be necessary to review the full C&E. Accordingly, it is recommended that the C&E information be reformatted following the template contained in Appendix C. This will support the response procedures and future maintenance regime, noting the C&E should be validated annually.

Reconfiguration of the zoning arrangements will also improve the cause and effect arrangements. For example, the current C&E states that all five lifts within the 'H' block core are disabled for any activations originating in the Pathology or Orthodontic Departments. This will have a considerable negative impact on vertical movement through the H block until such times as the alarm is reset.

5.2.4 Sounders

In hospital premises utilising Progressive Horizontal Evacuation (PHE), fire alarm sounders are usually configured to emit a continuous signal in the affected area and an intermittent alert in immediately adjoining areas, above and below, noting that the sounders should have distinctive yet similar sound characteristics. For example, bells and electronic sounders should not be mixed.

The Ysbyty Gwynedd fire alarm sounders are configured on this basis, however additionally a site wide alert is broadcast across the whole hospital regardless of where the activation occurs. This site wide alert is primarily intended to summon staff from remote areas to support the response procedures. Modern approaches to facilitate this action utilise paging systems or telephones.

SES would not normally endorse this site-wide alert approach in a major acute hospital due to the unnecessary disruption caused to patients remote from an incident. However, recognising the existing compartmentation deficiencies and zoning arrangements, it is recommended that this approach be retained until such times as the compartmentation and zoning issues are addressed.

5.2.5 Extent of Coverage

The 'as-installed' fire alarm drawings illustrate a high standard of coverage, which is broadly to an L1 standard throughout the main building. However, the fire risk assessments have identified a few rooms where additional detection is required, noting this is primarily attributed to a change of use of the room where typically a bathroom is now being used for storage.

With regard to the fire alarm equipment, the review of the zone boundaries and compartmentation will necessitate the provision of additional call points to reflect the zoning arrangements/boundaries.

It should also be noted that actuation devices have a limited service life. As detectors age they can become less sensitive and potentially more prone to causing false alarms. Therefore, consideration should be given to a replacement programme for older detectors.

5.2.6 Repeater Panels

In addition to the Graphical User Interface within the main entrance, repeater panels are strategically located around the hospital, including at each level within the 'T' and 'H' block cores. This provides reasonable access to fire alarm information albeit not to the standard promoted in Firecode, which recommends repeater panels should be located at all staff bases.

The recommended provision of additional panels, in accordance with Firecode, will not only facilitate earlier identification of the incident location, but can also supplement the arrangements to summon staff negating the need for the site-wide alert.

It is also recommended that up-to-date zone plans are displayed adjacent to all fire alarm and repeater panels.

5.3 Recommendations

> 5.3.1 The Board should reconfigure the fire alarm zone boundaries to reflect the departmental boundaries and compartmentation arrangements.

5.3.2   The Board should review the fire alarm device addresses and update where necessary to accurately reflect room designations and reconfigured zoning arrangements.

5.3.3   The Board should update the 'as installed' drawings upon completion of the zoning reconfiguration and also enhance the drawings to illustrate all devices interfaced with the fire alarm.

5.3.4   The Board should review the cause and effect matrix to reflect the reconfigured zoning. This should detail the operation of all devices interfaced with the fire alarm system, following the format contained in Appendix C.

5.3.5   The Board should provide repeater panels to staff bases in accordance with Firecode.

5.3.6   The Board should ensure fire alarm zone plans are displayed in proximity to the fire panels.

5.3.7   The Board should ensure the fire risk assessment recommendations for additional detection are addressed and also consider the need for a replacement programme for the ageing detectors.

5.3.8   The Board should ensure the complete fire alarm system is maintained in accordance with BS 5839:1, including annual verification of the C&E; reference should also be made to the 'Users responsibilities' as defined in the above standard.

6.0 FIRE PRECAUTIONS

6.1 Commentary

Means of escape in healthcare premises is based on the concept of Progressive Horizontal Evacuation (PHE). PHE is reliant on the provision of 60 minute compartmentation and 30 minute sub-compartmentation to limit the spread of fire and smoke and also reduce travel distances. Compartmentation should also provide separation between high life risk areas and high fire hazard areas.

In addition, Firecode recommends that localised fire hazards such as store rooms and ward pantries are enclosed in 30 minute fire resisting construction to contain any fire and further enhance the means of escape. 60 minute protected shafts are recommended where vertical movement through the building is required and/or where essential services penetrate compartment floors to maintain the fire resisting integrity of the hospital.

Firecode recommends that elements of structure for hospitals with floors up to 12m above ground attain a 60 minute period of fire resistance. Firecode also stipulates maximum travel distances and requirements for adequate illumination.

6.2 Observations

6.2.1 Fire Compartmentation and Hazard Rooms

The existing fire strategy (i.e. location of fire walls) is far from optimal. In particular, considering the use/layout of the wards, the location of the designated 60minute compartments and 30minute sub-compartments in proximity to the lift cores and stem approach to the wards are not logically configured.

During this review, ceiling void inspections were conducted in selected areas. Numerous and significant deficiencies were noted, typically including:

- Single sided plaster board partitions above ceiling with exposed metal studding. This form of construction will not achieve the required fire rated properties.
- Numerous fire wall penetrations were evident with inadequate or inappropriate fire stopping solutions to service penetrations.
- Various types of polyurethane foam (PU foam) have been used extensively as a fire stopping product. PU foam is only certified for certain limited applications. At this site its use is far beyond its tested application and is considered unacceptable.
- Inadequate fixing or missing fire collars to the pneumatic tube transfer system.
- Inadequate sealing of expansion joints through the floor slab.

It would appear that many of these aspects relate back to the original construction although it was evident that some of the more recent works are also not up to the required standard.

The findings of the sample inspection demonstrate the necessity for a full compartmentation survey. The survey should assess the integrity of fire walls that are required; these are not necessarily the fire walls currently illustrated on the fire drawings. Therefore, it will be necessary to review the existing fire strategy redefining the fire compartmentation and sub-compartmentation arrangements to reflect departmental boundaries and evacuation strategy. This exercise should also identify the enclosure of hazard rooms.

Following the survey, a prioritised action plan should be implemented to rectify the deficiencies identified.

Firecode also details requirements intended to protect against external fire spread. This includes space separation and tower and podium protection. Tower and podium protection aims to reduce the potential for vertical fire spread from low level roof abutments impacting on higher adjacent elevations.

There are a number of tower and podium situations at this hospital that should be identified and addressed through the risk assessment process and pending compartmentation survey.

6.2.2 Mechanical Ventilation

Fire dampers are a critical component for preventing fire/smoke spread through ductwork installations, particularly where progressive horizontal evacuation is utilised.

The Board have a reasonable set of schematic drawings indicating the majority of ducted ventilation systems (noting these require a degree of updating). That said, the current provision of fire dampers is far from code compliant. The majority of dampers observed are thermally actuated fire dampers.

	Fire and smoke damper activated by AFD	Fire damper (Thermal activation)	Air transfer grille – cold smoke (activated by AFD)	Air transfer grille (thermal activation)
Compartment floor	✓	X	X	X
Compartment wall	✓	X	X	X
Protected shaft	✓	X	X	X
Sub-compartment wall	✓	X	X	X
Cavity barrier	✓	✓	N/A	N/A
Fire hazard room	✓	✓	✓	X
Door to fire hazard rooms	N/A	N/A	✓	X
Doors in sub-compartment walls	N/A	N/A	✓	X
Doors in compartment walls	N/A	N/A	X	X
Doors to protected shafts	N/A	N/A	X	X

Notes:

Fire smoke dampers and air transfer grilles activated by the fire alarm provide more responsive containment than thermally activated devices and are considered preferable.

All dampers should be provided with suitable access panels for maintenance and servicing.

Air transfer grilles should not be fitted in fire doors unless accompanied by a test certificate provided by the door manufacturer.

Table 7 Permissible locations of transfer grilles, fire dampers, and fire and smoke dampers

As indicated in the table above (WHTM05/02 table 7), current codes require fire smoke dampers (motorised/triggered by the fire alarm) to compartment walls and floors as well as sub-compartments, whereas thermal fire dampers should only be used for hazard room enclosures and cavity barriers.

From a review of the schematic ventilation drawings and existing fire drawings for the 3rd floor alone, it is estimated that there are 44 fire dampers currently installed. However, based on the current layout there should be approximately 140 dampers at least 60 of which should be fire smoke dampers interfaced with the fire alarm.

Thermally activated fire dampers are not as responsive as fire smoke dampers interfaced with the fire alarm, neither do they achieve the same level of smoke containment.

Furthermore, the majority of air handling units (AHU's) are not currently interfaced with the fire alarm. Therefore, on activation of an alarm the supply and extract will continue to serve the affected area. This potentially creates a route for smoke spread throughout other areas and floors served by the same ventilation system. Conversely, if the AHU were to be interfaced with the fire alarm to switch off, this would create a neutral pressure within the related ducts which again would contribute to potential uncontrolled smoke spread. Appropriately located fire and smoke dampers are the only solution in this regard, noting these should be installed as a priority.

This situation primarily relates to the AHU's located in the plantrooms above the 3rd floor as these central AHU's serve multiple floors below.

Accordingly, in conjunction with the compartmentation survey, it is recommended that 'as-installed' CAD drawings are updated to illustrate the complete mechanical ventilation installation. Coordinating the duct routing arrangements with the defined fire walls and compartment floors will identify the damper omissions or defective installations, noting that any such omissions or defects should be prioritised for rectification as necessary.

With regard to testing and maintenance, the Board acknowledge that fire dampers are not universally addressed through the planned preventative maintenance (PPM) system due to resource pressures.

Current guidance recommends that fire dampers should be subject to an annual PPM and testing regime as a minimum, noting that dampers in dust laden areas may require more frequent attention. Therefore, the Board should review their current PPM arrangements ensuring compliance with BS 9999 annex W and the manufacturers' recommendations.

6.2.3 Fire Doors

Effective fire doors are vital for maintaining the integrity of compartmentation.

The Board's fire risk assessment process has identified numerous fire door issues, primarily relating to defective seals and omission of door closers.

Notwithstanding these issues, from a visual inspection, overall the majority of fire doors appeared to be of fair condition albeit not necessarily coordinated with the fire strategy.

During the review it was noted that some fire doors have individual door reference numbers whilst others have room numbers or a combination of both. Unique door numbers and the development of related fire door schedules can support more effective maintenance arrangements. Accordingly, it is recommended that the previously cited compartmentation survey should also address the condition of fire doors including a unique identification system and the preparation of a fire door schedule.

In accordance with BS 8214:2016[7], there is an expectation that all fire doors are subject to a risk based PPM and inspection regime. The frequency of inspections will be influenced by such issues as; frequency of use, propensity for damage and location of the door. Accordingly, it is recommended that the fire door maintenance regime be reviewed.

6.2.4 Emergency Escape Lighting

No drawings are available indicating the location of emergency escape lighting fittings. Whilst this review has not scrutinised the provision and location of emergency escape light fittings, from discussion with estate staff supported by a brief visual inspection, it appears that the escape lighting provisions again fall well short of what is expected under current standards.

BS 5266-1:2016[8], the latest British Standard for emergency escape lighting, has increased the level of illumination and the locations where lights are expected. Therefore, it is recommended that the emergency lighting provisions are assessed for compliance with the latest standard including the provision of external escape route lighting.

It is also recommended that future upgrades utilise a networked self-testing system.

The deficiencies with the emergency escape lighting should also be detailed in the fire risk assessment.

6.2.5 Fire Fighting Facilities

Internally, the hospital has a wet riser in the 'H' block central core supplemented by three dry risers located in each of the stairs 2, 3 and 7.

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[7] BS 8214:2016 Timber-based fire door assemblies – Code of practice
[8] BS 5266-1:2016 Emergency lighting – Part 1 Code of practice for the emergency lighting of premises
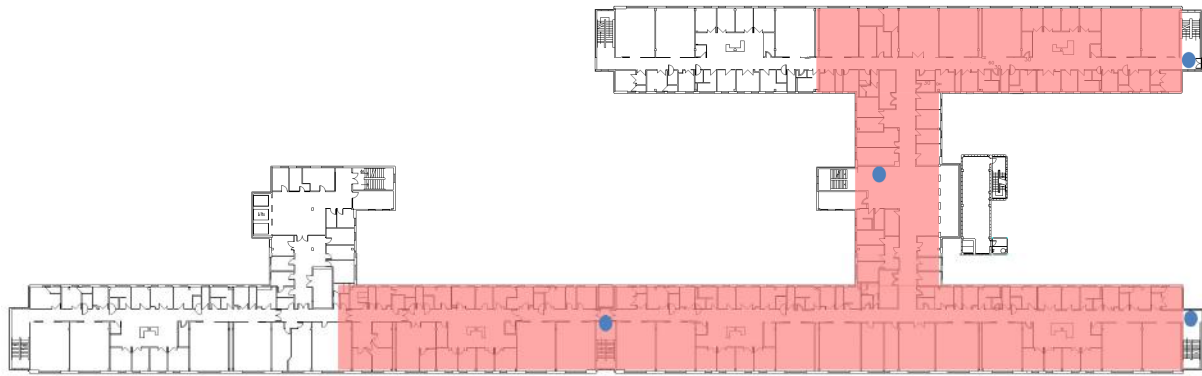
Figure 1 – approximate hose coverage (45m)

The figure above illustrates the approximate location of the wet/dry risers (blue circles) and the approximate area of coverage based on the 45m hose laying distance as required by Firecode (pink shading). The areas with no shading fall outside the hose reach and therefore are non-compliant.

This plan is indicative of the 2nd and 3rd floor only. It should also be noted that there are extensive areas to the deep-plan ground and first floors as well as roof top plant areas well beyond the standard hose reach distances.

Based on the floor area of the upper level, in accordance with Firecode (WHTM05-02 table 11), at least five fire-fighting shafts should be provided. Each of these fire-fighting shafts should have a dry riser. However, in order to comply with the hose laying distance requirements additional risers will be needed.

Furthermore, whilst the hospital has a fire main encircling the site with a number of hydrants (as illustrated in appendix A), it is noted that due to the location of the Oncology Unit extension, the inlet valve serving the Stairway 2 riser is approximately 125m away from the nearest hydrant. This is in excess of the 90m code compliant distance.

Whilst the dry riser inlets and their respective riser outlets are labelled, it is noted that the inlet feeding the stairway 7 riser is located within a padlocked compound. The FRS are apparently aware of this situation.

With regard to the existing 'fire-fighting shafts', a number of anomalies are noted, for example; protected routes from the base of the stairways are not evident, and stairway 3 doesn't provide access to the first floor.

The height of the building does not require the provision of fire-fighting lifts, albeit lifts 3 and 8 in each of the core blocks are provided with a fireman's override switch. It is unclear whether these switches and over-ride function are operational.

It is noted that the fire risk assessments do not fully identify the riser anomalies noted above.

In the short term, it is recommended that the suitability of the current provisions be discussed with the Fire and Rescue Service, this may result in amendments to their tactical fire-fighting plans for the site. In the longer term, it is recommended that the riser provisions be improved as necessary.

6.3   Recommendations

6.3.1   The Board should review and redefine the required fire compartmentation arrangements reflecting the departmental boundaries and evacuation strategy.

6.3.2   The Board should conduct a compartmentation survey utilising the redefined fire strategy drawings. The survey should also address the fire integrity of compartment floors, hazard room enclosures and external fire spread risks.

6.3.3   The Board should implement a prioritised action plan to address the compartmentation deficiencies.

6.3.4   The Board should review the ventilation arrangements in line with the redefined fire strategy. This will identify all required fire damper locations; any fire damper omissions should be prioritised for action as necessary, in particular noting the requirement for dampers in the main vertical risers.

6.3.5   The Board should ensure all fire dampers are tested in accordance with BS9999.

6.3.6   The Board should conduct a fire door survey in line with the redefined fire strategy. This should also include the introduction of a unique identification system and preparation of a fire door schedule.

6.3.7   The Board should review the fire door maintenance and inspection regime to ensure that all fire doors are maintained in accordance with BS8214 and address any fire door failings as necessary.

6.3.8   The Board should assess the emergency escape lighting provisions for compliance with the latest standard including the provision of external escape route lighting.

6.3.9   The Board should ensure that future emergency escape lighting upgrades utilise networked self-testing facilities, and that the testing regime follows the recommendations contained in BS5266.

6.3.10 The Board should discuss the suitability of the current riser provisions with the FRS. In the longer term, the Board should improve the riser provisions as necessary.

7.0 EVACUATION AND RESPONSE PROCEDURES

7.1 Commentary
The concept for means of escape in healthcare premises is based upon Progressive Horizontal Evacuation (PHE). This is achieved by moving patients on their beds or in wheelchairs from the affected fire area through fire resisting compartments and sub-compartments to an adjoining area on the same level. Only if absolutely necessary would vertical or external evacuation be considered.

Firecode currently promotes mattress evacuation; however, within the NHS there is a vast array of evacuation aids available, many specifically intended for vertical evacuation, and consequently there is no one standard approach. For example, some Boards adopt the concept of mattress evacuation utilising evac-sheets permanently located under every bed, whilst other Boards consider the evac-sheets to be an infection control problem thereby adopting an alternative approach.

Whatever evacuation strategy is adopted the Board should ensure and be able to demonstrate that all patients are able to be evacuated safely within a 'reasonable time', without reliance on support from external agencies.

Furthermore, a well-rehearsed and co-ordinated response to a fire emergency is a key element to safeguard the occupants and fabric of the building and is a requirement of Firecode. All staff should know what their specific responsibilities are during a fire incident and should be competent to fulfil those duties accordingly.

7.2 Observations

7.2.1 Occupants and Staff Levels

Patients
Firecode classifies patients as *independent*, *dependent* or *very high dependency* based on their mobility and alertness. The degree of dependency can be further sub-divided by assessing the age profile and the number of ambulant and non-ambulant patients that can be present at any one time.

Visitors
With the exception of protected mealtimes, the majority of wards operate open visiting.

Staffing Levels (Inpatient areas)
The wards generally have three 'staffing' shifts; early, late and night. Typically, staffing levels are at their lowest during the 'night' shift.

The following table provides data on the patient/staff ratios and an indication of the degree of non-ambulant patients typically present in the ward.

Inpatient Occupant/Staff Profile Data

Location	Floor	24/7	Inpatients	Staff Days	Staff Late	Staff Night	Dependency
AG/13 & 14 Dewi/Minffordd Wards	Grd	24/7	28	15 - 20	7	4	
AG/16 Alaw Unit	Grd	24/7	19	35	10	4	
A1/04 Cybi Ward & HDU	1st	24/7	8	16	0	11	High Dependency
A1/05 Enlli Ward	1st	24/7	16	6	6	4	
A1/09 Ffrancon Ward	1st	24/7	21	5	0	3	Varying Dependency
A1/10 LLifon Ward	1st	24/7	42	5	5	4	Pre/Post Natal Care
A1/11 Special Care Baby Unit	1st	24/7	10	4 - 5	3	3	High Dependency
A1/11A Labour Ward	1st	24/7	8	11	11	4	Varying Dependency
A1/13 Ty Celyn MLU	1st	24/7	2	10	5	3	
A2/01 Tegid Ward	2nd	24/7	28	13	0	6	Dependent & Very High Dependency
A2/02 Dulas Ward	2nd	24/7	31	20	8	5	Dependent & Very High Dependency
A2/03 Ogwen Ward	2nd	24/7	26	14	0	5	
A2/04 Conwy Ward	2nd	24/7	30	10	10	5	
A2/05 Prysor Ward	2nd	24/7	12	5	0	3	
A2/06 Glaslyn Ward	2nd	24/7	26	9 - 10	0	5	High Dependency
A3/01 Aran Ward	3rd	24/7	31	13	0	5	Dependent & Independent
A3/02 Gogarth Ward	3rd	24/7	28	16	0	7	Varying Dependency
A3/03 Glyder Ward	3rd	24/7	18	12	0	3	
A3/03a Coronary Care Unit	3rd	24/7	6	3	0	2	Very High Dependency
A3/04 Tryfan Ward	3rd	24/7	28	10 - 15	0	4 - 6	
A3/05 Hebog Ward	3rd	24/7	28	14	0	5	Dependent
A3/06 Moelwyn Ward	3rd	24/7	29	18	0	5	Dependent & Independent

Other non-inpatient departments are excluded from the above table.

It is acknowledged that the patient profile can change from day to day; however, the above figures have been extracted from the current fire risk assessments and are therefore considered typical for the purpose of this review.

Fire legislation requires that an organisation's fire procedures for safe evacuation of occupants must not be reliant on support from external agencies such as the FRS. Therefore, any strategy for evacuation will be reliant on adequate numbers of staff being present. This is even more so where patients

may need to be transferred from beds, baths, etc. to wheel chairs or other evacuation aids where applicable.

7.2.2 Means of Escape - Horizontal Movement

Firecode guidance for means of escape is based on the concept of PHE, only considering one fire at any one time. The provision of robust compartmentation and sub-compartmentation is intended to restrict fire spread and reduce the distance for the occupants to reach safer areas within the building, which as noted previously requires significant remedial works.

In the first instance, horizontal evacuation would be undertaken utilising beds, wheelchairs or staff-assisted walking to safer areas on the same level. The Site Operational Fire Strategy broadly discusses the evacuation strategy, however the departmental procedures provide greater detail indicating the preferred refuge areas or assembly areas for the respective department.

Whilst the local departmental folders contain fire drawings, the development of departmental emergency evacuation fire plans in accordance with BS ISO 23601[9], strategically displayed throughout the site, will further support these procedures.

7.2.3 Vertical Movement

The Board utilises Albac-mats as the sole means for vertical evacuation of mobility impaired patients. These are located within the wards in proximity of the internal stairways.

It is understood that the decision to use Albac-mats was influenced by the need to simplify the training regime, however it is questionable whether the Albac-mat is suitable for all categories of patient.

With regard to bariatric patients, Section 10b of the Site Operational Fire Strategy document encourages for patients to be located in areas where there is potential for progressive horizontal evacuation in alternative directions albeit this is not specifically detailed in the Bariatric admissions process. Therefore, currently there are no suitable evacuation procedures or equipment to cater for bariatric vertical evacuation.

Whilst the layout of the inpatient areas provide scope for progressive horizontal evacuation within the building, the footprint of the 2nd and 3rd floors form a 'T' block and 'H' block, therefore subject to the location of a fire, vertical evacuation via the stairways (1, 3, 6 and 7) may become necessary in the early stages of an incident. The preparation of patients for vertical evacuation (i.e. transfer of patients from beds to evacuation aids) can be a time-consuming process, accordingly it is recommended that 'holding bays/refuge areas' are created at the extremities of the wards. These should be constructed to sub-compartment standards.

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[9] BS ISO 23601 Safety identification – Escape and evacuation plan signs

Figure 2 – recommended location of holding bays/refuge areas

During the review a number of other issues were evident with regard to means of escape, including: -

- Numerous self-closing fire doors were wedged open. Where door closers may impede the day to day use of the area, consideration should be given to the provision of free-swing closers interfaced with the fire alarm system to close on activation. This will reduce the management burden and risk associated with wedging fire doors open.
- A number of fire doors and fire exits are fitted with magnetic locks interfaced with the fire alarm. These should failsafe open and be fitted with green override release facilities.
- The alternative escape route from HDU leads through the Anaesthetics administration offices. Consideration needs to be given to the magnetic locks and direction of door swings through this area.
- Escape stairways should have protected routes from the base of the stairway to a final exit.
- There is no subdivision along the length of the service tunnel resulting in excessive travel distances within the tunnel.
- There is limited separation along the main plant room above theatres.
- The exit signage from the H block rooftop plant room directs occupants on to the flat roof from where there is no escape.
- There are a number of external stairways serving as a means of escape. In the absence of physical weather protection, the Board should ensure procedures are implemented for clearing snow or ice during inclement conditions.

These issues should be addressed through the fire risk assessment process.

7.2.4 Evacuation Exercises

In risk assessment terms, the criteria for assessing whether the means of escape is acceptable are no longer judged solely on travel distance. It now includes the concept that escape must be achieved within a 'reasonable time', although 'reasonable time' is not actually defined.

Various factors will impact upon the time for evacuation, i.e.

- the dependency, age profile and number of ambulant and non-ambulant patients to be evacuated;
- the time taken to transfer patients to evacuation aids and the number of aids available;
- the time of the fire incident which influences the number of staff present; and,
- fatigue, which can have a considerable impact on staff undertaking repeated evacuation.

The effectiveness of the evacuation procedures can only be demonstrated through practical exercises. To this end, the fire policy promotes that training exercises should be conducted on an annual basis. The Site Operational Fire Strategy document (section 4.4) amplifies this stating '*Fire drills should be conducted by each ward and department at least once in every period of twelve months*'.

It is acknowledged that this requires extensive resource to achieve, therefore the Board currently adopt a 'walk and talk' approach to drills supplemented with desktop exercises. The response to false alarms is also utilised to test the response procedures. Whilst these approaches are generally supported, it is recommended that more comprehensive exercises are periodically conducted. In particular, these should test the vertical evacuation procedures and the response procedures for departments treating very high dependency patients.

7.2.5 Response Procedures

As noted previously, the response procedures are referenced in the Site Operational Fire Strategy document, which are further supplemented by the departmental specific procedures.

In brief, the Board operate a well-rehearsed fire response team whereby the following key members have specific roles to fulfil: -

- Deputy fire safety manager (bleep 100)
- Assembly point officer (bleep 021)
- Portering staff
- Estates operational engineer

The 3rd stage site wide alarm prompts wards to release a member of staff to the assembly point to further support the response procedures.

As noted previously, the existing compartmentation and zoning arrangements are far from optimal, therefore, reconfiguration of the zoning will enhance the existing procedures by providing a more focussed area of operations.

As noted above, evacuation exercises will influence the development and refinement of the response procedures. Therefore, the Board's fire procedures should be continually reviewed to reflect the outcomes of future exercises as necessary.

7.2.6 Fire and Rescue Service

The FRS are summoned via a 999 call made by the hospital telephonists. The FRS initial attendance is to the main entrance where, upon arrival, they are met and directed to the incident by the porters.

At the scene of the incident, the FRS will assume control of the incident from the Deputy Fire Safety Manager (Bleep 100 holder).

To support the FRS's operational procedures, the previously referenced fire manual (held on reception at the main entrance) details information about the building and associated fire precautions installed. Section 6 of this report details the existing and proposed firefighting facilities for the FRS.

The Board's procedures should also reflect the operational procedures of the FRS. Therefore, it is recommended that the FRS are invited to participate in future exercises / familiarisation visits to ensure effective coordination.

7.3 Recommendations

7.3.1 The Board should re-assess the suitability of the Albac-mat as the sole means for vertical evacuation with consideration also given to provisions for bariatric vertical evacuation.

7.3.2 The Board should enhance the protection of patients potentially facing vertical evacuation with the provision of 'holding bays/refuge areas' adjacent to the stairways.

7.3.3 The Board should ensure means of escape aspects are cited in the fire risk assessments and actioned accordingly.

7.3.4 The Board should supplement the response procedures with the development of departmental fire plans following the principles of BS ISO 23601.

7.3.5 The Board should continue to review the response procedures in the light of any learning outcomes following future exercises, which should ideally include interaction with the Fire and Rescue Service where possible.

8.0   GUIDANCE ON PRIORITISING THE RECOMMENDATIONS

To accord with the ethos of the FSO, the Board should develop a prioritised action plan for implementing the recommendations identified in this report in an acceptable timeframe agreed with the FRS.

Whilst it is suggested that all of the recommendations made in this report should, where possible, be addressed as soon as possible, it is recognised that this will be particularly challenging to achieve in a working hospital environment. Accordingly, the programme of remedial works is likely to extend over many years. However, it will still be necessary to prioritise the following as soon as possible: -

- Reassess the fire strategy and ensure the integrity of primary 60 minute compartment lines.
- Install fire/smoke dampers to the ventilation ducts in the main vertical risers.
- Reconfigure the fire alarm zone boundaries to reflect the primary compartmentation and ensure the new fire smoke dampers are interfaced with the alarm and C&E.
- Create holding bays/refuge areas to adjacent to the ward stairways.
- Review the suitability of vertical evacuation aids including facilities for bariatric evacuation.
- Enhance the dry riser facilities for the FRS.

Appendix B details the suggested prioritisation of the recommendations made in this report.

Appendix A

Site & Floor Plans

Site Plan

Hydrant Locations

H

H

ST 7

ST 3

H

ST 5

ST 6

ST 2

H

ST 4

H

ST 1

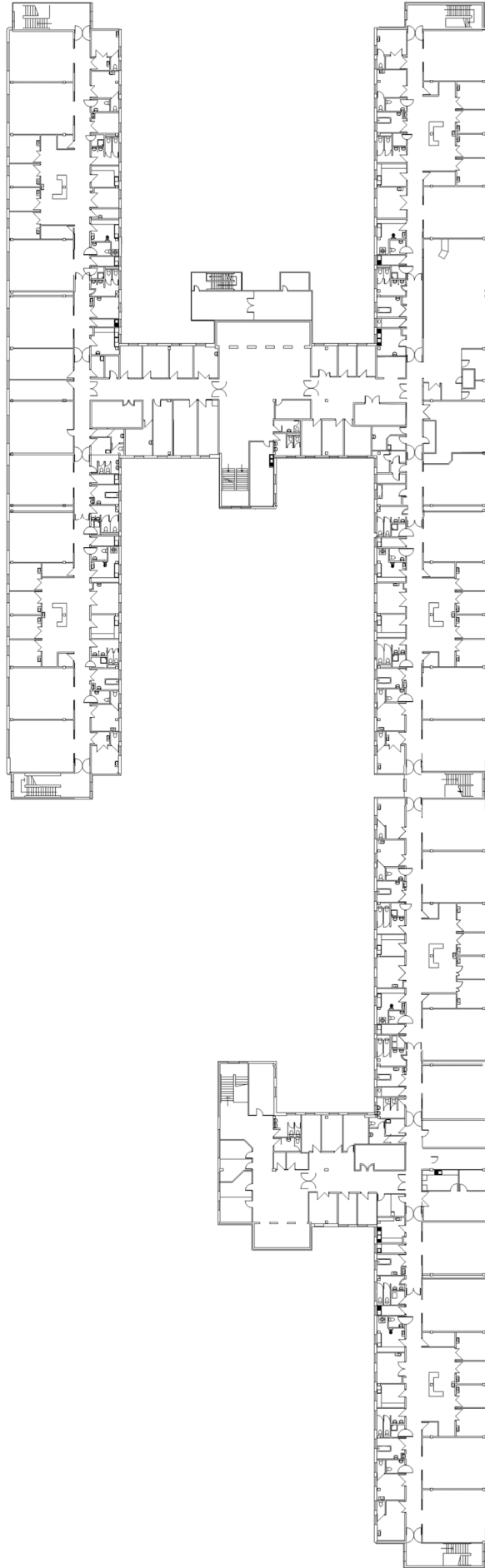|	Main stairways 1 - 7
	Main Service Risers
	Service Tunnel
	Wet/Dry Risers
H	Approximate Hydrant locations

H
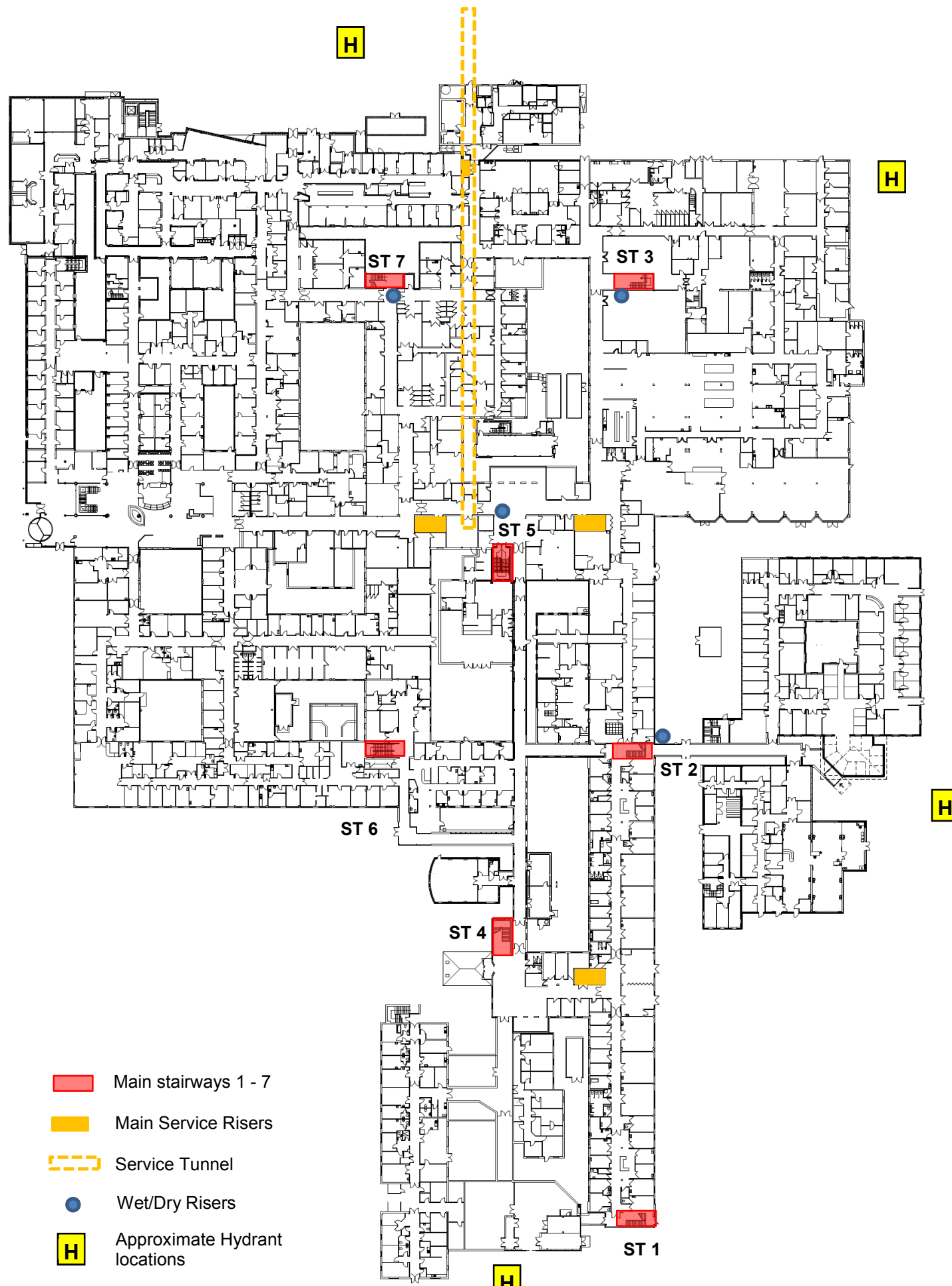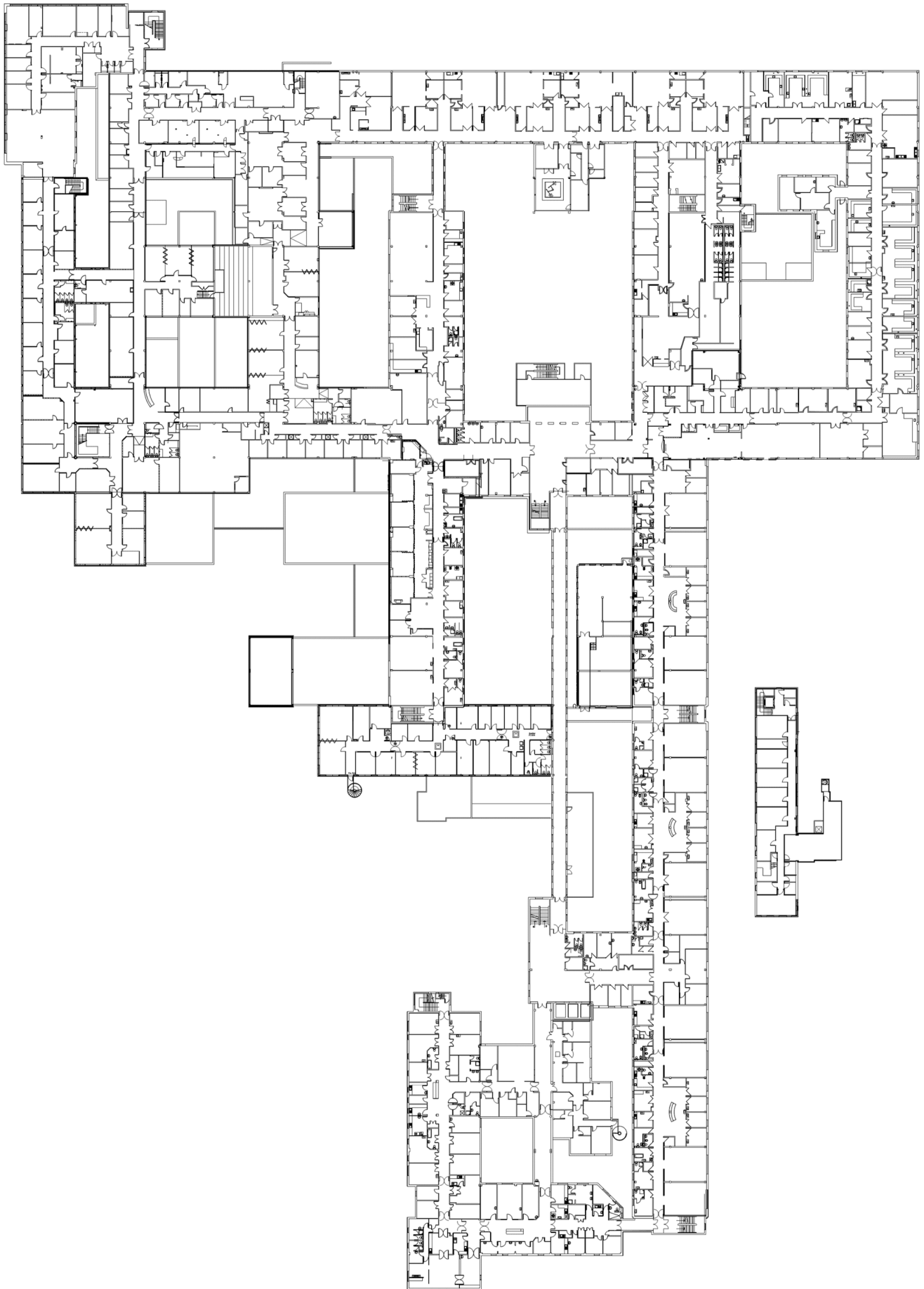
Ground Floor Plan

1st Floor Plan

2nd Floor Plan

3ʳᵈ Floor Plan

APPENDIX B

PRIORITISED RISK RATING

Ref. No.	Recommendation	Risk Rating
4.3.1	The Board should ensure the roles and responsibilities and related management arrangements detailed in the Fire Policy continue to be implemented.	L
4.3.2	The Board should continue to refine and update the content of the fire manual to reflect the fire safety measures and procedures at this hospital.	L
4.3.3	The Board should ensure an accurate up-to-date set of 'as installed' drawings are available and retained with the fire manual.	L
4.3.4	The Board should continue to review the risk assessments to address the anomalies and reflect the findings of this report.	M
4.3.5	The Board should ensure the fire risk assessment recommendations are prioritised and addressed as necessary within the agreed timescale.	M
5.3.1	The Board should reconfigure the fire alarm zone boundaries to reflect the departmental boundaries and compartmentation arrangements.	H
5.3.2	The Board should review the fire alarm device addresses and update where necessary to accurately reflect room designations and reconfigured zoning arrangements.	H
5.3.3	The Board should update the 'as installed' drawings upon completion of the zoning reconfiguration and also enhance the drawings to illustrate all devices interfaced with the fire alarm.	L
5.3.4	The Board should review the cause and effect matrix to reflect the reconfigured zoning. This should detail the operation of all devices interfaced with the fire alarm system, following the format contained in Appendix C.	H
5.3.5	The Board should provide repeater panels to staff bases in accordance with Firecode.	M
5.3.6	The Board should ensure fire alarm zone plans are displayed in proximity to the fire panels.	L
5.3.7	The Board should ensure the fire risk assessment recommendations for additional detection are addressed and also consider the need for a replacement programme for the ageing detectors.	L
5.3.8	The Board should ensure the complete fire alarm system is maintained in accordance with BS 5839:1, including annual verification of the C&E; reference should also be made to the 'Users responsibilities' as defined in the above standard.	M

Ref. No.	Recommendation	Risk Rating
6.3.1	The Board should review and redefine the required fire compartmentation arrangements reflecting the departmental boundaries and evacuation strategy.	H
6.3.2	The Board should conduct a compartmentation survey utilising the redefined fire strategy drawings. The survey should also address the fire integrity of compartment floors, hazard room enclosures and external fire spread risks.	H
6.3.3	The Board should implement a prioritised action plan to address the compartmentation deficiencies.	H
6.3.4	The Board should review the ventilation arrangements in line with the redefined fire strategy. This will identify all required fire damper locations; any fire damper omissions should be prioritised for action as necessary, in particular noting the requirement for dampers in the main vertical risers.	H
6.3.5	The Board should ensure all fire dampers are tested in accordance with BS9999.	M
6.3.6	The Board should conduct a fire door survey in line with the redefined fire strategy. This should also include the introduction of a unique identification system and preparation of a fire door schedule.	H
6.3.7	The Board should review the fire door maintenance and inspection regime to ensure that all fire doors are maintained in accordance with BS8214 and address any fire door failings as necessary.	M
6.3.8	The Board should assess the emergency escape lighting provisions for compliance with the latest standard including the provision of external escape route lighting.	H
6.3.9	The Board should ensure that future emergency escape lighting upgrades utilise networked self-testing facilities, and that the testing regime follows the recommendations contained in BS5266.	L
6.3.10	The Board should discuss the suitability of the current riser provisions with the FRS. In the longer term, the Board should improve the riser provisions as necessary.	H
7.3.1	The Board should re-assess the suitability of the Albac-mat as the sole means for vertical evacuation with consideration also given to provisions for bariatric vertical evacuation.	H
7.3.2	The Board should enhance the protection of patients potentially facing vertical evacuation with the provision of 'holding bays/refuge areas' adjacent to the stairways.	H
7.3.3	The Board should ensure means of escape aspects are cited in the fire risk assessments and actioned accordingly.	H
7.3.4	The Board should supplement the response procedures with the development of departmental fire plans following the principles of BS ISO 23601.	L

Ref. No.	Recommendation	Risk Rating
7.3.5	The Board should continue to review the response procedures in the light of any learning outcomes following future exercises, which should ideally include interaction with the Fire and Rescue Service where possible.	M

APPENDIX C
CAUSE AND EFFECT TEMPLATE

FIRE ALARM SOUNDERS			ACCESS CONTROL DOORS TO RELEASE	FIRE DOORS DETENTES TO RELEASE	FIRE/SMOKE DAMPERS TO CLOSE	MECHANICAL PLANT TO ISOLATE	LIFTS TO OPERATE	ADDITIONAL ANCILLARY DEVICES TO OPERTATE	Remarks
Zone Of Activation - Evacuate (Continuous Tone)	Zones To Alert (Intermittent Tone)	Additional Sounders To Evacuate (Continuous Tone)	Door Ref No.	Door Ref No.	Damper Ref No:	AHU Ref.	Lift Ref. and function	Function And Location Of Ancillary Device (Gas valves, roller shutters etc)	
Zone 1 (OPD)									
Zone 2 (X-Ray)									
Zone 3 (Ward 1)									
Zone 4 (Ward 2)									
Zone 5									
Zone 6									
Zone 7									
Zone 8									

Notes.

Cyfarfod a dyddiad: Meeting and date:	Quality Safety and Experience Committee 28th August 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Pharmacy & Medicines Management Annual Report 2019-20
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr David Fearnley, Executive Medical Director Dr Berwyn Owen, Chief Pharmacist
Awdur yr Adroddiad Report Author:	Mrs Louise Howard-Baker Assistant Area Director Pharmacy & Medicines Management
Craffu blaenorol: Prior Scrutiny:	Pharmacy Management Team
Atodiadau Appendices:	1. The Pharmacy & Medicines Management Annual Report 2019-20.

Argymhelliad / Recommendation:
The Committee is asked to receive the report for information

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:
This annual report has been set around the themes of the Health and Care Standards framework to deliver person-centered care by ensuring that BCUHB handles medicines safely and securely, in accordance with legislative requirements and best practice and ensures safe and effective medicines use for optimal outcomes in accordance with medicines optimisation best practice.

Cefndir / Background:
The annual report for 2019-20 covers the systems, processes and support in place for Pharmacy and Medicines Management to ensure the quality, safety and cost-effectiveness of medicines selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to producing informed and desired outcomes of patient care. It also highlights the red (≥15) risks on the service risk register.

Asesiad / Assessment & Analysis

The safe and secure handling and optimisation of medicines on both the hospital and primary care settings requires appropriate policies, procedures and quality assurance systems to be in place. It covers processes throughout the organisation, not just in pharmacy.

Strategy Implications

The annual report demonstrates the strategic and business plans of BCUHB and Welsh Government:

- Care closer to home
- Unscheduled care
- Financial balance
- A Healthier Wales

Financial Implications

As an annual report, it contains some finance information, but has no financial implications.

Risk Analysis

The medicines governance focuses on the safety and risk management issues concerned with medicines and importantly, systems risks that can lead to error and resultant adverse incidents.

This report describes the high (≥15) risks on the Pharmacy & Medicines Management risk register. Although all have mitigation, most are waiting for capital funding, investment from others service, or a national solution, such as electronic prescribing and administration system (WHEPMA).

Legal and Compliance

The Pharmacy & Medicines Management annual report 2019-20 describes progress with compliance with the legislative framework since the 2018-20 report was submitted to the BCUHB Board.

Impact Assessment

None

Pharmacy & Medicines Management Annual Report 2019-20

1.0 Executive Summary

The three Area pharmacy teams continued to focus their efforts to ensure that patients received safe and correct therapeutic treatments through the procurement, distribution, manufacturing, prescribing, administration and disposal of medicines. Upholding the principles of prudent healthcare, pharmacists and pharmacy technicians have worked across interfaces to add value and improve outcomes, including stopping medicines no longer indicated. New community pharmacy enhanced services to improve access for patients for minor illness have successfully been tried and are being rolled out across North Wales.

The over-riding theme for pharmacy for 2019 was almost certainly medicines shortages, affecting some 200 per month. Despite this, the procurement team worked with clinicians and colleagues to ensure that where necessary stock was recalled, and safe alternatives sourced and substituted, so patients were not harmed. They have also supported community pharmacy with information and advice.

The impact of these shortages and drug price changes (Category M, No Cheaper Stock Obtainable (NCSO)) to meet the funding needed for the community pharmacy contract, has resulted in significant price volatility and higher prescribing costs. There were no windfall savings from expired patents in 2019 and together with rumours of stockpiling by patients, BCUHB experienced growth in both items and cost in excess of the savings schemes. However it is worth reflecting from the graph below how far BCUHB has moved when comparing the six counties of north Wales with the rest of Wales and England.

The appointment of a third assistant director for the central area, thereby separating the role of Chief Pharmacist, has enabled significant progress to be made with both governance and strategic direction, the latter being progressed through the Medicines Management Improvement Group (MMIG), chaired by the Executive Medical Director. The focus for the MMIG going forward will be prudent prescribing and clinical pathways which will require investment to deliver improved patient outcomes, and better value. The business cases will be taken through the BCUHB project management office (PMO) process.

Key Achievements

- Savings from the cost effective use of medicines and from de-prescribing are forecast to be in excess of £6.6m by the end of March 2020.
- Significant progress has been made to address the recommendations from the Welsh Audit Office report of 2015, which are being monitored by the Audit Committee. However, the lack of a clear timescale and funding plan for the implementation of electronic prescribing remains outstanding.
- An external review, commissioned by the Executive Director for Primary and Community Care has been published. Upwards of 70 staff from BCUHB at varying levels, including the Chief Executive were interviewed. The document will provide the strategic direction on where to focus the workforce to deliver medicines optimisation for patients. Progress will be monitored by the Community Transformation Board.

- The workload continued to grow, but at a lower rate than 2018 with 1.61 million items dispensed or supplied from the four hospitals (including Llandudno), more than 90,000 doses of sterile medicines prepared and the equivalent of 37,000 clinical safety interventions.
- A Medicines and Healthcare Regulatory Authority (MHRA) inspection of the Wrexham Maelor pharmacy department took place in December in lieu of an application for a Wholesale Distribution Authorisation. The subsequent letter from the MHRA confirmed that with some minor improvements and assurances the standards had been met and so the supply of medicines to third parties e.g. hospices, Air Ambulance, WAST can legally take place from Wrexham on behalf of the Health Board.
- Runner up in the Pharmacy Technician Association UK Pre-registration of the Year award;
- 2 BCUHB Achievement Award nominations; 1 winner;
- Poster winner for the pre-registration pharmacist category at the UK Clinical Pharmacy Association (UKCPA);
- Co-producer of the revised, rewritten and expanded Handbook of Perioperative Medicines on behalf of the UK Clinical Pharmacy Association (UKCPA), endorsed by the Preoperative Association and the Royal College of Physicians and Surgeons of Glasgow;
- 2 Pharmacists shortlisted for awards at the 1st Advancing Healthcare Awards, one in the Pharmacist of the Year category and the other for the award for Improving Public Health Outcomes;
- BCUHB was one of 19 non-profit making organisations internationally to receive a grant from Gilead Sciences for the routine rapid testing and treatment of hepatitis C among the homeless population in Wrexham by specialist pharmacists and supported by the harm reduction team.
- BCUHB is at the forefront of exploring new ways of working and extending roles for community pharmacists to support the unscheduled care agenda and take pressure off GP practices, Out of Hours services and Emergency Departments.
- Ysbyty Gwynedd took part in a UK multicentre trial, the ARK Study (Antibiotic review toolkit), which is a stewardship tool for secondary care. It uses behavioural change science to improve prescribing. The antibiotic prescription review rate at Bangor increased from the baseline of 23% to 92% and the antibiotics stopped rose from 22% to 34% by the end of the trial.
- Several members of the pharmacy team are working as part of a Wales-wide collaboration led by Welsh Government, the Transforming Access to Medicines Supply (TrAMS). Several work streams are looking at technical services including sterile manufacturing, logistics, procurement and Homecare which will have an impact on how these services are delivered across Wales in the future.

Governance, Leadership and Accountability

In 2019 a third assistant director for pharmacy and medicines management was appointed for the central area, thereby enabling the Chief Pharmacist to focus on his role in ensuring that policies, processes and systems are in place for the safe, secure

and cost-effective handling of medicines within BCUHB and medicines optimisation is clearly defined.

The Chief Pharmacist accountability sits now with the Executive Medical Director, who also chairs the Medicines Management Improvement Group, which as well as considering finance and savings, will set the strategic direction for medicines optimisation.

Wholesaler Distribution Authorisation (WDA)

In 2012, the Medicines and Healthcare Regulatory Authority (MHRA) put more stringent regulations in place for the supply of medicines by hospitals to third party organisations, including hospices, Welsh Ambulance, Air Ambulance, Mountain Rescue etc. Their objective was to ensure the safety of medicines, including unlicensed medicines, the recall of defective products and to prevent diversion or the introduction of falsified medicines.

A series of events prevented all three acute hospitals from achieving their aim to each hold a licence: the redevelopment of the Glan Clwyd pharmacy and the installation of the new robot at Bangor. The Wrexham Maelor Hospital agreed to be the first to apply. It was a significant piece of work to comply with the Good Distribution Practice of Medicinal Products for Human Use (GDP) and involved re-writing procedures covering all aspects of medicines procurement, receipt, supply, recall and disposal, staff training and embedding new practice which has taken two years to complete.

The Medicines and Healthcare Regulatory Authority (MHRA) visited the Wrexham Maelor Hospital in December 2019 for the preliminary inspection. The post-inspection letter, in January 2020 highlighted a number of minor deficiencies that required a response within 28 days, including an action plan and also a decision about the future supply to third parties from two non-compliant hospitals in BCUHB. The minor deficiencies cover quality management systems, personnel, premises and operations. There were no critical or major concerns. It has been decided that Wrexham will supply all third parties in North Wales until such time that the other two hospitals are ready to apply for a licence.

Staying Healthy

1.1. Health promotion Protection & Improvement

Choose Pharmacy

A national Choose Pharmacy IT platform supports community pharmacy delivered services, which include the following enhanced services commissioned by BCUHB:

- The Common Ailments Scheme
- Sore Throat Test and Treat
- Discharge Medication Review
- Flu vaccination
- Emergency Medicines Supply
- Emergency Contraception

Common Ailments Scheme and Sore Throat test and treat

The Common Ailments Scheme (CAS) offers free access to advice and treatment for 26 common conditions in 150 of the 153 of community pharmacies in BCUHB. Of these, 63 also offered the sore throat test and treat service, an extension to the CAS. Both have had a significant impact on the use of unscheduled care services. Patient feedback indicates that over 75% would otherwise have made an appointment to see their GP, so saving almost 11,000 GP appointments over an eleven-month period.

Action patients would take if CAS/Sore throat test and treat was unavailable	Frequency (%)
Made an appointment with a GP	10,833 (77.6%)
Bought medication from the pharmacy	2,170 (15.5%)
Done nothing	354 (2.5%)
Made an appointment to attend the out of hours service	282 (2.0%)
Made an appointment with other (e.g. dentist or optometrist)	149 (1.1%)
Made an appointment with a nurse or health visitor	126 (0.9%)
Attended the accident and emergency department at hospital	35 (0.3%)
Called NHS Direct for advice	13 (0.1%)

Table 1 - Patient reported planned action if common ailment service had not been available (BCUHB data from December 2018 to October 2019 inclusive)

An electronic CAS summary sent to the patient's GP via the Welsh Clinical Portal was tested by BCUHB to reduce paper, improve information governance and safety. This will now to be extended to the other modules within the Choose Pharmacy Platform.

Sore Throat Test and Treat Service

Patients with a sore throat are assessed using the FeverPAIN or Centor scoring systems and where indicated, a rapid antigen test (RADT) is used to confirm the presence of *streptococcus A* and appropriate antibiotic therapy supplied via a PGD. For negative results, the pharmacist gives reassurance and self-care advice.
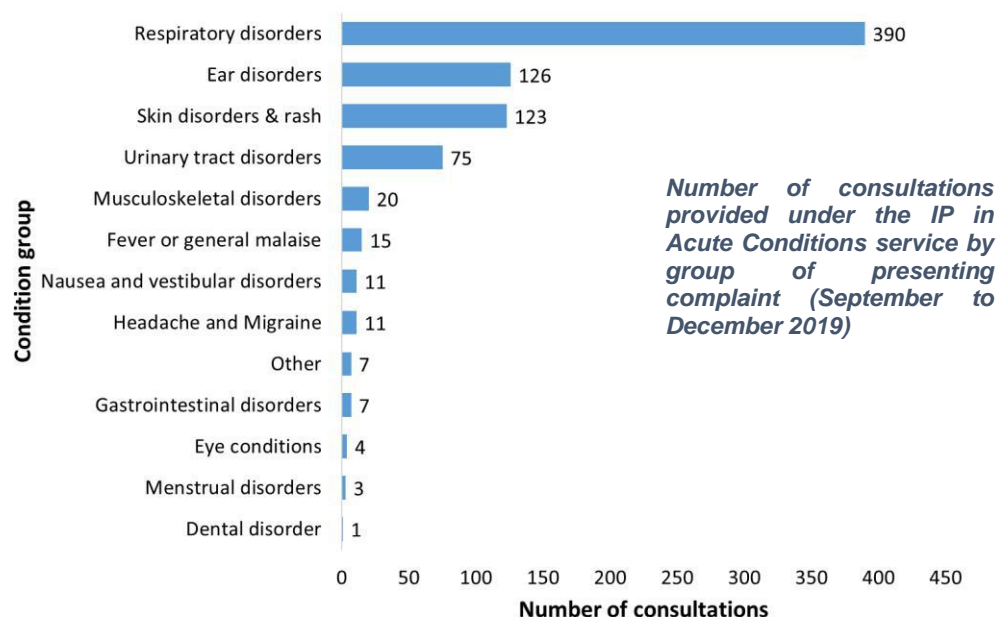
3,500 patients were seen in the pilot pharmacies in BCUHB and CTMUHB at the point of the service evaluation in July 2019. Of those seen, 97% reported that they would have consulted their GP or the out of hours (OOH) GP. A follow-up questionnaire indicated a 99% satisfaction rating and intention to re-use the service.

- During the pilot phase, two cases of epiglottitis were correctly identified and referred for urgent care.
- A review of quinsy presentations in local hospitals (the most likely complication from under treatment of sore throat with antibiotics) showed no rise in cases, suggesting that the service is being safely provided.
- Consultations at two GP surgeries local to the service were monitored and reported the lowest number of consultations for sore throat in the past 5 years.
- A lower rate of antibiotic use (1 in 5) was seen compared to the typical rate for general practice (around 3 in 5), which led to NWIS winning the Innovation and Technology category of the National Antibiotic Guardian awards.

The positive impact of this pilot in early 2019 means that the service will be extended from 63 to 110 pharmacies in 2020.

Independent prescribing in acute conditions

Further extending their role, the Health Board sponsored a number of community pharmacists to become independent prescribers; initially three were commissioned to see, assess and treat or refer patients as appropriate. In the last quarter of 2019, 793 patients were seen for a range of conditions, the most common being respiratory disorders, including COPD and asthma exacerbation, suspected upper respiratory tract infections, sore throats, and sinusitis.

Number of consultations provided under the IP in Acute Conditions service by group of presenting complaint (September to December 2019)

Consultations requiring an urgent referral included:
- NEWS score 7, suspected sepsis;
- Cough with blood, smoker;
- Fall with loss of consciousness;
- Lump on throat, with numerous red flags - haemoptysis, weight loss, smoker, swallowing difficulties, smoker
- Asked to attend a pub across the road as patient had collapsed and having asthma attack. 999 already called
- Breathlessness and faint
- Oxygen Saturation 91%, dropping to 88%

Again, the feedback was extremely positive with 94% citing that their alternative course of action would be to attend their GP or the OOH service.

GP practices referred approximately two fifths of patients (42%) with the remainder self-referring. Approximately 7% were temporary residents in the area. A further 6 pharmacies will begin the service in early 2020.

Flu vaccination service

Now an established service, the number of people vaccinated through community pharmacy has grown substantially to 13,010 in the 2019/20 winter season (Nov 19). Prioritising individuals of working age with one or more risk factors, pharmacists were given discretion to vaccinate patients over 65 if they do not consider the patient will attend their GP practice. In addition, the service was extended to include staff from adult care homes and domiciliary care workers.

Emergency Medicines Service

For local residents when their surgery is closed and for temporary residents at any time, the Emergency Medicines Service (EMS) allows pharmacists to assist patients who have run out/lost their medicines, by confirming the details of those regular medicines needed via the Choose Pharmacy platform and provide a supply. The OOH GP service benefits greatly from this service, which in the 2018/19 year saw 8,645 patients accessing an emergency supply of medicines.

5

Emergency Contraception

Although emergency contraception is available for purchase over the counter, 140 pharmacies also provide advice and free supplies via this enhanced service. Ease of access is particularly important because of the critical timing to ensure effectiveness and also helps tackle inequalities for women unable to pay. Around 8,000 consultations take place each year and in a minority of cases there may be a need to refer patients to other services for further advice or treatment.

Continuity of Services

Continuity of services has been a problem because of difficulties with recruitment and retention leading to a reliance on locum staff, who may not be accredited to provide the BCUHB services. To improve the reliability of the common ailment scheme, a continuity incentive was introduced in October 2019. Initially rewarding pharmacies able to offer the service for over 60% of the days that they are open, the minimum requirement rose to 70% in January and on the 1st April 2020 this will rise again to 80%. In December 2019 115 (77%) met the threshold.

Pharmaceutical Needs Assessment

BCUHB will be required to publish a Pharmaceutical Needs Assessment (PNA) by 1st April 2021 following new Pharmaceutical Regulations coming into force on 1st April 2020. The PNA will include:

- Evaluation of the need for pharmaceutical services across North Wales, including enhanced services.
- Matching the identified needs to existing service provision.
- Identification of any gaps in services, which must be articulated in the report.

New contracts may then be applied for on the basis where there is an unmet need for a pharmaceutical service, allowing the Health Board to guide the development of new contracts in a way that is not possible under the existing regulations. A Steering Group, chaired by The Executive Director for Primary and Community Care was convened in January, and has commissioned an external agency, Primary Care Commissioning, to prepare the PNA document.

Safe Care

2.1 Managing Risk and Promoting Health & Safety

Medicines Storage – PSN015 & PSN030

The medicines management nurses and the safety lead pharmacists have repeated the medicines storage audit to assess compliance with the Patient Safety Notice. Some improvements have been seen since 2018 with further compliance improvement notices in place (see table on page 7). Some points to note on the standards:

Standard	Monitoring/Notes
Medicines Storage cupboards/Fluid storage cupboards are locked	Monitored on Matron's walkabouts; medicines management collaborative; annual audit
Medicines fridges are locked	
Fridge temperatures are consistently monitored	
Room temperatures are consistently monitored	
Secure access utility room (with swipe access door)	Some wards will have to wait for refurbishment/redevelopment to achieve the standard.
Patient POD lockers are locked	Should always be locked.

Table to demonstrate BCUHB compliance with PSN015 and PSN 030

	East Area			West Area			Central Area		
	WMH including ED	Mental Health	Community Hospitals	YG including ED	Mental Health & LD	Community Hospitals	YGC including ED	Mental Health	Community Hospitals
Medicines storage cupboards	⇔	⇔	⇔	⇔	⇧	⇔	⇔	⇔	⇔
CD cupboards	⇔	⇔	⇔	⇔	⇧	⇔	⇔	⇔	⇔
Medicines fridges	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇧
Patients own POD lockers	⇔	⇔	N/A	⇩	N/A	⇔	⇔	N/A	⇔
Secure access- Utility room	⇔	⇔	⇔	⇩	⇔	⇔	⇔	⇔	⇧
Fluid storage	⇔	N/A	⇔	⇔	N/A	⇔	⇔	N/A	⇧
Room Temperature Monitoring	⇧	⇧	⇧	⇔	⇔	⇩	⇔	⇔	⇧
Fridge Temperature Monitoring	⇩	⇔	⇔	⇔	⇧	⇧	⇧	⇔	⇧

Medicine Procurement and Business continuity

National shortages and supply disruptions of medicines continue with around 200 medicines affected per month. This has impacted on a wide range of clinical specialities, across all care settings and created additional demands on pharmacy staff to maintain supplies to patients. Each medicine will have different requirements and so requires an individual management plan. In community pharmacy, there are also complex supply chains and, in some cases, quotas and limits on the quantities that can be ordered, further adding to the challenge and workload.

The BCUHB medicines procurement lead pharmacists work closely with an advisory group that was set up by Welsh Government to coordinate intelligence and provide advice on shortages and a Health Board-wide pharmacy communication cascade has been established for primary and secondary care, extended to include a surveillance process for community pharmacists to report local issues.

Successful medicines shortage management relies on collaborative working with clinicians. Following initial assessment of where stock is held and its usage, plans are developed which may include centralisation of stock, re-distribution between sites, or procurement of licensed or unlicensed alternatives, which have to be risk-assessed for safety and approved by the Drugs and Therapeutics Group. Ring-fencing supplies in secondary care for access by primary care patients proved effective in the recent case of an antidepressant, phenelzine.

Critical Medicines shortages in 2019/20	
Bupivacaine 4% injection (epidural)	Digoxin injection (atrial fibrillation)
Epirubicin and mitomycin injection (chemotherapy)	Ranitidine (widely used for reflux oesophagitis)
Procyclidine injection (acute dystonia)	Dinoprostone pessaries (induction of labour).
Diamorphine (analgesia)	Phenytoin (epilepsy)

In December 2019, Welsh Government passed legislation, the Serious Shortage Protocol (SSP), permitting community pharmacists to endorse a change, such as a formulation or quantity on a WP10 prescription, without prescriber consultation.

Planning for a No-deal EU exit in 2019, the procurement lead pharmacists were active members of the BCUHB working group, leading on the business continuity plans for managing concerns and maintaining supplies of medicines for patients in North Wales.

Because medicine contracts are negotiated nationally, there are few advantages to centralising all procurement, but there are exceptions e.g. ordering the 2019/20 annual influenza vaccine for occupational health and the 15 managed GP practices, with 38,000 vaccines ordered and successfully distributed.

Homecare (Care closer to home)

The new Pharmacy Medicines Homecare team manages the governance procedures for all homecare prescriptions generated across the Health Board from one site. As well as processing prescriptions, it provides a single contact point for dealing with queries and concerns. Actively involved in a national collaborative, they are developing "Once for Wales" service level agreements for new medicines approved for homecare supply.

Fifteen different specialities within the Health Board now use this route to supply these medicines and the number of patients has risen by 14% up to 2739. Despite this growth, the total expenditure in 2019 remained static at £10.1 million. This was due to a successful switch programme (recognised as the most successful in Wales) for the biosimilar adalimumab implemented across dermatology, gastroenterology and rheumatology saving £1.8 million, so offsetting the growth from other newly approved high cost medicines.

Some of the new medicines supplied via homecare will have a significant impact on spend, such as a £500k increase for cancer and respiratory; £400k for the management of atopic eczema and £230k for oral dosing formulations of biologic medicines for rheumatoid arthritis. Despite this, the VAT exemption on these prescriptions has saved the Health Board approximately £2m.
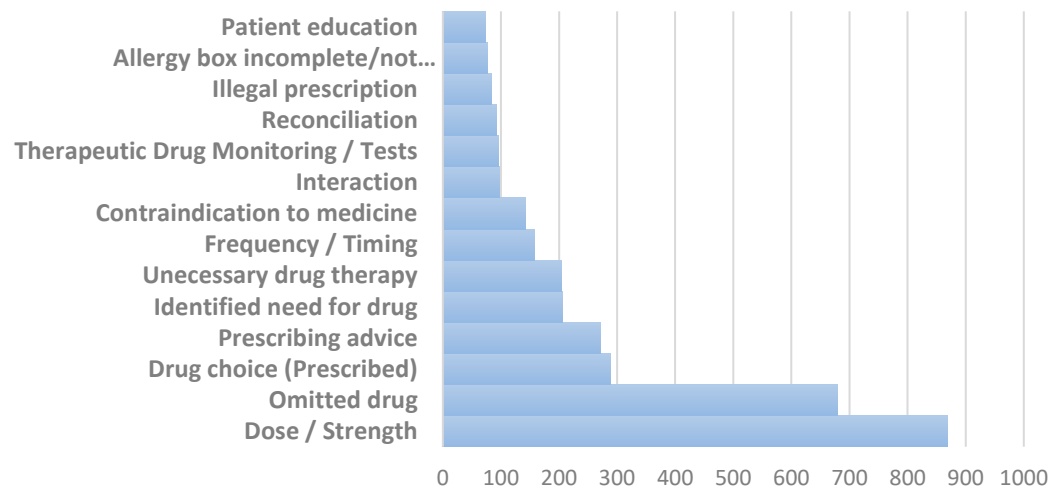
Interventions

The interventions collected by pharmacists on twelve days in 2019-20 across secondary care within BCUHB totalled 1790, of which 52 were classed as potentially lethal. The cost avoidance of those actually reported was £560,000* or £48,000 per day from harm reduction, admission avoidance and reduced length of stay.

* based on the Equipp study

Row Labels	Interventions Count	Cost avoidance/ Intervention		Cost avoidance	
Minor	305	£	3.00	£	915.00
Not Applicable	48			£	-
Potentially lethal	52	£	1,500.00	£	78,000.00
Serious	383	£	1,000.00	£	383,000.00
Significant	1002	£	100.00	£	100,200.00
Grand Total	1790			£	562,115.00

Case: Patient presented to ED with constipation, confusion and slurred speech. Recognised on drug history that diltiazem had recently been started ~3 weeks ago, and patient on carbamazepine. Diltiazem can increase concentration of carbamazepine. Highlighted to medical team that patient may be showing signs of carbamazepine toxicity and level should be checked; medical team had not considered as potential diagnosis and were treating patient for constipation. Level= 24mg/L (more than twice therapeutic) and patient was admitted based on this and managed for carbamazepine toxicity.

Intervention by Type

Interventions Count
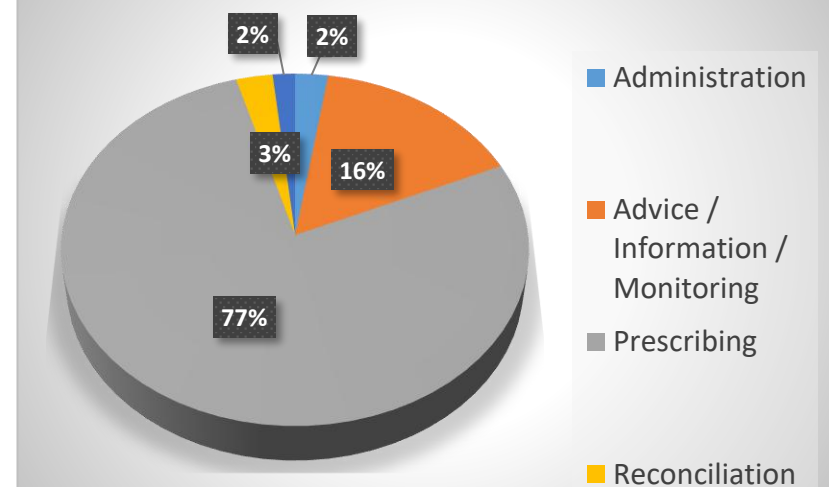
## 2.4 Infection Prevention and Control (IPC) and Decontamination

Antimicrobial stewardship

Primary Care

The widespread and often excessive use of antimicrobials has been identified as one of the main causes of the increasing emergence of antimicrobial resistance.

BCUHB (the green line ranked 3rd best in Wales) contiues to demonstrate a steady decline in prescribing volume of antibiotic items with an overall reduction of 8.03% exceeding the Wales target of 5%. All 14 BCU cluster areas achieved the target.

Figure 12. Trend in antibacterial prescribing items per 1,000 STAR-PUs
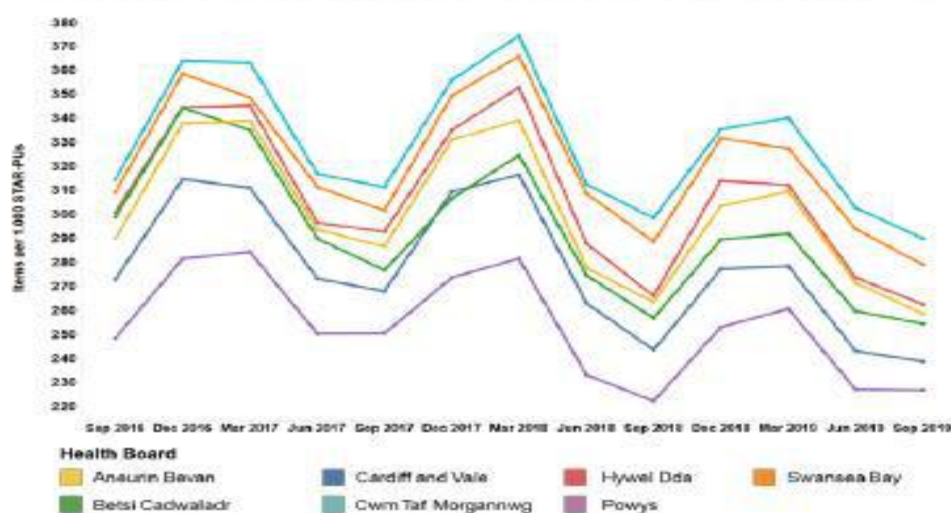
In primary care the pharmacy teams have continued to build on the successful projects of last year including:

- The primary care Urinary Tract Infection (UTI) treatment guidelines were updated in 2019. Working collaboratively with the practice development nurses, care home training included how to take mid-stream urine samples; stopping urine dipstick testing (as per NICE guidelines), with the aim of supporting care staff to make decisions on when it is appropriate to seek medical advice for suspected UTI
- Focussed support on the outlier high prescribing practices and clusters including Dwyfor who achieved a significant prescribing reduction.
- Visits to primary schools by the antimicrobial pharmacists as part of a health promotion project, eBug, to educate the next generation on the importance of antimicrobial resistance. Train the teacher events have started in Conwy to reach more schools in the future. An e-Bug collaboration with Techniquest Wrexham is currently being scoped to enable education and awareness across all schools in North Wales.

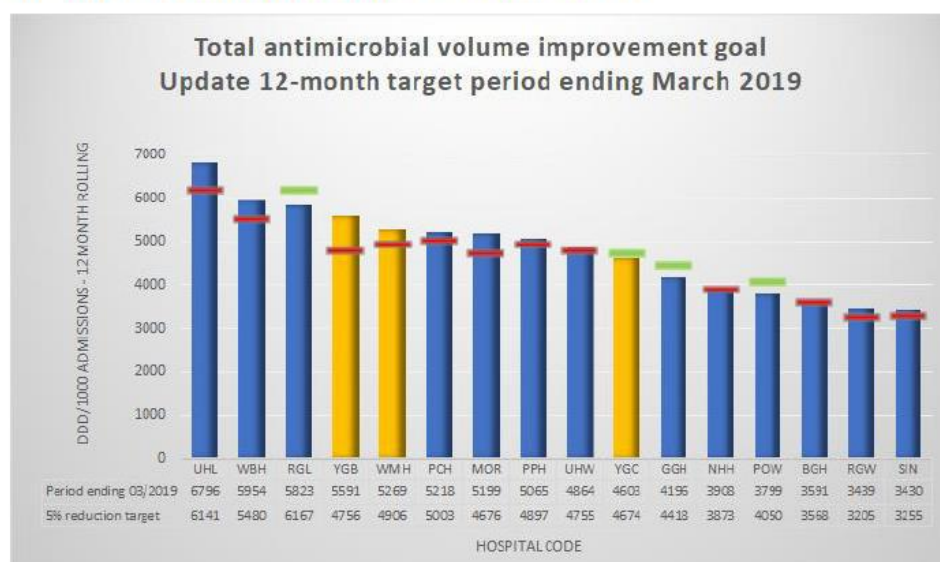### OPAT (Outpatient Parenteral Antimicrobial Therapy)

Limited progress has been made with OPAT, a service to enable patients who would normally require a hospital bed to receive their antibiotic treatment in another setting e.g. IV suite, community hospital. This is still a far from an equitable service across North Wales but BCUHB hosted a national conference at Glyndwr University, which highlighted areas where OPAT is working and facilitated some strategic planning. An overarching policy is now in place and a patient management system has been purchased to allow virtual ward rounds and regular review of patients to ensure patient safety and antimicrobial stewardship through regular multidisciplinary team review.

This will address many governance concerns and allow further development of services across BCUHB.

Secondary Care

Ysbyty Glan Clwyd was the only one of the 3 acute sites to achieve the WG target for total antibiotic reduction, and one of only 4 hospitals in Wales.

TOTAL ANTIMICROBIAL VOLUME DATA

Total antimicrobial volume improvement goal
Update 12-month target period ending March 2019

HOSPITAL CODE	UHL	WBH	RGL	YGB	WMH	PCH	MOR	PPH	UHW	YGC	GGH	NHH	POW	BGH	RGW	SIN
Period ending 03/2019	6796	5954	5823	5591	5269	5218	5199	5065	4864	4603	4196	3908	3799	3591	3439	3430
5% reduction target	6141	5480	6167	4756	4906	5003	4676	4897	4755	4674	4418	3873	4090	3568	3205	3255

Key: BGH – Bronglais; GGH – Glangwili, MOR – Morriston, NNH – Nevill Hall, PCH – Prince Charles, POW – Princess of Wales, PPH – Prince Philip, RGL – Royal Glamorgan, RGW – Royal Gwent, SIN – Singleton, UHL – University Hospital Llandough, UHW – University Hospital of Wales, WBH – Withybush, WMH – Wrexham Maelor, YGB – Ysbyty Gwynedd, YGC – Ysbyty Glan Clwyd

Further improvements to limit the broad spectrum antibiotics to reduce the risk of Health Care Associted Infections and resistance via a restriction policy are in progress. Wrexham Maelor hospital achieved the target of 55% or more antibiotics being from the "access aware", or narrow spectrum category, set by the World Health Organisation and both YG and YGC saw improvements.
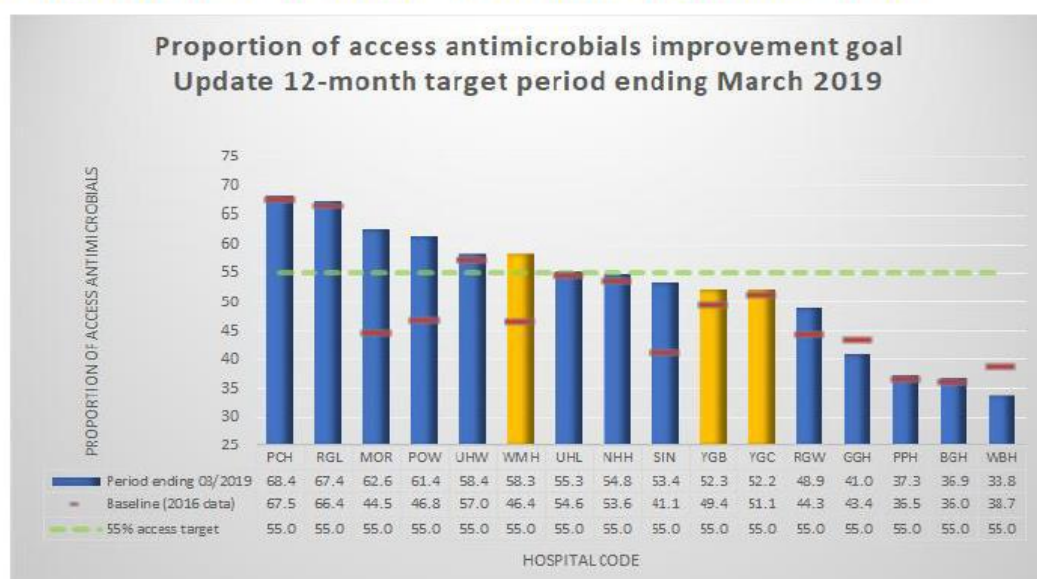
PROPORTION OF ACCESS ANTIMICROBIALS DATA

Proportion of access antimicrobials improvement goal
Update 12-month target period ending March 2019

HOSPITAL CODE	PCH	RGL	MOR	POW	UHW	WMH	UHL	NHH	SIN	YGB	YGC	RGW	GGH	PPH	BGH	WBH
Period ending 03/2019	68.4	67.4	62.6	61.4	58.4	58.3	55.3	54.8	53.4	52.3	52.2	48.9	41.0	37.3	36.9	33.8
Baseline (2016 data)	67.5	66.4	44.5	46.8	57.0	46.4	54.6	53.6	41.1	49.4	51.1	44.3	43.4	36.5	36.0	38.7
55% access target	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0	55.0

Figure 5: Proportion of access antimicrobial usage by acute hospital - 31/03/19

Ysbyty Gwynedd took part in a UK multicentre trial, the ARK Study (Antibiotic review toolkit), which is a stewardship tool for secondary care. It uses behavioural change science to improve prescribing. An eLearning package explains the principles, which include an initial prescription of antimicrobial treatment for 72 hours and then a hard stop. This ensures that patients get an early decision for the need for ongoing treatment. A finalised prescription is written by the prescriber if antibiotics are still indicated based on diagnosis and sensitivity, switching to oral therapy where possible.

Fully implemented in Bangor and Wrexham, a further roll out of the ARK to Ysbyty Glan Clwyd is planned when staffing allows. The antibiotic prescription review rate at Bangor increased from the baseline of 23% to 92% and the antibiotics stopped rose from 22% to 34% by the end of the trial. Recent data shows these rates are being sustained.

The Ysbyty Gwynedd and Swansea Bay sites presented their results at the Wales Antimicrobial Resistance Delivery Board following which a recommendation for a national rollout was made to the Chief Medical Officer for Wales.

2.5 Nutrition and Hydration

Home Parenteral Nutrition (HPN)

In August 2019 Calea, the supplier of Home Parenteral Nutrition (HPN) to BCUHB patients, suffered severe disruption to supply following a suspension notice by the MHRA. This caused significant distress to patients dependent on HPN.

With no spare capacity at other commercial suppliers, the Wrexham Pharmacy Sterile Production Unit stepped in to manufacture bags. 70 of these labour intensive formulations compounded from scratch were manufactured in the first two months and staff worked additional hours and at weekends in order to achieve this. During this period, Calea's communication on the formulation for patients was frequently incorrect, requiring daily communication between pharmacy, the nutrition team and patients. This also meant that planning work in advance was impossible, and frequently bags had to be made at short notice.

Calea's capacity stabilised in September at a reduced level and another supplier was able to take on some patients, so Wrexham now supplies for a single HPN patient.

Dietetic Food Supplements

Medicines management dietitians have now been employed by each area to review patients and provide support to the pharmacy team and GP practices to ensure that repeat prescriptions are appropriate and guidelines for initiation of dietetic products and formulary choice are being followed. They are also delivering training to nursing homes to encourage 'food first' practice and reduce the use of supplements.

2.6 Medicines Management

Medicines Storage

BCUHB has the greatest number of automated medicines cabinets installed in the UK, with 75 in situ across the three sites. They offer better safety by reducing errors from incorrect selection of medicines and enhanced security, because access is via fingerprint and ID badge. A forthcoming article soon to be published in the Clinical Services Journal also highlights that in a study in Wrexham Theatre B sustained savings were demonstrated when compared to Theatre A.

However, a significant problem has been highlighted, that will need resolution in early 2020-21 in that many of the automated cabinets are being operated with computers that are running on Windows 7, that soon will be unsupported by Microsoft or are too old for an upgrade to Windows 10. Touchpoint Supplies, the pharmacy department and BCUHB IT departments are working closely to prioritise and make the necessary changes.

Controlled Drugs

The Accountable Officer's responsibility is to oversee that arrangements are in place for the safe use of controlled drugs (CDs) of all schedules across North Wales (post Shipman). Vigilance on pregabalin and gabapentin increased this year following their re-classification to Schedule 3, due to their potential for diversion and misuse.

Renamed the North Wales CDLIN to reflect the network's wide-ranging functions from within the Health Board, external agencies and independent bodies across the region, it is chaired by the Chief Pharmacist as the BCUHB Accountable Officer.

Nationally this group has led work to:
- Address variation in the procedures for the private supply of CDs to Ministry of Defence personnel;
- Introduce a management procedure for the circulation of controlled drug alerts;
- Adopt the English NHS CD incident reporting tool;
- Form a collaboration between the Dan247 all Wales Drug and alcohol helpline and the England based Drug Watch scheme;

A locally developed (BCUHB) electronic-based CD monitoring tool was recognised nationally by a Health Inspectorate Wales report.

An area of high risk remains around the ability to scrutinise individual doctors' prescribing practice particularly in GP practices reliant on locums. However, this problem is not unique to BCUHB, and is awaiting a national solution e.g. the introduction of a personal prescriber PIN.

Medicines Information

More than 1000 queries from healthcare professionals were dealt with by the BCUHB Medicines Information Service, whose function is to support the safe, effective, economical and rational use of medicines both in the hospitals and the community, with a strong emphasis on promoting quality care and ensuring safety. These queries concerned individual patient care that could impact on safety, experience and treatment effectiveness and outcomes. Split across three acute sites in BCU the MI team work together to ensure access to information is available five days a week. Pharmacists providing on-call services are trained by the MI team to be able to provide quality advice on request. Some recent examples of queries include:

Request	Response
Genitourinary Medicine; female, 24 weeks gestation, concern of pre-term labour. If a tocolytic is needed, what could be used with the antiretrovirals being taken?	Nifedipine may be used if needed but caution that the antiretrovirals can increase concentrations of the calcium channel blocker. Advice provided regarding dosing and monitoring.

Tertiary neurology centre requested a switch from pregabalin to oxcarbazepine to aid pain control. How should the swap be managed? Also on other antiepileptic medicines.	Comprehensive literature search and pharmacological knowledge used to produce regimen for titration. Advice also given on how to manage phenytoin doses during, and following the swap due to drug-drug interactions.
Patient having difficulty in swallowing their medicines (including antiepileptic). Can we offer any advice on changes to support her?	Supply of alternative formulations arranged where possible (e.g. granules or liquids). Advice regarding crushing tablets and taking with apple sauce provided for rivaroxaban.

Single Patient

- **Presented at 24 weeks gestation with provisional diagnosis of diffuse large B cell lymphoma. We provided advice regarding the chemotherapy regimen and supportive medicines in pregnancy with information on the potential risks to the foetus and any monitoring that may be required postnatal. Clinicians were encouraged to register the drug exposures in pregnancy with the UK Teratology Information Service to add to the evidence base for the use of these medicines in pregnancy.**
- **At 26 weeks gestation we were asked to give advice on appropriate pain relief.**
- **At 27 weeks gestation we advised on alternative administration sites/routes of rituximab to avoid subcutaneous injection into the abdomen.**
- **Also at 27 weeks we risk assessed each of the options for pneumocystis carinii pneumonia (PCP) prophylaxis and made a recommendation which to use, whilst also providing additional information on post-natal monitoring.**
- **Postnatal; contacted by the GP to advise regarding the infection risk of using the Mirena coil.**
- **Postnatal; asked to advise regarding the risks of using live vaccinations in child given in utero exposure to chemotherapy.**

Community Hospitals

Pharmacy support for community hospitals is limited to a once weekly visit by a pharmacist and pharmacy technician. Whilst this may have been appropriate in days gone by, now when acute hospitals are often in escalation, higher acuity patients are being transferred to community beds, to make way for patients with greater needs. As a consequence, patients may not have their medicines reviewed by a pharmacist for up to seven days. This does not meet the NICE guidelines and may mean that patients continue on unnecessary, or have unmet treatment needs for longer than necessary. A business case will be prepared in 2020 to address the community hospital gap in service.
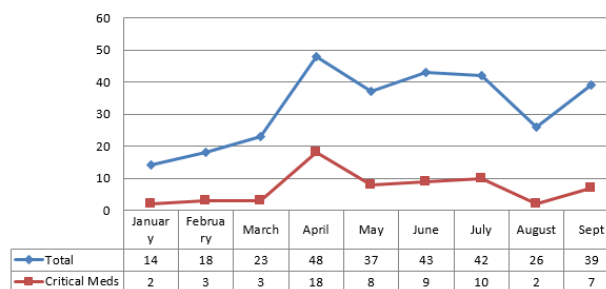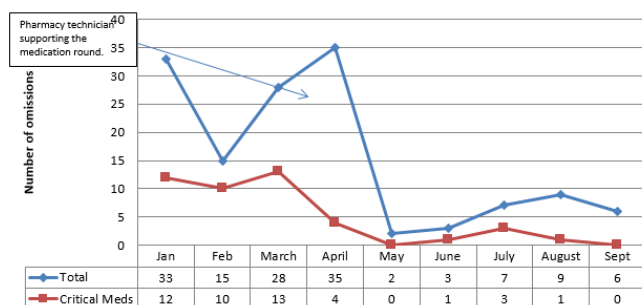
Llandudno Hospital

Pharmacy worked with nurse leads at Llandudno Hospital to develop an action plan following a number of administration omission errors. As a result, two new pharmacy technicians and the medicines management nurse supported nurses on two wards by:

- Delivering Back to Basics administration training for identified nursing staff
- Adopting the Parkinson's UK 'Get it on time' campaign and resources.
- Re-configuring ward stock lists and storage to make it easier to find medications.
- Adopting a formal handover of the medication chart by nurses at shift changes
- Pharmacy technician attendance at morning handovers, support on the morning medication round which helped identify medicines and obtain supplies not available

on the ward. This and the advice to promote good medicines management, which resulted in fewer interruptions and less time spent on the medication round.

However, due to a lack of funding these pharmacy technicians have had to be re-deployed to other duties.

These charts show the omission rate on two wards, one supported by a pharmacy technician and the other not.

<table>
<tr><td></td><td>Jan</td><td>Feb</td><td>March</td><td>April</td><td>May</td><td>June</td><td>July</td><td>August</td><td>Sept</td></tr>
<tr><td>Total</td><td>33</td><td>15</td><td>28</td><td>35</td><td>2</td><td>3</td><td>7</td><td>9</td><td>6</td></tr>
<tr><td>Critical Meds</td><td>12</td><td>10</td><td>13</td><td>4</td><td>0</td><td>1</td><td>3</td><td>1</td><td>0</td></tr>
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<tr><td></td><td>January</td><td>February</td><td>March</td><td>April</td><td>May</td><td>June</td><td>July</td><td>August</td><td>Sept</td></tr>
<tr><td>Total</td><td>14</td><td>18</td><td>23</td><td>48</td><td>37</td><td>43</td><td>42</td><td>26</td><td>39</td></tr>
<tr><td>Critical Meds</td><td>2</td><td>3</td><td>3</td><td>18</td><td>8</td><td>9</td><td>10</td><td>2</td><td>7</td></tr>
</table>

Manufacturing

Independent Audit of the YG, YGC and WMH Sterile Production Units (SPU)

An external audit of the four BCU Sterile Production Units was undertaken in September and October 2019 by the National Quality Assurance Lead for Wales. Although internal audit takes place against Medicines and Healthcare Regulation Authority (MHRA) standards, this independent assessment is particularly important, as the licensed sites (YGC & YMW) are due inspections by the MHRA. As NHS licensed manufacturing units are treated the same as commercial organisations, any deviations from the Good Manufacturing Standards need to be addressed urgently.

The MHRA tightened its standards around Pharmaceutical Quality Systems (PQS) as a result of contaminated neonatal TPN supplied by a pharmaceutical company which resulted in the deaths of 3 neonates in Hampshire during 2014 and more recently a commercial supplier of parenteral nutrition for homecare had to significantly reduce production due to MHRA standards not being met. PQS covers everything from maintenance of facilities, document version control, training and competence and deviations investigation. An example of a deviation might be environmental, where bacterial growth from routine monitoring is detected. The expectation is that approximately 25% of time is devoted to PQS. Data shows that the SPU are running at 90-104% capacity, which does not leave enough time for PQS. All three sites will need to consider how they can build capacity for this essential function.

Each audit report is accompanied by an action plan and each site provided its response within the required timescale. Progress with the action plans monitored by the pharmacy senior management team meeting. The summary comments for each site are outlined thus:

Comment	WMH	YGC	YG
Progress since last audit	✓	✓	✓
Resource for Pharmaceutical Quality System	✗	✗	✗
Facilities	**Cosmetic issues**	**Poor (see below)**	✓
Replacement programme for isolators required	✓	✓	✓

Review of level & type of investigation into microbiological contamination	✓	✓	✓
Documentation control improvements needed	✓	✗	✓

Site Specific Comments supplementary to the above:

Ysbyty Maelor Wrecsam

Improvements are needed to address the variation in staff technique for the transfer process with regard to contamination control identified.

Ysbyty Glan Clwyd

The Cancer Centre is of poor design and fabrication and the Sterile Production Unit is past its recommended working life and the Air Handling Unit (AHU) is condemned. There is considerable vulnerability around the AHU at the SPU site which has stopped the merging of the Cancer Centre into the SPU. However this option is currently being considered by the Health Board Capital and Estates prioritisation process for 2020-21 while longer term solutions are being planned and coordinated as part of a wider Welsh Government capital replacement programme called Transforming Access to Medicines (TRAMs).

Ysbyty Gwynedd:

The existing resource of Authorised Pharmacist (AP) and Accountable Pharmacist (AcP) is at present vulnerable. Another AP is required for contingency and must have regular sessions in order to release time for the existing AcP and AP to carry out Pharmaceutical Quality System activities.

Prescribing

Independent prescribing

Registered on the BCUHB database are 694 non-medical prescribers, which includes both independent and supplementary prescribers. The breakdown by profession is as follows:

Nurse prescribers	Pharmacists	Allied healthcare
563	78	53

Continuous Professional Development is arranged and supported by the medicines management nurses through the Non-Medical Prescribers Forum, covering therapeutic topics throughout the year and encouraging the sharing of good practice.

One of the key objectives for 2020/21 will be to update the Health Board's Non-medical prescribing policy to ensure our guidance both safeguards and empowers all prescribers to meet the need of our patients and to consider the future role of Physicians Associates within the policy.

Junior Doctors

Each of the acute hospitals has a pharmacist, funded by the NHS Wales Service Incremental Fund for Teaching (SIFT) to tutor undergraduate doctors on prescribing. In addition to learning how to use the Wales Medicines Administration Chart, they have sessions covering the prescribing of high risk medications such as insulin, anticoagulants and opioids, interactions and drug interactions. In future programmes there are plans to cover more of the human factors that can lead to errors.

The additional sessions that they undertake with the newly qualified doctors is currently unfunded, which is particularly important for those who did not train in Wales. Topics covered include: Recent prescribing errors, common themes; key information to be aware of; 'Hot prescribing topics' as requested by the F1 doctors.

In primary care, there has been a focus on tackling medicines waste and polypharmacy. This has been both transactional, but also involved high quality face to face medication reviews. The diagram below summarises the activity they have been undertaking:

6 Care Medicines Management in 2019-20

33,000 Level 1 Medicine Reviews
Technical review of the list of a patient's medicines to address any issues relating to the prescription or a medicine

15,820 Level 2 Medicine Reviews
Treatment review of medicines with the full patient notes

7,400 Level 3 Medicine Reviews
Clinical review of medicines with the patient and carer in discussion making decisions about their medicines and addressing any difficulties

360 Medicine Reviews in the patient's home
A level 3 medicine review particularly valuable if there are concerns that the patient may not be taking their medicines

41,500 Ad Hoc Medicines Enquiries

6,383 Medicines Stopped

The information in the box below represents the work taking place in the Medicines Management Collaborative to support the All Wales Policy for Medicines Administration, Recording, Review, Storage (MARRS) and Disposal.

FACTS

Established in November 2018 to focus on:

- Safe storage of medicines
- Education standards
- Clinical standards

Safe Storage of Medicines

Working to improve compliance with controlled drugs checks, fridge temperature monitoring and ensuring that medicines storage cupboards are locked using PDSA cycles and tests of change for improvement. Support is given by the medicines management specialist nurses. Where compliance is sustained, the Matrons undertake the monitoring as part of their monthly Leadership Walkabouts

Participation

⇒ Several wards including the emergency department at Ysbyty Glan Clwyd.
⇒ All acute wards in Ysbyty Gwynedd and Ysbyty Wrecsam Maelor
⇒ East Area community hospital wards
⇒ Mental Health wards
⇒ Womens Division

Problems:

A common theme is inconsistent reporting

Educational Standards

- Medicines Management competence workbook for nursing has been reviewed and updated
- Medicines Policy Chapter 8 and the standards have been completed, covering the education and governance arrangements for health care support workers to allow them to assist or administer medicines delegated by a Registered Nurse. A training package is to be delivered by Llandrillo College.

Clinical Standards

The care for patients receiving medication on discharge was identified as an area that required improvement. This followed a thematic review of incidents which highlighted that patients may go home without their medicines, without any counselling on their take home medicines, or occasionally with another patient's. A discharge checklist was in place but not being used.

Participation

⊳ Discharge lounge and pilot wards, Ysbyty Gwynedd
⊳ Central area community hospitals
⊳ Discharge lounge, Ysbyty Wrecsam Maelor

Automated Medicines Storage Cabinet

New Developments:

The medication section of the Harms Dashboard has been refreshed, to include administration incidents. A new field to capture 2nd independent check incidents has been added to Datix.

Medicines Management Nurses

Support safe medicines administration through training at undergraduate level and for registered nurses at all levels, with group training and individual mentoring if errors have occurred.

Administration of Intravenous Morphine by Nursing Staff for adults with acute severe pain ➔ A new BCUHB Guideline is near completion and a competency & assessor's document for all appropriate nurses in designated areas has been prepared together with an implementation plan for competency assessment. Oxygen Cylinder Competence ➔ An improvement plan was put in place for the safe transfer of patients on oxygen between departments and wards. This includes the use of a checklist and knowledge of cylinder use for ensure nurses and healthcare support workers. Registered nurse compliance in secondary care is 85%.

2nd Independent Check ➔ From April 2018 to April 2019 there were 97 reported incidents due to inappropriate or absent second independent check by another healthcare professional. Ysbyty Gwynedd has done a significant amount training all newly registered nurses and following reported incidents. IV Pump training has been delivered in key areas in YG following an audit that identified issues with the use of libraries and pump locks, revisiting competencies. Medicines management back to basics training across the Health Board includes the importance of separating pumps (not stacking) outside critical care wards to minimise associated errors.

MEDICINES MANAGEMENT COLLABORATIVE
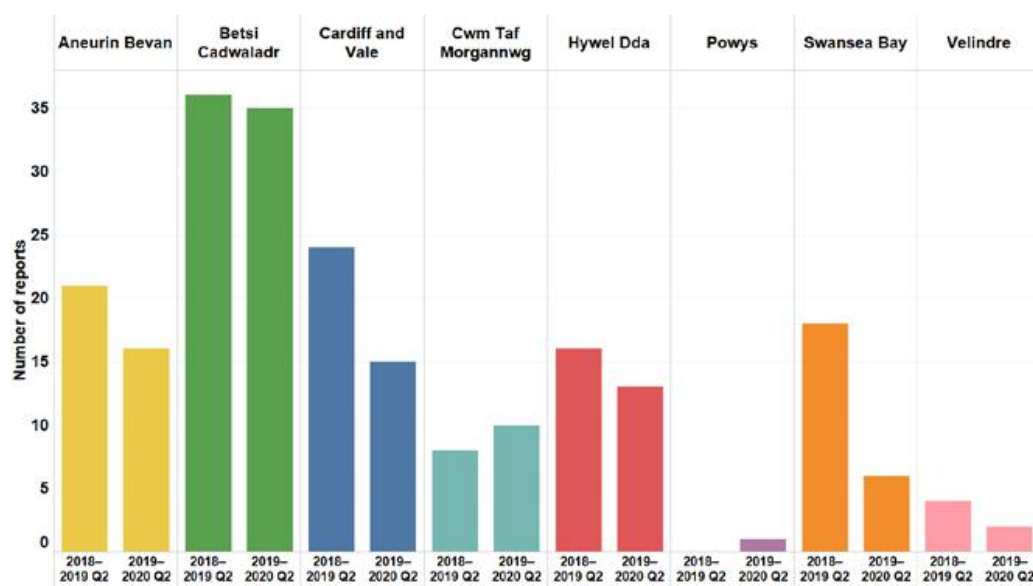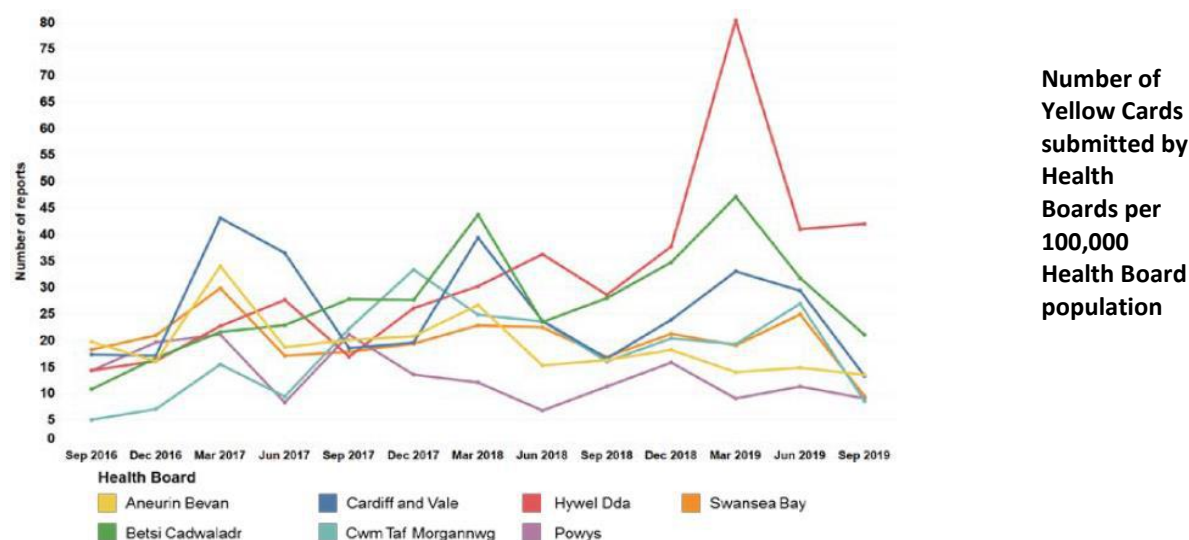
Incidents

There were 4 major medication incidents in BCUHB in 2019-20, down from 10 in the previous year. Three related to medication-related admissions and the fourth to a delayed administration of an antibiotic to a septic patient, with a recorded allergy to penicillin (1st choice treatment of sepsis), while an alternative was sought.

Pharmacy Incidents

SAFETY	West	Centre	East
Total number of incidents reported last year	62	86	38
Number of incidents overdue	5	4	11
Number of WG reportable incidents last year	0	0	0
Number of serious incidents reported last year	0	0	0

Adverse Drug Reactions and Medicine Related Adverse Incidents

Surveillance on adverse drug reactions via Yellow Card reporting is key for patient safety. Even for well-established medicines, new themes, such as drug-drug interactions can be picked up, which may result in changes to treatment recommendations. For GPs there is a set minimum target for Yellow Card reports included in the enhanced service for medicines management.

Number of Yellow Cards submitted by Health Boards per 100,000 Health Board population

Number of Yellow Cards submitted by secondary care – Quarter ending September 2019 vs quarter ending September 2018

19

Collection of medication-related admission data by pharmacists has highlighted that acute kidney injury (AKI) is a significant burden of preventable harm for BCUHB and is associated with a poor prognosis for patients. Thirteen of the 14 clusters in north Wales have agreed to focus their quality improvement interventions on reducing the harm from medicines that can cause AKI in acute illness for their Mandatory Patient Safety Programme of the Quality Assurance and Improvement Framework (QAIF). This quality improvement programme in BCUHB will be supported by Improvement Cymru.

Policies & Procedures, PGDs

The extensive work to ensure robust governance underpins the safe use of medicines across the Health Board continued in 2019, resulting in the publication of the revised Medicines Policy together with the launch of new Injectable Medicines and Unlicensed Medicines Policies respectively. The medicines management nurses have worked towards a more streamlined authorisation process to improve the governance arrangements for Patient Group Directions (PGD) and will be in place in 2020. There will be PGD education sessions for staff running alongside this process to ensure PGD use is aligned to best practice recommendations.

The Medicines Polices Procedures PGD Subgroup (MPPP) of the BCU Drug and Therapeutics Group (DTG) met 11 times and reviewed 124 documents, 11 of which were deferred and at year end were awaiting resubmission. The 113 approved documents were:
- 63 Written Control Documents (i.e. guidelines, SOPs, prescription charts)
- 6 Policies
- 44 PGDs

The Group remains without medical representation as required by its terms of reference, so clinical queries are escalated to DTG for further discussion and subsequent approval. In addition a replacement senior nurse with corporate responsibility for medicines management is being sought.

2.9 Medical Devices, Equipment and Diagnostic Systems

The Medicines and Healthcare Regulatory Authority (MHRA) has introduced new standards for dose calculators. As a result, pharmacy and medicines management is improving the governance on those used across BCUHB. Those already in use have been registered with the Medical Devices Oversight Group (MDOG) and a standard operating procedure is being produced for the introduction of any new dose calculators to include validation, and logging and monitoring of any incidents associated with their use before introduction. The review of any reported incidents will be undertaken as part of the Pharmacy Patient Safety Lead Network meetings to identify and remedy any related issues.

Effective Care

3.1 Safe & Clinically Effective Care

DTG

The BCUHB Drug and Therapeutics Group (DTG) met eleven times in 2019. It has 40 members from across BCUHB, including primary and secondary care doctors and pharmacists, nurses (medicines management), midwives, dentist, physiotherapist independent prescriber, patient, finance and Association of the British Pharmaceutical Industry (APBI) representative respectively.

DTG actions	Approved	Declined
New medicines for formulary inclusion	21	2
Applications for individual patients (non-formulary)	134	22

The Wound and Dressing sub-group revised and launched its formulary in 2019. Now available on the MicroGuide app, it enables access to invaluable information is at hand for assessment of wounds and appropriate dressing choice.

NICE & AWMSG Impact Assessment Group

BCUHB remains fully compliant with the formulary inclusion of NICE/AWMSG approved drugs within the 60 day timeframe. However 2019/20 has proven to be a challenging year within the cancer service due to the volume of new NICE drugs approved that are now fulfilling a previously unmet need. These require not only access to new services for treatments but also the need for ongoing care for surveillance thereafter.

In 2019, treatment pathways had to be considered for 48 new NICE/AWMSG approved drugs. The cost per patient per course/annum for these treatments ranged from £6 to £90k. The net full year impact of the drugs assessed was estimated to be £3.77m in year 1 taking into account the cost of the drugs displaced. Two novel Cystic Fibrosis treatments were approved by Welsh Government in November 2019 and will be provided by tertiary centres through WHSSC contracts, which alone have an additional impact of £2.96m for BCUHB.

Of the 46 new drugs, 41 are for specialist secondary care prescribing only.

Speciality	Number of drugs	Speciality	Number of drugs
Cancer	17	Cardiology	1
Dermatology	2	SMS	1
Pain	1	Infection	3
Gastroenterology	2	Respiratory	1
Neurology	11	Diabetes	3
Surgical	1		

HMP Berwyn

The pharmacy department at HMP Berwyn continues to play a major role in medicines optimisation and safer prescribing with pharmacy technicians and pharmacists reconciling medicines and supporting administration. Newly developed face to face medication review clinics identify and support any difficulties with adherence.

The introduction of the remand population took place in December 19. Sent directly from courts to HMP Berwyn, there are significant difficulties obtaining an accurate medical history, which has challenged the pharmacy technicians to ensure continuity of care as they may be under that care of both their GP and the substance misuse service. In addition because the men often arrive from court out of normal working hours, there are some difficulties with access to the men's' summary NHS record to allow the GPs to prescribe safely to prevent sudden alcohol or drug detoxification. Education and training has been delivered to other members of the health care team on medication used for detoxification and withdrawal.

The pharmacy robot is operational two years after installation allowing improved scrutiny of prison stock levels and improved data for analysis by finance and for

discussion at the monthly Medicines Management Group. There has also been a reduction in near misses and errors from incorrect drug selection.

A lack of sufficient prison officer support to allow safe and effective clinics, room checks and administration of medicines is a common issue which has been raised at multiple forums, including the Medicines Management Group, the Local Health Delivery Group and the Quality, Service and Performance meeting.

Mental Health & Learning Disabilities

Pharmacists and pharmacy technicians provide an outstanding clinical service to the inpatient wards, supporting staff, answering queries and dispensing specialist psychotropic drugs. They also support the Medicines Management group (MHMMSG) and medicines governance for the MHLD Division. This year:

- Several policies /protocols have been reviewed and updated.
- New policies and guidelines have been developed and approved.
- Mediwell automated medicines cabinets for the adult and older persons mental health (OPMH) acute wards have been purchased and planning is in progress for their installation.
- A pilot is underway to support two community MH teams and an OPMH community team to demonstrate benefits to support a previously unsuccessful bid for pharmacist support.
- A successful bid has secured funding for EMIS (electronic prescribing) for community mental health teams, to address safety issues raise by GPs.
- Purchase of MicroGuide app for easy access to prescribing policies and pathways, although progress with uploading documentation has been slow because of pharmacist and clinician capacity.

All this, delivered with insufficient resource which impacts on staff morale and other support functions, including savings. For example the technicians spend the majority of their time dispensing when they could be providing ward-based patient care and there is insufficient capacity for pharmacists to attend ward rounds or counsel patients prior to discharge or in even provide basic pharmacy input on some acute mental health wards. No further resources have yet been made available and a letter following the visit by the WG Chief Pharmaceutical Officer is seeking assurance by the Health Board to invest in MHLD pharmacy resources.

Cancer Services

In 2019 it was recognised that the increased patient numbers and quantities of systemic anti-cancer treatments (SACT) being managed by the pharmacy teams across BCUHB was creating a strain on service provision which could impact upon safety and was affecting the welfare of staff. A review of staffing levels using the British Oncology Pharmacy Association (BOPA) standards identified a shortfall in YG and YWM. Following a successful invest to save bid, two additional team members were recruited to make the service more robust.

The latest version of Chemocare, the cancer electronic prescribing system, has been tested and will be rolled out across BCUHB in 2020. The priority is to upload the haematology protocols to mitigate the risk of the failing OPMAS system used in the North Wales Cancer Treatment Centre. Chemotherapy production on the YGC site has been consolidated into the sterile production unit to facilitate the efficient use of staff although the air handling unit is recognised as being fragile as mention on page 16. A capital business case is being prepared to renovate and ensure the viability of this unit over the next 5-10 years.

1. Safety indicators:

1. Proton Pump Inhibitors (PPI) – DDDs per 1000 Pus

PPIs have been a key element of BCUHB's prudent prescribing Local Enhanced Service for 3 years now. The pharmacy team has worked collaboratively across primary and secondary care to ensure best practice in the prescribing of PPIs. Education initiatives have been developed for both health care professionals and the public, and include step down guidance. Posters & banners were produced for patient and public events e.g. Eisteddfod. In addition, the AWMSG PPI patient leaflet was printed professionally for distribution from GP surgeries and community pharmacies.
The graph below demonstrates the trend over the last few years. BCUHB has shown the sharpest decline in prescribing in Wales since 2015. The upward trend in late 2019 is as a result of a national shortage of ranitidine.
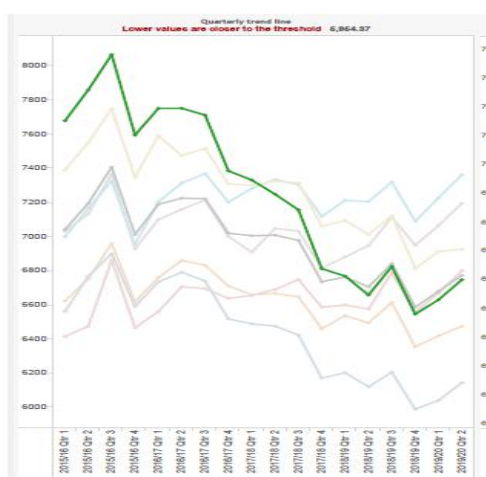
Trend in PPI prescribing DDDs per 1,000 PUs
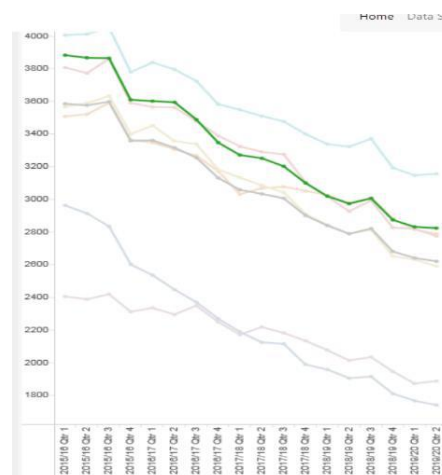
Trend in hypnotic & anxiolytic prescribing ADQs per 1,000 STAR-PUs

**2. Hypnotics and Anxiolytics – ADQs per 1000 STAR-PU**

Of note are independent prescribing pharmacists who with technicians support patients to slowly reduce their hypnotics or anxiolytics.   BCUHB also hosts a 'Prescribed Support Medication Service' to reduce patients' use of benzodiazepine, opiate, antidepressant etc. Patients can be referred into this nurse-led service for managed withdrawal and intervention, including signposting to other local services, alternative strategies for pain management and holistic care discussion. Whilst capacity is relatively low, it is another avenue for patient intervention and GPs find these resources useful, as reducing these medicines requires patience and time over weeks if not months. The positive downward trend has been maintained.

2. Efficiency indicators

The biosimilar switch programme, led by specialist pharmacists working with their clinical teams in rheumatology, dermatology, gastroenterology and cancer services continued in 2019. BCUHB now has the highest proportion of biosimilar use in Wales.

Figure 21. Biological reference and biosimilar as a proportion of total reference plus biosimilar prescribed – Quarter ending September 2019
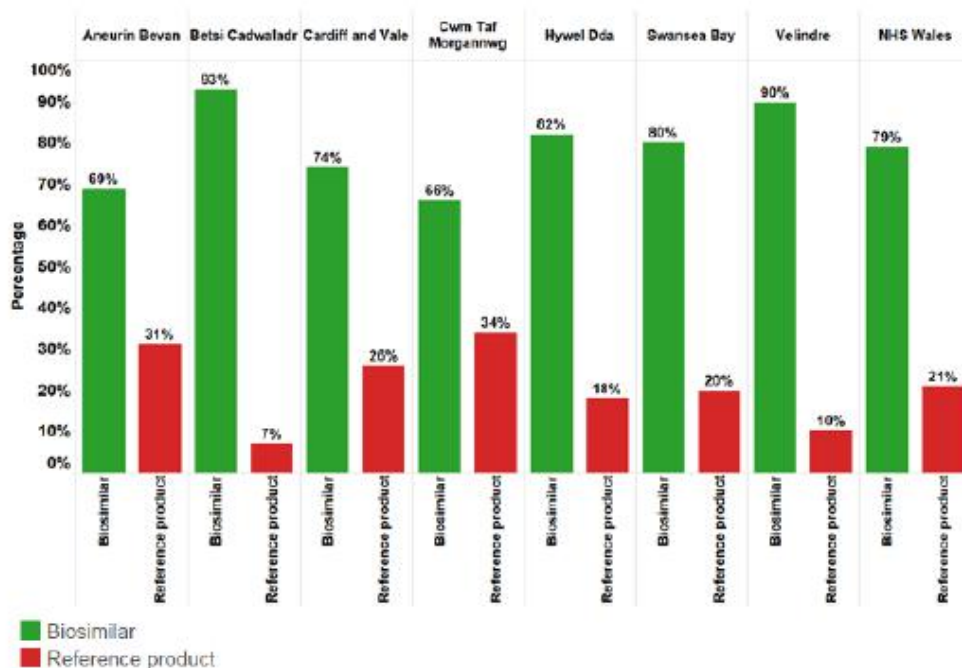
The new direct-acting antivirals (DAAs) for hepatitis C, introduced in 2015, have revolutionised treatment, particularly with the greatly improved cure rate, lower incidence of side-effects, and a shorter treatment duration than older alternatives.

In 2019, 136 patients were treated bringing the total number of patients in BCUHB treated since 2015 to 547 patients. With a success rate of 95% this equates to over 500 being cured of the disease in north Wakes, thereby reducing the incidence of liver disease, liver cancer and deaths related to end-stage liver disease. To achieve the World Health Organisation aim to eradicate hepatitis C by 2030, BCUHB needs to treat 194 patients per year. Staff capacity to test and treat some harder to reach groups of patients means that the Health Board has fallen short of the target, but plans are in place (see below).

- 40 patients have been treated at HMP Berwyn since the end of 2018.
- A new pharmacist-led pathway developed in 2019, is being run at the Homeless Hub in Wrexham as a 12 month project with care delivered to patients in the community. Adherence to treatment is supported through weekly medicine collection, provision of mobile phones with reminder alarms and with help from the Harm Reduction Team. This innovative project has received a £53K grant from Gilead (pharmaceutical company) which has enabled the team to rent a point of care test (POCT) machine to enable diagnosis in less than an hour. Thus rapid access to testing and treatment for hepatitis C is available for homeless patients whose only other route would be via secondary care.

A new national HIV antiretroviral prescribing guideline was introduced into BCUHB in 2019 and two new part-time specialist HIV pharmacist posts were appointed in Wrexham and Glan Clwyd Hospitals this year. Working as part of the multidisciplinary team, they offer specialist pharmacist support on all 3 sites for clinical verification of

prescriptions, drug history taking, advice on HIV medicines and adherence ensuring the most suitable and cost effective choice of agents.

3.2 Communicating Effectively

This year has seen considerable activity in promoting the use of Welsh at Glan Clwyd Hospital where they have been successful in recruiting a number of Welsh speakers. Ten members of staff from reception, dispensary and the administration team are enjoying role specific Welsh lessons. Three attended a residential course which they found to be very intense but useful. Our Welsh learners were nominated for a BCUHB Achievement Award.

3.3 Quality Improvement, Research and Innovation

North Wales Pharmacy Conference

The inaugural North Wales Pharmacy Conference took place at the OpTIC Centre in May 2019. The event offered an opportunity for pharmacy staff to share the wide range of research, service improvement and audit work they undertook through the year. The wider team were joined by guests from Cardiff and Swansea Universities and the Royal Pharmaceutical Society who joined the judging panel for the best presentation. Projects shared at the event included:

- An audit to determine the extent of omitted medicine doses at Ysbyty Glan Clwyd.
- Assessing prescribing in the treatment of renal anaemia for dialysis patients at Ysbyty Gwynedd and Ysbyty Alltwen
- Review of medication transfer and wastage at admissions in Wrexham Maelor's Emergency Department
- Improving patient counselling services in the dispensary setting.
- Direct Oral Anticoagulants: are we counselling patients, providing information leaflets and communicating effectively with primary care?

Pharmacy studies featured at the 2019 Welsh Medicines Research Symposium, organised by Bangor University, Royal Pharmaceutical Society and Health and Care Research Wales, included an evaluation of "*Patient Satisfaction with a pilot sore throat test and treat point of care service provided in community pharmacies in Wales*" and "*Cost utility analysis of fidaxomicin versus vancomycin for the management of Clostridium difficile infection in BCUHB*".

Several members of the pharmacy team have either completed or are in the process of completing Research Masters level Modules and Programmes. Outputs include assessed research and evaluation protocols and completed research projects e.g.

- Evaluation of patient and healthcare providers perceptions of homecare medicines services
- Influences on the decision making process for prescribing antimicrobial agents

Two pharmacists have successfully applied for research funding awards: a HCRW Clinical Research Time Award and BCUHB Pathway to Portfolio Award.

The Health Board are collaborating with the Centre for Health Economics and Medicines Evaluation at Bangor University to develop an evidence base for the delivery of Value-Based healthcare. The initial focus will be on usage of Direct Oral Anticoagulant Agents (DOACs) and Intravitreal Biologic Agents, exploring variation in usage of these agents and scoping Patient Reported Outcome Measures.

Pharmacy & Medicines Management continues to host Clinical Trials of Investigational Medicinal Products, ensuring procedures are in place to enable BCUHB compliance

with the relevant regulations, guidelines and directives. Work is ongoing to ensure the Health Board has sufficient pharmacy capacity to meet the current opportunities for investigational studies across each site and Division.

Dignified Care

4.1. Dignified Care

Palliative Care

In collaboration with Macmillan UK, a third specialist palliative care pharmacist for East Area was appointed to work collaboratively across north Wales. Providing clinical pharmacy services across primary, secondary care and hospices to support complex symptom management for palliative care patients, they aim to optimise medicines to ensure that patients are pain and symptom-free. In addition, BCUHB are the first Health Board in Wales to appoint a Macmillan Pharmacy Technician to expand medicines management services for palliative patients.

Improving access to palliative medicines both in and out of hours to support end of life care for patients in whichever setting they wish to die has been a priority this year, this includes the governance to prevent diversion and educational strategies to promote the safe prescribing of strong opioids and medicines that can cause dependence.

Continence

Each of the areas has dedicated Medicines Management Continence Nurse in their pharmacy team. Working with patients, families, carers and colleagues they provide advice and education on products, including appropriate ordering quantities and assessment of patients' needs to prevent catheter-related and continence problems, referring to a specialist as appropriate. Whenever possible and when appropriate, patients are encouraged to have a trial without a catheter.

These specialist nurses also support district nurses with the development of pathways and education, work with Dispensing Appliance Contractors to address governance concerns, and visit GP practices to encourage adherence to the continence formulary.

This work has demonstrated better patient care, greater compliance with the formulary, release of savings and a valuable resource for the pharmacy team, GPs, nurses (in all settings) and patients alike. Next steps include Independent Prescribing.

The West have developed this concept further with a community-based stoma nurse. Working with GP practices to identify patients, she invites those no longer under secondary care who may not have been reviewed for some time. Stoma changes can take place over time and for 60% of the 163 patients reviewed, the wrong size appliance was in use and skin problems had developed as a result of leaks. Patient feedback has been very positive. As well as the ongoing emotional and psychological support, there has been less demand for stoma accessories. As a result, a pathway has been developed for the handover of new patients after their first post-surgery review.

Communication with the Dispensing Appliance Contractor and regular contact with GP practices prevents incorrect ostomy supplies being delivered to patients resulting in savings.

4.2. Patient Information

The Medicines Information (MI) and Advice Service provided advice for 56 patients in 2019 via the medicines helpline. The majority of the patient advice calls concerned complementary and alternative medicines and whether they were safe to use in combination with prescribed medicines or if there are other cautions or contra-indications to their use.

Other examples of queries covered:
- Administration of medicines
- Travel
- Vaccines
- shortage concerns; availability in primary care; how to arrange a new prescription
- Suitability of over the counter medicines
- Dental

Plans are underway to promote the medicines helpline more widely in 2020.

Timely Care

5.1. Timely Access

MTeD (Electronic Discharge Advice Letters)

There has been no further rollout of MTeD in 2019/20 and so the average number of discharge advice letters sent out each month remains static and the dashboard development stalled because additional resource is needed. A business case is awaiting a funding decision for further roll out across Wrexham Maelor Hospital, community hospitals and Mental Health and Learning Disabilities.

Testing of a new version of MTeD is in progress at the hospital admission stage, which can import the patient's drug history from the patient record and allow pharmaceutical care planning to be documented electronically thus enabling access by the wider multi-disciplinary team.
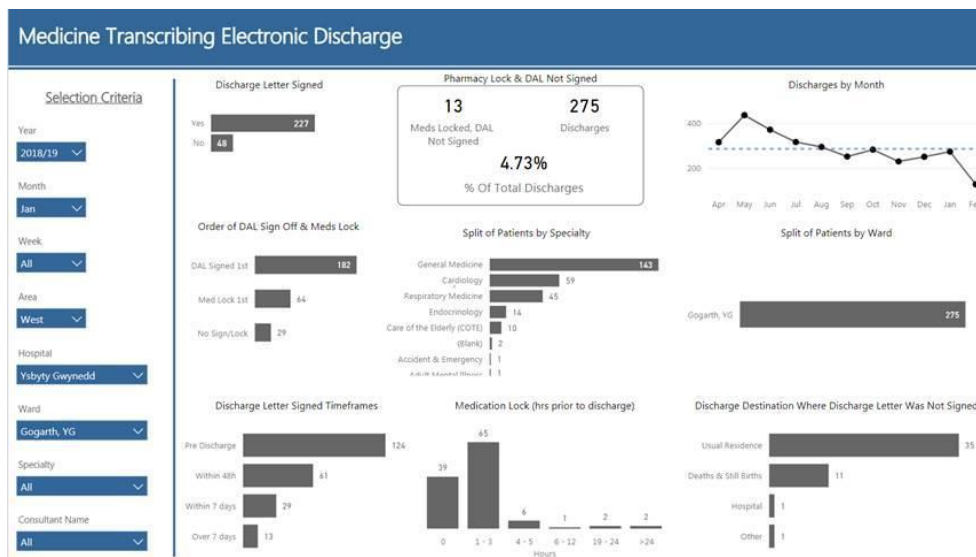
The dashboard tracks the volume of discharge letters, but also identifies areas of concern such as the timeliness of completion and number of unsigned letters, which can increase the likelihood of a patient's re-admission

Pharmacy in Emergency Departments (ED)

Winter pressure money has enabled a pharmacy technician to join a pharmacist working in the emergency departments. When there may be long waits for inpatient beds, it is imperative that patients taking time critical medicines e.g. antiepileptic, insulin, Parkinson's disease, have their charts written up and have access to treatment. Medicines frequently do not get transferred with the patient, which may mean that critical medicines are omitted. The pharmacy technician presence in ED

enables the medicines reconciliation and medicines supply to be completed by the most appropriate healthcare professional and frees the pharmacist to focus on the clinical interventions, safety and medicines governance.

In one ED department alone, in addition to savings from improved transfer of patients own drugs, the pharmacist collected interventions to preventing life threatening and serious medicines harm over 4 weeks:

Intervention Grading	Number of Interventions	Cost Avoidance (£)
Serious (£1000)	180	180,000
Life Threatening (£1500)	37	55,500
Total	**217**	**£235,500**

Individual Care

6.3. Listening and Learning from Feedback

1. A diploma pharmacist project asked inpatients whether they wanted all their medicines dispensed when they went home. They said that as long as they have a supply at home they would rather only new medicines or those where the dose has changed are dispensed. This has now been implemented in Wrexham.

2. A concern was raised at Glan Clwyd Hospital that a mum picking up her medicines from the children's ward did not understand the dose change. Mum was collecting from the ward rather than pharmacy as it was more convenient but in doing so did not get to speak to anyone from pharmacy. On reflection the gap in the pharmacy service was recognised and it is believed that a Carers will not be collecting from the pharmacy and they need more information they are now contacted by telephone or other arrangements made. This learning has been shared across the three sites.

3. Nursing staff at Ysbyty Gwynedd requested a satellite dispensary on H block similar to T block which is now being built as part of the pharmacy automation and redevelopment project due for completion by April 2020.

4. The reception area at the main Ysbyty Gwynedd pharmacy dispensary has been separated to improve confidentiality for outpatients.

COMPLAINTS	West	Centre	East
CATEGORY			
On the Spot	2	2	5
AM/MP	5	4	6
Formal Complaint	3	2	2
Formal CHC	1	0	0

Staff and Resources

7.1 Workforce

Multi Sector Training

BCUHB was the first organisation to train its pre-registration pharmacists in hospital, community and primary care and as a result, the model is being adopted nationally. Now this multi-sector training is to be extended to pre-registration pharmacy technicians and the Foundation Pharmacist training programme. This is in addition to nine hospital based posts which have placements in the primary care team and HMP Berwyn (in the east). These innovative programmes result in well-developed and

rounded professionals who are able to work flexibly in any sectors, and help to attract high calibre candidates from across the country for training opportunities.

These programmes are not without difficulties, due to limited desk and clinic space in GP practices and competition with other professional groups for mentorship from non-pharmacy staff.

Advanced Practice

Each year pharmacists and pharmacy technicians are being supported to work at an advanced level through postgraduate courses. For 2019-20 these include:

- Independent prescribing (8 pharmacists) in general practice and specialist areas such as HIV medicine, Respiratory and Paediatrics.
- Advanced clinical practice module (including physical examination/diagnostics and minor illness modules)
- Research Methods module at Cardiff University (4 pharmacists) in preparation for a research project within their areas of work.
- Diploma in therapeutics (2 pharmacists)
- Postgraduate certificate in Psychiatric Therapeutics from Aston University (1 pharmacist)
- Postgraduate Diploma in Diabetes (1 pharmacist)
- Pharmacy Clinical Services Diploma at Bradford (5 pharmacy technicians)

Career and Recruitment Events

Committed to developing a future pharmacy workforce, numerous career and recruitment events were attended in schools, colleges and universities across North Wales and the UK respectively during 2019-20.

A new "Science in Healthcare" career event was organised in conjunction with Cardiff University's School of Pharmacy and Pharmaceutical Sciences at the MSparc Science Park on Anglesey in September 2019. Supported by dentistry, speech and language therapy and psychology, it gave years 12 and 13 students from local secondary schools opportunities to enjoy an interactive day covering the application of science within healthcare as well as advice regarding applying to universities.

Workforce Performance

STAFFING	West	Centre	East
Current Staffing Numbers	126.24		120.46
Number of vacant posts	20.2		10.68
% of staff who have had a PADR	67.3%→	72%↓	89%↑
% of staff compliant with mandatory training	91%↓	86%↑	93%↑
Sickness rate	3.99%↓	2.8%↑	2.9%↑
Maternity rate	5.1%→	1.62%→	1.36%↑
Staff turnover rate	3.8%↓	9.5%↑	9.1%↑

Community Pharmacy

Changes to funding model – off site dispensing; closures; withdrawal of unfunded services

Recent changes to the funding structure of the national Community Pharmacy Contractual Framework aimed to refocus income towards services and reduce the cost of dispensing prescriptions. This has resulted in steps being taken to restructure staffing in community pharmacies. Larger companies, taking advantage of economies of scale are adopting a 'hub and spoke' dispensing models. These changes will

ultimately enable community pharmacy to deliver a better value supply service for their patients. However, during the implementation phase, there have been a number of challenges around communication and the need for other parts of the system to change the way they work to accommodate the new systems (e.g. patients ordering and GP practices issuing prescriptions earlier). As a result a number of complaints and concerns have been raised.

Other repercussions have been difficulties with cash flow, home deliveries and provision of medicines dispensed in monitored dosage systems (MDS). Partly in consequence of this, two pharmacies have given notice on their NHS contract and closed in Q4 of 2019/20 and a number of other pharmacies have changed their opening hours, to close earlier on weekdays and open for less time, or not at all, at weekends. This inevitably impacts on other parts of the health system, particularly unscheduled care, as there are fewer self-care access options available. Restriction on delivery service and MDS will have a disproportionate effect on the most vulnerable in our communities and has the potential to contribute to increased health inequalities.

Recruitment of community pharmacists is proving challenging across North Wales, but is particularly acute in the West area and can also extend to securing locum cover which can result in pharmacies having to close for part, or all, of the day. When available, contractors often have to pay significant fees to secure locums who would normally work in England and so may not have the necessary accreditation for some of the key enhanced services. This affects service continuity and patient experience and creates additional pressures elsewhere in the system.

In the West area, temporary closures peaked in August 2018, with 70 closures for at least some of the day in Gwynedd and Anglesey. Since meeting representatives from Rowlands, the largest pharmacy operator in the area, there has been a significant reduction, although there are still 6-7 closures per month.

Secondary Care

Recruitment of pharmacy staff at Ysbyty Gwynedd is challenging and there are high vacancy rates. The national ORIEL pre-registration pharmacist recruitment system, implemented during 2016 appears to be having a detrimental effect on local recruitment and staff retention.

The Glan Clwyd hospital pharmacy team are taking part in the pioneer Be Proud programme to build and enhance team engagement. Their Be Proud team are driving forward changes which are impacting on staff morale and the efficiency of the department. There is a strong focus on communicating openly and honestly with staff and of keeping the wider team informed and involved at every stage. This is energising colleagues and has a ripple effect outwards.

Mentoring

Junior pharmacists in secondary care now are often appointed to a rotation, with time spent in different specialties. Mentoring is provided by the respective specialist pharmacists and this new rotation is proving to produce well rounded individuals, ready to take on more senior roles.

In primary care a monthly education is facilitated by the clinical lead specialist supported by GPs, which involves role play, case-based discussions, sharing of good practice and NICE guideline updates. These sessions enable the primary care team to hold more in depth, confident and effective medication reviews with complex patients.

Risks

Benchmarking and analysis of prescribing data in both primary and secondary care have identified significant growth and cost pressures for the 2020-21 financial year. These include implementing NICE approved medicines in primary care e.g. direct oral anticoagulant (DOAC), which have new indications and revised thresholds for treatment; treatment and monitoring of diabetes. Blueteq®, shortly to be introduced will give greater assurance on NICE compliance with high cost medicines.

The fact that the prescribing budgets were set without an uplift or due consideration of potential growth, the impact of medicines shortages, or volatility of the market emphasises the need to establish a single planning process for drug budgeting and monitoring in 2021-2. A recent finance report suggested that there is till the potential to save £12m-£21m from the primary care prescribing budget. This was calculated using flawed benchmarking data and has been recalculated using an appropriate selection of health organisations (County & Coastal). The comparative data gives a figure of £3.4m with potential scope for savings in respiratory, nutrition, skin and stoma. All areas are included in the financial savings scheme planning

RISK (HIGHEST RATED RISKS – TAKEN FROM RISK REGISTER)			
RISK	SCORE	DESCRIPTION	MITIGATION/ MONITORING
Lack of funded pharmacy resource for Mental health at Wrexham	20	There is insufficient pharmacy resource to provide the required dispensing and clinical functions for the MH division. This poses a risk to the patients on Heddfan and increases pressure on the pharmacy dispensary at Wrexham. There are currently 0.8 pharmacist and 2 technicians in total and no annual leave or sickness cover. 3000 items are being dispensed per month over and above what is funded. National workforce recommendations for the unit size recommend 5 Pharmacists and 8 Pharmacy technicians.	A locum pharmacy technician has been funded to support dispensing. EMIS has been purchased & will be implemented
Failure of dispensing robot resulting in delayed medicines supplies to patients	16	There is a risk to patient safety as the Pharmacy Dispensing Robot is no longer reliable. This is due to the robot being twelve years old and has reached the end of its life expectancy (10 years) with replacement parts becoming more difficult to obtain and there are problems with operating system. The old robot also makes it more difficult to automate the Falsified Medicines Directive (FMD).	East Area priority for capital (medical device). Monitoring via east area
Pharmacy Support for Community Hospitals & Rehabilitation Wards	16	The current funded pharmacy support for the east area community hospitals and rehabilitation wards (160) beds only allows for a once weekly visit from a pharmacist and technician respectively. This means that patients may wait for up to 7 days for a medicines reconciliation to be undertaken, which does not meet the standard of 24 hours set by NICE. This can lead to significant harm to patients who may have critical medicines omitted from the prescription chart.	Business case in development. Monitoring via area teams
There is a risk of patient harm from a failure of the production unit delaying chemotherapy	16	There is a risk of the failure of operational systems within one or both Pharmacy manufacturing and compounding facilities within the Central Region BCUHB. Following the breakdown of the SPU air handing unit in 2019 Estates advised that the unit could fail catastrophically and would not be repairable. Both facilities are poor, the Cancer Centre is of poor design and fabrication and the SPU is past its recommended working life and the Air Handling Unit (AHU) is condemned. The lay out of the Cancer Centre production unit is not fit for purpose and production has been consolidated in the SPU unit. Merging has enabled the staff could be better utilised and some of the organisational issues addressed but the Cancer centre unit cannot be fully shut down as it remains the contingency provision should SPU fail.	Business case to convert band 7 to fixed term band 8a whilst longer term solution is put in place. Monitored via East Area.

		Products that would be affected are; Chemotherapy, radiotherapy, total parenteral nutrition for adults and babies, prepared products that reduce risk e.g. insulin and morphine syringes and antibiotic infusions, and over labelled packs for discharge.	
Implementation of new pharmacy computer system	15	The current pharmacy computer system EDS is to be replaced on an All Wales basis with WellSky. Contracts have been signed by WG and an implementation plan is required on sites. There is a risk that there is insufficient staff resource to maintain current services whilst implementing a major change. There is also a need for IT support which will require significant resources to assist implementation.	BCUHB have members on each of the WG module working groups and the overarching implementation group. Further ID of personnel to continue support post implementation required.
Risk of breaching legal requirements to store prescriptions securely	15	There is a risk that BCUHB will breach legal requirements for storing controlled pharmacy documents. This is because the scanner in the department is no longer working and any future procurement of a replacement is not possible because it is unsupported by BCUHB IT. This could have a financial and information governance impact. The estimated financial impact per year is £10,000. Legally, pharmacy required to store adult prescriptions for 2 years, paediatric prescriptions until they reach 21 years of age; worksheets for a period of 13 years (26 years for paediatrics); purchase invoices for 5 years. The pharmacy previously scanned all the documentation, keeping the hard copies for 1-2 months before destruction.	Paper prescriptions, worksheets etc are being kept, but lacking storage capacity. Awaiting IT support for solution/ Monitored via area teams
There is a risk of patient harm from a failure of the production unit delaying chemotherapy	15	There is a risk of the failure of operational systems within one or both Pharmacy manufacturing and compounding facilities within the Central Region BCUHB. Following the breakdown of the SPU air handing unit in 2019 Estates advised that the unit could fail catastrophically and would not be repairable. Both facilities are poor, the Cancer Centre is of poor design and fabrication and the SPU is past its recommended working life and the Air Handling Unit (AHU) is condemned. The lay out of the Cancer Centre production unit is not fit for purpose and production has been consolidated in the SPU unit. Merging has enabled the staff could be better utilised and some of the organisational issues addressed but the Cancer centre unit cannot be fully shut down as it remains the contingency provision should SPU fail. Products that would be affected are; Chemotherapy, radiotherapy, total parenteral nutrition for adults and babies, prepared products that reduce risk e.g. insulin and morphine syringes and antibiotic infusions, and over labelled packs for discharge.	Business case developed. On central area estates capital plan. Monitored via Central Area
Prescription charts in pharmacy therefore not on ward.	15	There is a risk that patients will not receive critical or emergency medication or consultant review due to prescription charts being sent to pharmacy for a clinical check. This is because Pharmacy needs to undertake the clinical check for all newly prescribed drugs to ensure that there are no interactions with co-prescribed medicines and that the dose, and route are correct. If this coincides with a consultant ward round it could result in the chart not being available for review, so medicines could be continued inappropriately, or new medicines not started. If it coincides with a medicines round it may result in omission of critical medicines e.g. insulin, antiepileptics, Parkinson's drugs. New electronic ordering form has been developed in the east, which will reduce the need to send charts down to pharmacy.	All actions to mitigate have been taken. Awaiting Electronic prescribing.

There is a risk that patients in mental health are harmed by poor prescribing practice as pharmacy support is minimal	15	Lack of pharmacy staff both pharmacists and technicians to support MH interventions and lack of regular medication review and reconciliation,education to doctors and nurses poses a risk to safety of patients. Increasing specialist services being provided in primary care with no dedicated pharmacy support. Ongoing recruitment issues for nursing and doctors increase medicines related risks and dispensing which requires pharmacy support but no extra funding is being considered to support this	Business case has been developed. Pursuing opportunities for further MH funding from WG.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 28th August 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Annual Organ and Tissue Donation Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Mr Adrian Thomas, Executive Director of Therapies and Health Sciences
Awdur yr Adroddiad Report Author:	Dr Pierre Peyrasse Consultant Anaesthetist and Clinical Lead Organ Donation Mrs Abi Roberts Specialist Nurse –Organ Donation
Craffu blaenorol: Prior Scrutiny:	BCUHB Organ and Tissue Donation Committee Quality Safety Group
Atodiadau Appendices:	1. Organ and Tissue Donation Annual Report 2. NHSBT Summary Report Actual and Potential Deceased Organ Donation 1 April 2019-31 March 2020 3. Health Board Plan July 2020

Argymhelliad / Recommendation:
The Committee is asked to note the report content and the future aims and objectives of the Organ and Tissue Donation Committee.

| 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:
This paper aims to inform the Committee of the Organ Donation Activity achieved across North Wales during 2019-2020. The paper highlights the hugely successful work undertaken by the Organ and Tissue Donation Committee and describes the priorities set for 2020-2021 to ensure that Organ/Tissue donation remains an integral part of end of life care planning within Critical Care and the Emergency Department.

Cefndir / Background:
This paper is for information purposes and the specific Donation related terminology is explained at the beginning of the Annual report.

Asesiad / Assessment & Analysis

Strategy Implications
N/A.

Options considered
N/A

Financial Implications
N/A

Risk Analysis
N/A

Legal and Compliance
N/A

Impact Assessment
N/A

ORGAN AND TISSUE DONATION

ANNUAL REPORT

2019/2020

Introduction

Organ donation is a gift that transforms and saves lives. We would like to remember and thank all our donors and their families who have made this precious gift in the last year.

Deceased patients can become organ donors if they die in one of 2 circumstances. They have either suffered a devastating brain injury and death is diagnosed by neurological criteria (Donation after Brain Death DBD) or they die following withdrawal of life sustaining treatment (Donation after Circulatory Death DCD). These patients will either be cared for in the Emergency Department (ED), or more commonly on the Intensive Care Unit (ICU). The number of people who die in a way that allows them to become an organ donor is very small. Therefore it is critical that we identify all such individuals and facilitate their prior decision to become an organ donor wherever possible. The Betsi Cadwaladr Organ and Tissue Donation Committee have been working hard to ensure that this happens. While all members of the group contribute to this key members of the team are the 3 Specialist Nurses – Organ Donation (SNODs) and 3 ICU consultants who act as Clinical Leads for Organ Donation (CLODs). They work in pairs on each of the 3 acute sites to embed best practice in organ donation and follow up any missed donation opportunities.

Organ Donation Activity 2019-2020

We are pleased to report that in 2019/20, from 21 consented donors our Health Board facilitated 12 solid organ donors, which resulted in 29 patients receiving a life-saving or life-changing transplant. Out of the 12 donors 7 were donors after DBD and 5 were donors after DCD.

In addition to the 12 proceeding donors there were a further 9 consented donors that did not proceed to donate due to clinical instability, prolonged time to asystole and organs not being accepted by transplant centres. All declines for donation were because the patient had either 'opted out' of donation in life or deemed consent was not supported by the family.

In addition to the local donation data collected by the SNODs, NHS Blood and Transplant (NHSBT) provide an annual report for all UK Health Boards and Trusts (please see Appendix 2 for BCUHB's Summary Report – the full report is available on request).

The NHSBT report has highlighted areas in which the Health Board can improve to increase consent rates and as an Organ Donation Committee we have already addressed these and taken actions as below:

To ensure best quality care in Organ Donation our goal is that every patient who meets the referral criteria should be identified and referred to the NHS Blood and Transplant Services Team. During the period 2019-2020 there were 4 occasions identified where the opportunity to refer a potential donor had been missed. Each case has been reviewed by the clinical team and an action plan instigated to increase Organ Donation education within our Emergency Departments.

An additional goal highlighted in the report is that a SNOD should be present during every organ donation discussion with families, and on 1 occasion this did not occur. However, in this particular case the region was exceptionally busy and there was no available SNOD to attend the ICU in person. The ICU staff were encouraged to discuss donation with the family after guidance from an NHSBT Team Manager over the telephone. The situation does highlight the need for a timely referral of all potential donors to the NHSBT to ensure that a SNOD is available to support families through this important end of life care decision.

Key Achievements

The last year has been a busy and exciting one for our Organ Donation Committee team, which is chaired by Mr Adrian Thomas. There have been a few changes over the last year and we were pleased to welcome Dr Andrew Foulkes as the new Clinical Lead in Ysbyty Glan Clwyd and Mrs Victoria Carroll as our NHSBT Tissue Donation Lead for BCUHB.

- We have visited local schools and provided an overview of Organ Donation and Transplantation to year 12/13 pupils. This is an ongoing initiative.
- The SNOD team ran a second study day for the organ and tissue donation link nurses based in ED's, ICU's and theatres. This day ensures that their clinical knowledge is up to date and that collectively we can educate our colleagues to ensure donation is always an integral part of end of life care planning.
- The Welsh Health Minister Vaughan Gething and Rowena Thomas-Breese officially opened the new Memorial for Organ Donor and Transplant Families at the front of Ysbyty Glan Clwyd in August 2019. This wonderful event was attended by local donor families, transplant recipients as well as hospital staff and key members of the local community.

- We held our third successful Organ Donation SIM day for Critical care, ED and theatre medical and nursing staff at Ysbyty Wrexham Maelor in September 2019. The aim of the course is to encourage staff to recognise a potential donor, manage their care and teach them how and when to involve the Specialist Nurse for Organ Donation for end of life care discussions. We plan to run one of these courses annually and rotate it through the 3 hospital sites.
- On October the 26th our ODC members alongside the Cronfa Elen organ donation charity took part in the Snowdonia Marathon. We competed as a relay team to promote organ donation within our local community. It was a very long tiring day but something we all felt a huge sense of achievement for completing!

- We finished 2019 with our Annual Memorial Service in remembrance and celebration of all our Organ and Tissue Donors, their families and the Transplant recipients of North Wales. This service is held at St Asaph Cathedral and is an event that is much appreciated and attendance grows every year. For us as an ODC it is our opportunity to thank those families for supporting organ donation and bravely giving the gift of life to others.

Priorities for 2020-2021

As a committee we have agreed to focus upon the following areas;

- Increase SNOD visibility and Education sessions with the Emergency Department.
- Improve the referral process of the Tissue Alliance Programme.
- Implement and audit actions to reduce the length of the organ donation process and contribute the findings on an all Wales basis.
- Report of ODC activity to Trust Board and the Welsh Transplantation Advisory Group.
- Continue performance in NHSBT audit cycle.
- Work in collaboration with BCUHB Communications to increase the media profile of Organ and Tissue Donation in North Wales.

Please see the Appendix 3 for the full Key Strategic and Performance Plan 2020-2021

Organ Donation Week 2020

Organ Donation Week will take place from Monday 7th- Sunday 13th September. In light of the COVID-19 pandemic, the campaign will be digitally focused, and will be encouraging local campaigners and colleagues from our organ donation community to support the campaign via their online and social channels.

Actual and Potential Deceased Organ Donation 1 April 2019 - 31 March 2020

NHS Blood and Transplant

Betsi Cadwaladr University Health Board

Taking Organ Transplantation to 2020, 1 April 2019 - 31 March 2020

In 2019/20, from 21 consented donors the Health Board facilitated 12 actual solid organ donors resulting in 29 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

In addition to the 12 proceeding donors there were 9 consented donors that did not proceed.

Best quality of care in organ donation, 1 April 2019 - 29 February 2020*

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
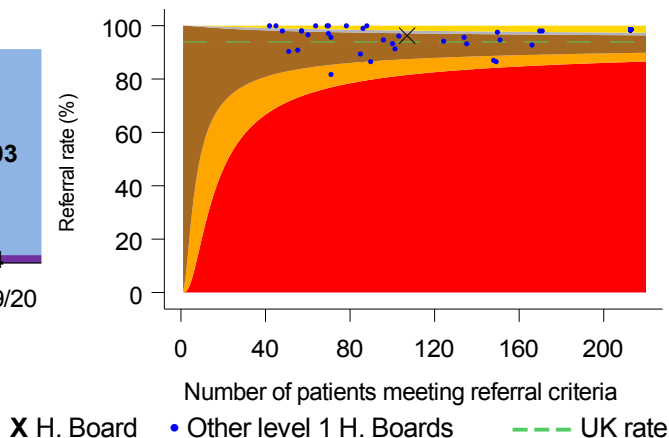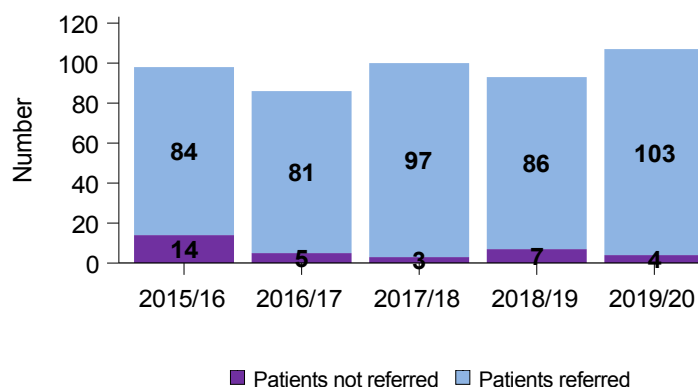
Gold | Silver | Bronze | Amber | Red

The Health Board referred 103 potential organ donors during 2019/20. There were 4 occasions where potential organ donors were not referred.
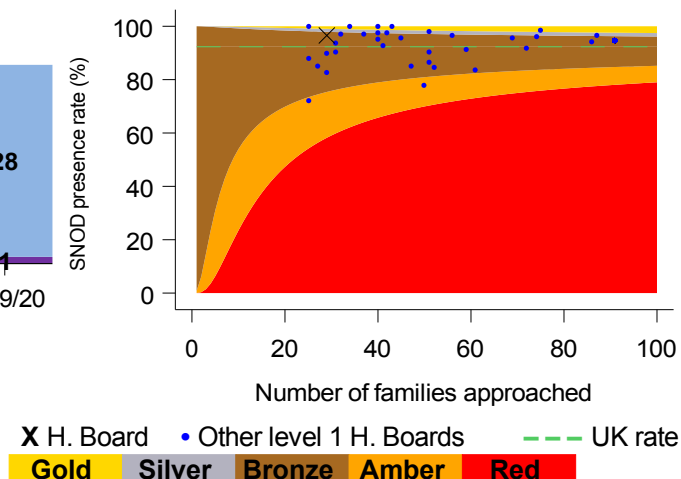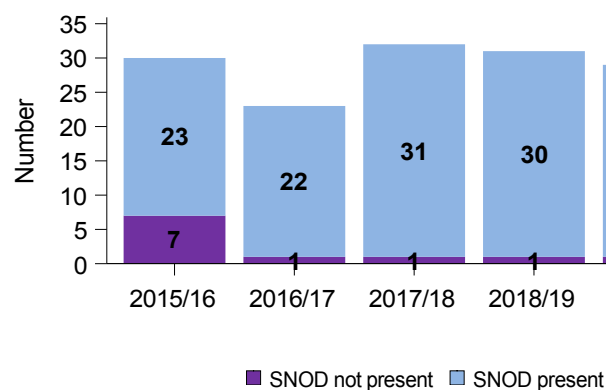
When compared with UK performance, the Health Board was average (bronze) for referral of potential organ donors to NHS Blood and Transplant.

Presence of Specialist Nurse for Organ Donation

NHS

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 28 organ donation discussions with families during 2019/20. There was 1 occasion where a SNOD was not present.

When compared with UK performance, the Health Board was average (bronze) for SNOD presence when approaching families to discuss organ donation.

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 2019 - 31 March 2020		
Deceased donors	75	1,582
Transplants from deceased donors	156	3,749
Deaths on the transplant list	19	394
As at 29 February 2020		
Active transplant list	253	6,138
Number of NHS ODR opt-in registrations (% registered)**	1,282,366 (41%)	25,980,113 (40%)

*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 2019 - 29 February 2020

	DBD H. Board	DBD UK	DCD H. Board	DCD UK	Deceased donors H. Board	Deceased donors UK
Patients meeting organ donation referral criteria[1]	16	1845	91	5676	107	7324
Referred to Organ Donation Service	16	1828	87	5235	103	6876
Referral rate %	G 100%	99%	B 96%	92%	B 96%	94%
Neurological death tested	16	1615				
Testing rate %	G 100%	88%				
Eligible donors[2]	15	1542	37	3985	52	5527
Family approached	13	1368	16	1712	29	3080
Family approached and SNOD present	13	1315	15	1528	28	2843
% of approaches where SNOD present	G 100%	96%	B 94%	89%	B 97%	92%
Consent ascertained	6	983	11	1099	17	2082
Consent rate %	B 46%	72%	B 69%	64%	B 59%	68%
Actual donors (PDA data)	5	876	4	598	9	1475
% of consented donors that became actual donors	83%	89%	36%	54%	53%	71%

[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/

*Quality of care data relating to organ donation has been restricted to exclude the period most significantly impacted by the COVID-19 pandemic. Data presented include activity from 1 April 2019 to 29 February 2020.

Taking Organ Transplantation to 2020 Theme	Key Action Plan – 2020-2021	Responsible Individual	Measurable Outcome	Target Date	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Comments (Optional)
	Organ Donation Promotion, Public Engagement & Education		**Aim for consent rate above 80%**						
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	Continue the Education Programme for Secondary schools.	CLODs/SNODs	Visit at least one school in each area of BCU	Apr-21					Success dependant on the COVID-19 situation
	Donor families & Transplantation Community Liaison Group	Abi Roberts	Group members invited to support all Organ donation Promotional events	Ongoing					Success dependant on the COVID-19 situation
	Contribute to all Wales reports on organ donation	CLODs/SNODs	Inclusion of performance data in National report	Annually					
	Work with BCU Communications Team to improve and maintain the Organ & Tissue Donation website	Comms/SNODs/Tissue Lead	Meet with Comms team to review website content	Nov-20					
	Report activities of ODC to BCU Trust Board	CLODs	Attendance at Trust executive meeting	Aug-21					
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	SNODs/CLODs	One organ donation simulation days per annum	Oct-21					
	Ensure SNOD present in all potential donor approaches	All ITU Consultants	Potential Donor Audit	Monthly report					
	Improve ITU/ED staff engagement with the Tissue Alliance Programme	SNODs/CLODs/Tissue Lead	Audit monthly Tissue donation date. Consider more robust referral methods. Link with the BCU Medical Examiner Role.	Apr-21					
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 following best practice	CLODs	Transplant outcome data. NHSBT Audit	Monthly report					
	Aim for DCD withdrawal in theatre where possible	All ITU Consultants	PDA Data	Monthly report					
	Aim for NDT 6hrs after loss of last brain stem reflex where possible	All ITU Consultants	Audit Length of donation process	Quartely Review					
	Introduction of a standardised BCU bedside observation chart for consented donors	SNODs/CLODs	Transplant outcome data/ length of process audit	Apr-21					
	Good performance in NHSBT potential donor audit	All staff	NHSBT Audit	Ongoing					
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 collaborative to lead local improvement in organ donation, retrieval and transplant practices and in local peomotion of	NHSBT	PDA data/National data	Ongoing					
	Representation from NWODCM to BCU Clinical Legal & Ethical Group	CLODs	CLEG membership	Ongoing					
	Representation from Critical Care Network Lead	Dr D Southern	Critical Care Network engagement	Ongoing					

Betsi Cadwaladr University Health Board (BCUHB)

Key Achievements 2019 - 2020
1	Implementation of a BCUHB Policy for Organ and Tissue Donation.
2	Formal opening of YGC Organ Donation Memorial by Vaughan Gething AM: Minister for Health and Social Services.
3	Ran "Organ Donation Simulation Course" in Wrexham Maelor Hospital and Link-nurse organ donation study day.
4	Continued the education programme for local secondary schools and the N Wales Medical students.
5	Promoted organ donation through team participation in the Snowdonia Marathon.
6	Held our annual Organ donation memorial service at St Asaph Cathedral 16th November

Missed Opportunities and Opportunities to Develop Practice 2019- 2020
1	Ensure all referrals are timely and reduce staff pre-approach to families
2	Work with ED to reduce the missed referrals/missed potentials.
3	Awareness of the high activity within the ED/ICU units and the high turn over of staff to train.

Key Strategic and Performance Priorities 2020 - 2021
1	Increase SNOD visability and education sessions within the Emergency Departments
2	Improve the referral process and rates of the Tissue Alliance Programme
3	Implement and audit actions to reduce the length of the organ donation process and contribute findings on an all Wales basis.
4	Report of ODC activity to Trust Board and the Welsh Transplanation Advisory Group
5	Continue performance in NHSBT audit cycle
6	Work in collaboration with BCUHB Communications to increase media profile of organ donation in North Wales

Please submit with NHS Blood and Transplant Actual and Potential Deceased Organ Donation Summary Report :
April - Sept
April - March

Organ and Tissue Donation Annual Report 2019/2020

Donation Activity 2019-20

- 21 families consented to their loved one becoming an organ donor, 12 of whom went on to become a solid organ donor.

- This resulted in 29 patients receiving a life saving transplant.

- The remaining 9 consented donors did not proceed to donation due to prolonged time to asystole and no suitable/matching transplant recipients.

- The SNOD team were involved in other end of life care decisions in Critical Care, however donation was declined due to a known 'opt out' decision by the patient or deemed consent was not supported by their families.

Achievements

- Structured education programme for clinical staff and our local community.

- Official opening of the Organ & Tissue Donation memorial at YGC.

- ODC engagement in promotional events with our dedicated Organ Donation Charity 'Cronfa Elen'.

- Annual Service of Remembrance for our donors and their families at St Asaph Cathedral.

- Continued support for our donor families and transplant recipients.

Priorities 2020-21

- Increase SNOD presence and education within our Emergency Departments.

- Work with NHSBT Tissue Service to improve the Tissue Donation Alliance Site referral process.

- Work in partnership with our critical care colleagues to implement clinical measures to streamline the donation process.

- Continue to work with BCUHB Communication team to raise awareness of Organ Donation and Transplantation within our hospitals and wider community.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

NHS
Blood and Transplant

Final thought

Organ Donation is a gift that transforms and saves lives. We would like to remember and thank all our donors and their families who have made this precious gift in the last year.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 28th August 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Care Quality Commission (CQC) report and ratings for Shrewsbury and Telford NHS Trust
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Acting Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience and
Craffu blaenorol: Prior Scrutiny:	Review by responsible director and executive director
Atodiadau Appendices:	Care Quality Commission (CQC) report and ratings for 1. Shrewsbury and Telford NHS Trust (April 2020) 2. Royal Shrewsbury Hospital report and ratings (August 2020) 3. Princess Royal Hospital report and ratings (August 2020)

Argymhelliad / Recommendation:

The QSE Committee is asked to note this report.

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:

This report provides the QSE Committee with the most recent reports and ratings by the Care Quality Commission (CQC) regarding Shrewsbury and Telford NHS Trust and its two main hospitals; Royal Shrewsbury Hospital and Princess Royal Hospital. The most recent reports were published on 14 August 2020.

Cefndir / Background:

Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin and mid Wales. The Trust has two main hospital sites: Royal Shrewsbury Hospital and Princess Royal Hospital in Telford.

The Care Quality Commission (CQC) (health care regulator in England) carried out a core service inspection and well led review between 12 November 2019 and 10 January 2020 and published their report and ratings on 08 April 2020. Under the CQC ratings methodology, the Trust was rated for the Safe, Effective, Responsive and Well Led domains as Inadequate and for the Caring domain as Requires Improvement).

A further inspection took place of Royal Shrewsbury Hospital and Princess Royal Hospital on 09 and 10 June 2020 and the reports and ratings were published on 14 August 2020. In accordance with the CQC ratings methodology, both hospitals were rated for the Safe, Effective, Responsive and Well Led domains as Inadequate (with caring remaining rated as Requires Improvement). The overall rating for each hospital is Inadequate. The CQC took enforcement action including the use of urgent enforcement powers where they placed conditions on the Trust's registration in relation to the assessment and management of risk, care planning, and incident management. They also served two warning notices to the Trust requiring them to make improvements in the following areas; end of life care staffing, end of life staff competencies, end of life governance systems and the way the staff support patients in line with their personal preferences and individual needs.

Some North Wales patients will be treated by services provided by Shrewsbury and Telford NHS Trust. This activity relates to small numbers of elective and emergency care for patients on the border, and for renal dialysis and IVF treatments commissioned via the Welsh Health Specialist Services Committee (WHSCC). Formal contract meetings are in place led by the lead commissioner of the Trust, NHS Shropshire Clinical Commissioning Group (CCG), and the Health Board attends as an associate commissioner (in accordance with the English NHS commissioning framework). The Health Board coordination of involvement is through the Director of Performance who oversees the Healthcare Contracting Team. The Head of Quality Assurance attends on behalf of the Quality Assurance Team. The Trust provides updates on its improvement plans at these meetings, recognising there are separate formal processes underway by NHS England and the CQC as the regulators.

Donna Ockenden Ltd was commissioned by the English Secretary of State for Health and Social Care to review maternity concerns at the Trust. As part of this review, the Health Board was approached to provide information to the review. The Health Board is committed to engaging with the review so families from North Wales have their cases heard, and has sought clarity over the scope and legal framework for information to be shared in line with guidance from the Welsh Government and in-line with the approach taken by Powys Teaching Health Board. A meeting has been organised by the English Department of Health and Social Care with all relevant parties to progress this for 15 September 2020.

Asesiad / Assessment & Analysis

The QSE Committee is asked to note this report and the Health Board's attendance at the contract meeting with Shrewsbury and Telford NHS Trust. The contract meeting is reported to the Contract Review and Governance Group (CRGG) and upwards to the Finance and Performance (F&P) Committee of the Health Board. The Head of Quality Assurance attends the CRGG to ensure quality representation as well as the contract meeting with the Trust. A quarterly report on contracts is also provided to the Quality and Safety Group (QSG) from the CRGG, as well as to F&P Committee.

Shrewsbury and Telford Hospital NHS Trust

Inspection report

Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XQ
Tel: 01743261000
www.sath.nhs.uk

Date of inspection visit: 12 November 2019 to 10 January 2020
Date of publication: 08/04/2020

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall trust quality rating	Inadequate 🔴
Are services safe?	**Inadequate** 🔴
Are services effective?	**Inadequate** 🔴
Are services caring?	**Requires improvement** 🟠
Are services responsive?	**Inadequate** 🔴
Are services well-led?	**Inadequate** 🔴

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin and mid Wales. The trust has two main hospital sites: Royal Shrewsbury Hospital and Princess Royal Hospital in Telford.

The two hospitals have approximately 650 inpatient beds. Royal Shrewsbury Hospital has nine operating theatres, and Princess Royal Hospital 10 operating theatres. The trust employed 6,146 staff as of July 2019.

Princess Royal Hospital is the trust's specialist centre for inpatient head and neck surgery. It includes the Shropshire Women and Children's Centre, the trust's main centre for inpatient women's and children's services.

The trust provides acute inpatient care and treatment for specialties including cardiology,

clinical oncology, colorectal surgery, endocrinology, gastroenterology, gynaecology, haematology, head and neck, maternity, neonatology, nephrology, neurology, respiratory medicine, stroke medicine, trauma and orthopaedics, urology and vascular surgery.

(Source: Routine Provider Information Request (RPIR) – Context acute tab; trust website)

Hospital sites at the trust

A list of the trust's acute hospitals is below. Both hospitals provide acute hospital inpatient services and outpatient services to Shropshire, Telford and Wrekin and mid Wales.

- Princess Royal Hospital - Apley Castle, Telford, Shropshire TF1 6TF

- Royal Shrewsbury Hospital - Mytton Oak Road, Shrewsbury, Shropshire, SY3 8XQ

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Inadequate 🔴 ➜ ⬅

What this trust does

Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin and mid Wales. The trust has two main hospital sites: Royal Shrewsbury Hospital and Princess Royal Hospital in Telford. The two hospitals have approximately 650 inpatient beds. Royal Shrewsbury Hospital has nine operating theatres, and Princess Royal Hospital 10 operating theatres. The trust employed 6,146 staff as of July 2019. Princess Royal Hospital is the trust's specialist centre for inpatient head and neck surgery. It includes the Shropshire Women and Children's Centre, the trust's main centre for inpatient women's and children's services. The trust provides acute inpatient care and treatment for specialties including cardiology, clinical oncology, colorectal surgery, endocrinology, gastroenterology, gynaecology, haematology, head and neck, maternity, neonatology, nephrology, neurology, respiratory medicine, stroke medicine, trauma and orthopaedics, urology and vascular surgery.

(Source: Routine Provider Information Request (RPIR) – Context acute tab; trust website)

Key questions and ratings

We inspect and regulate healthcare service providers in England.

Summary of findings

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We carried out a core service inspection and well led review. We visited both hospitals and inspected the following core services between 12 to 20 November 2019:

Princess Royal Hospital (PRH):

- Urgent and emergency care.

- Medical care.

- Surgery.

- Maternity.

- Children and young people.

- End of life care.

- Outpatients.

Royal Shrewsbury Hospital (RSH):

- Urgent and emergency care.

- Medical care.

- Surgery.

- End of life care.

- Outpatients.

We carried out a well led review on 8 to 10 January 2020. To assess if the organisation was well-led, we interviewed the members of the board, the executive team and held a focus group with non-executive directors and a range of staff across the hospital. We met and talked with a wide range of staff to ask their views on the leadership and governance of the trust. We looked at a range of performance and quality reports, audits and action plans, board meeting minutes and papers to the board, investigations and feedback from patients, local people and stakeholders. The well-led review team comprised of a head of hospital inspection, inspection manager, inspector, pharmacy specialist, an executive reviewer from another NHS trust, two special clinical advisors with significant experience of governance and NHS trust boards and NHS England/improvement.

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

What we found

Overall trust

Summary of findings

Our rating of the trust stayed the same. We rated it as inadequate because:

- The safe, effective, responsive and well led key questions were all rated as inadequate.

- The caring key question went down to requires improvement.

- Royal Shrewsbury Hospital was rated requires improvement.

- The Princess Royal Hospital was rated as inadequate.

Are services safe?

Our rating of safe stayed the same. We rated it as inadequate because:

- Princess Royal Hospital (PRH) was rated as inadequate for safety overall.

- Core services urgent and emergency care and medical care at PRH were rated as inadequate for safety.

- Outpatients at PRH was rated as good for safety.

- Surgery, maternity, services for children and young people and end of life care at PRH were all rated as requires improvement for safety.

- Royal Shrewsbury Hospital (RSH) was rated as requires improvement for safety overall.

- Urgent and emergency care at RSH was rated as inadequate for safety.

- All other core services were rated as requires improvement.

Are services effective?

Our rating of effective went down. We rated it as inadequate because:

- Princess Royal Hospital (PRH) was rated as inadequate for effective overall.

- Core services urgent and emergency care and medical care at PRH were rated as inadequate for effective.

- Maternity at PRH was rated as good for effective.

- We do not rate outpatients for effectiveness.

- All other core services were rated as requires improvement for effective at PRH.

- Royal Shrewsbury Hospital (RSH) was rated as requires improvement for effective.

- Urgent and emergency care at RSH was rated as inadequate for effective.

- We do not rate outpatients for effectiveness.

- All other core services at RSH were rated as requires improvement.

Are services caring?

Our rating of caring went down. We rated it as requires improvement because:

- Both hospitals were rated as requires improvement for caring.

- Surgery, maternity and outpatients at Princess Royal Hospital were rated as good for caring. The other core services inspected were rated as requires improvement.

- End of life care and outpatients at Royal Shrewsbury Hospital were rated as good for caring. The other core services inspected were rated as requires improvement.

Summary of findings

Are services responsive?

Our rating of responsive went down. We rated it as inadequate because:

- Princess Royal Hospital (PRH) was rated as inadequate for responsive overall.
- Core services urgent and emergency care and children and young people at PRH were rated as inadequate for responsive.
- Outpatients at PRH was rated as good for responsive.
- The other core services inspected at PRH were rated as requires improvement.
- Royal Shrewsbury Hospital (RSH) was rated as requires improvement for responsive.
- Urgent and emergency care at RSH was rated as inadequate for responsive.
- All other core services inspected at RSH were rated as requires improvement.

Are services well-led?

Our rating of well-led stayed the same. We rated it as inadequate because:

- Royal Shrewsbury Hospital was rated as requires improvement for well led.
- Princess Royal Hospital was rated as inadequate for well led overall.
- Overall, the trust was rated as inadequate for well led.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in some areas, see below for more information.

Areas for improvement

We found areas for improvement including 92 breaches of legal requirements that the trust must put right. We found 75 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

Action we have taken

We issued nine requirement notices to the trust. We also took urgent action and issued eight new conditions of registration and varied two existing conditions of registration as well as issuing a section 29 A warning notice.

What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Summary of findings

Outstanding practice

We found examples of outstanding practice in:

In Outpatients at PRH:

- The service implemented a nurse-led wound clinic to provide continuity of care for patients and free up space in other clinics.

- The service were currently trialling a virtual fracture clinic to reduce unnecessary visits for patients.

In Surgery at RSH:

- We saw examples of excellent support for patients living with dementia on most wards. The hospital had a dementia support team who visited all patients identified as living with dementia. They undertook a review to ensure their needs were being met. The service used 'this is me' forms effectively. We saw transparent stands were provided where this is me forms were placed in the stand at the bedside. This meant staff visiting patients could immediately see the form and understand the patients' specific communication needs. They also supported wards by providing them with resources to support patients and organised finger foods for patients with limited appetite to ensure there was a variety of options. The service also had a dementia café that operated twice a month, where patients living with dementia could take time out of the ward and participate in activities such as singling and quizzes.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Actions the trust must take to improve:

At trust Well led level:

- Ensure there are effective governance systems and process in place to effectively assess, monitor and improve the quality and safety of services. Regulation 17 (1): Good governance.

- Ensure there are effective systems and process to assess monitor and mitigate risks. Regulation 17(2): Good governance.

- Ensure there is consistent use and completion of the incident investigation form for serious incidents, that learning is clearly identified, actions developed, and impact reviewed. Regulation 17(1): Good governance.

- Ensure the backlog of incidents awaiting review is reduced. Regulation 17(1): Good governance.

- Ensure that robust processes are in place to confirm all directors are fit and proper for the role. Regulation 5: Fit and proper persons – directors

In Urgent and emergency care at PRH:

The service MUST take action to:

- Ensure nurse staffing levels are adequate to keep all patients safe and skill mix must be reviewed to include appropriate cover for paediatric patients. Regulation 18 (1): Staffing.

Summary of findings

- Ensure medical staffing levels are adequate to keep all patients safe, especially during the night shifts. Regulation 18 (1): Staffing.

- Ensure provide guidance to enable staff to consistently manage and review deteriorating patients, in line with national guidance. Regulation12 (1) (2) (a) (c): Safe care and treatment.

- Ensure they review its performance against all targets set out in national key performance indicators and in line with the Royal College of Emergency Medicine (RCEM) audits. Regulation 17 (1) (2) (a): Good governance.

- Ensure that all appropriate staff are trained to the required levels in both adult and children's safeguarding. Regulation 18 (1) (2) (a): Safe care and treatment.

- Ensure the emergency department (ED) report the standards around caring for patients promptly; patients must be seen for a face-to-face assessment within the fifteen minutes of registering on arrival to ED. Regulation 12 (1) (2) (a): Safe care and treatment.

- Ensure all PEWS's are escalated appropriately for medical reviews and early intervention as required. Regulation 12 (1) (2) (a) (b): Safe care and treatment.

- Ensure all staff complete risk assessments for each patient on admission / arrival, using a recognised tool, and review this regularly. Staff must complete, or arrange, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Regulation 12 (1) (2) (a) (b): Safe care and treatment.

- Ensure accurate and complete records of all patient restraint are maintained Regulation 17 (1) (2) (c): Good governance.

- Ensure all staff carrying out patient restraint are trained and competent. Regulation 12 (1) (2) (c) Safe care and treatment.

In Medical care at PRH:

The service MUST take action to:

- The trust must ensure that medical staff within medical services at the Princess Royal Hospital complete the mandatory training assigned to them. Regulation 18 (2): Staffing.

- The trust must ensure that medical staff within medical services at the Princess Royal Hospital complete the mandatory safeguarding training assigned to them Regulation 13: Safeguarding.

- The trust must ensure that policies and procedures in place to prevent the spread of infection are adhered to in medical services at the Princess Royal Hospital. Regulation 12 (2)(h): Safe care and treatment.

- The trust must ensure that equipment is used in a safe manner to protect patients from the risk of injury or harm. Regulation 12 (2)(e): Safe care and treatment.

- The trust must ensure that deteriorating patients are identified and escalated in line with trust policy within medical care at the Princess Royal Hospital. Regulation 12 (2)(a): Safe care and treatment.

- The trust must ensure that medical patients at the Princess Royal Hospital have their individual needs assessed and planned for. Regulation 9: Person-centred care.

- The trust must ensure that policies and procedures in place surrounding the mental Capacity Act 2005 and Mental health Act 1983 are understood and correctly and consistently applied. Regulation 13: safeguarding.

- The trust must ensure that ward moves per admission and ward moves at night are recorded so that individual needs are accounted for. Regulation 9: Person-centred care.

Summary of findings

- The trust must ensure that effective governance systems and process are in place to assess, monitor and improve all aspects of care delivered. Regulation 17 (1)(2)(a): Good governance.

In Maternity at PRH:

The service MUST take action to:

- The trust must ensure staff complete mandatory training, including training on safeguarding of vulnerable children and adults, in line with the trust target. Regulation 12 (1)(2)(c): Safe care and treatment.

- The trust must ensure high risk women are reviewed in the appropriate environment by the correct member of staff. Regulation 12 (1)(2a,b,h): Safe care and treatment.

- The trust must ensure grading of incidents reflects the level of harm, to make sure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance. Regulation 20: Duty of candour.

- The trust must ensure all women receive one to one care when in established labour. Regulation 12(1)(2a, b): Safe care and treatment.

- The trust must ensure that carbon monoxide monitoring assessments and records are in line with trust policy. Regulation 12 (1)(2a,b): Safe care and treatment.

- The trust must ensure that women are asked about domestic violence in line with trust policy. Regulation 12 (1)(2a,b): Safe care and treatment.

- The trust must ensure ward level safety huddles are performed in all areas to ensure information is shared with all staff. Regulation 17 (1)(2): Good governance.

- The trust must ensure that the senior leadership team has processes for governance and oversight of risk and quality improvement. Regulation 17(1)(2): Good governance.

In Children and Young People care at PRH:

The service MUST take action to:

- The service must provide enough nursing staff with the right qualifications, skills, training and experience to keep providing the right care and treatment. Regulations 2014: Regulation 18 (1): Staffing.

- The service must ensure relevant staff are competent in their roles to care for children and young people with mental health needs, learning disabilities and autism. Regulation 18 (2): Staffing.

- The trust must provide a dedicated recovery area for paediatrics and ensure children and young people attending the day surgery unit do not mix with adult patients on the ward. Regulation 12 (d): Safe Care and Treatment.

In End of life care at PRH:

The service MUST take action to:

- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.

- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing.

- The service must ensure it fully completes do not attempt cardiopulmonary resuscitation (DNACPR) and ReSPECT forms. Regulation 11: Need for Consent.

Summary of findings

- The service must ensure it staff carry out and complete mental capacity act assessments for all patients who are deemed to not have capacity. Regulation 11: Need for Consent.

- The trust must ensure it had full oversight of end of life care services and fully embeds the end of life care team into the scheduled care group governance processes. Regulation 17(1)(2)(a): Good Governance.

- The service must have an electronic system which accurately identifies and tracks end of life and palliative care patients. Regulation 12(2)(a): Safe Care and Treatment.

In Urgent and emergency care at RSH:

The service MUST take action to:

- The service must ensure the emergency department (ED) nursing and medical staff consistently complete mandatory training, including safeguarding training in line with trust compliance rates. Regulation 18 (1)(2)(a): Staffing.

- The service must provide safe and appropriate facilities for the assessment of patients who present at the ED with acute mental health concerns that conform with national guidance. Regulation 15 (1)(c)(d)(e) and (f): Premises and equipment.

- The service must ensure that they are assessing their performance against the Royal College of Paediatrics and Child Health (RCPCH) emergency care standards and that effective action plans are in place to ensure where possible action is taken to meet these standards. Regulation 17 (1)(2)(a) and (b): Good governance.

- The service must ensure that effective systems are in place to ensure emergency equipment in the ED is in date and available for use. Regulation 12 (1)(2)(e) and (f): Safe care and treatment.

- The service must ensure the premises are secure to protect patients from the risk of harm and to mitigate the risk of equipment from being tampered with or missed. Regulation 15 (1)(b): Premises and equipment.

- The service must ensure that equipment that could be used for self-harm or harm to others is stored securely. Regulation 15 (1)(b): Premises and equipment.

- The service must ensure that all patients are triaged within 15 minutes of arrival to the ED. Regulation 12 (1)(2)(a): Safe care and treatment.

- The service must ensure that nationally recognised tools are used within the ED, in line with guidance to identify and escalate deteriorating patients. Regulation 12 (1)(2)(a)(c) Safe care and treatment.

- The service must ensure that national guidance is followed in the ED with regards to the prompt treatment of suspected sepsis. Regulation 12 (1)(2)(a)(c) Safe care and treatment.

- The service must ensure the risk associated with falling and developing pressure ulcers are promptly assessed on arrival to the ED and ensure appropriate action is taken to mitigate these risks. Regulation 12 (1)(2)(a) Safe care and treatment.

- The service must formally assess and record individual patients' suitability to use bed/trolley rails. Regulation 12 (1)(2)(a) Safe care and treatment.

- The service must formally assess the risks associated with patients who present at the ED with acute mental health conditions. Appropriate action must be taken to mitigate these risks. Regulation 12 (1)(2)(a): Safe care and treatment.

- The service must ensure that ED records are stored securely and contain a clear and contemporaneous account of the care and treatment provided. Regulation 17(1)(2)(c): Good governance.

- The service must ensure that all medicines are stored securely and correctly with restricted access to authorised staff. Regulation 12 (1)(2)(g) Safe care and treatment.

Summary of findings

- The service must ensure that emergency medicines are always available within the ED. Regulation 12 (1)(2)(f) Safe care and treatment.

- The service must ensure that effective systems are in place to enable managers to take prompt and immediate action to reduce the risk of avoidable incidents from reoccurring in the ED. Regulation 17 (1)(2)(b): Good governance.

- The service must ensure that the incident reporting systems in place supports ED staff to consistently identify and report safety incidents and near misses. Regulation 17 (1)(2)(b): Good governance.

- The service must ensure national and local guidance is followed with regards to the practice of physical restraint within the ED. Regulation 13 (1)(4)(b): Safeguarding service users from abuse and improper treatment.

- The service must ensure that the rights of patients who present in the ED under the Mental Health Act 1983 are consistently protected. Regulation 13 (1)(5) Safeguarding service users from abuse and improper treatment.

- The service must ensure that clinical staff in the ED understand and can apply the requirements of the Mental Capacity Act 2005. Regulation 11 (1)(3): Need for consent.

- The service must ensure that patients in the ED are only deprived of their liberty when it is lawful to do so in accordance with the Mental Capacity Act 2005. Regulation 13 (1)(5): Safeguarding service users from abuse and improper treatment.

- The service must ensure that patients within all areas of the ED consistently have their right to privacy respected. Regulation 10 (1)(2)(a): Dignity and respect.

- The service must ensure all complaints are managed in accordance with trust policy. Regulation 16 (2): Complaints.

- The service must ensure that an effective leaders are in place to design and action an improvement plan within the ED to improve the safety, effectiveness and responsiveness of the service and to ensure improved standards of care are consistently achieved. Regulation 17 (1)(2)(a)(b): Good governance.

- The service must ensure that all relevant risks within the ED are included and planned for in the service's risk register. Regulation 17 (1)(2)(b): Good governance.

- The service must ensure patients are consistently involved in plans to improve ED services. Regulation 17 (1)(2)(e). Good governance.

In Medical care at RSH:

The service MUST take action to:

- The service must ensure that the mandatory training rates meet the trust target. Regulation 18 (2): Staffing.

- The service must ensure venous thromboembolism assessments are consistently carried out. Regulation 12 (2)(a): Safe care and treatment.

- The service must ensure risk assessments are carried out for patients in side rooms living with mental health conditions. Regulation 12 (2)(a): Safe care and treatment.

- The service must ensure deprivation of liberty safeguards reassessments are carried out. Regulation 13: Safeguarding service users from abuse and improper treatment.

- The service must ensure weight, height and body mass index are consistently recorded. Regulation 12 (2)(a): Safe care and treatment.

- The service must ensure that staff consistently adhere to infection prevention and control practices. Regulation 12 (2)(h): Safe care and treatment.

Summary of findings

- The service must ensure all staff moved to other ward areas/escalation areas practice within their competencies. Regulation 18(2): Staffing.

- The service must ensure that privacy and dignity of patients attending the renal unit is maintained. Regulation 10: Privacy and dignity.

- The service must ensure that concerns identified during our inspection are addressed. Regulation 17(2)(b): Good governance.

In Surgery at RSH:

The service MUST take action to:

- The service must ensure all patients at risk of falls undergo a risk assessment, regular monitoring and management in line with the trust policy and care plan. Regulation 12(2)(a): Safe care and treatment.

- The service must ensure that intra-operative temperatures are routines recorded during procedures in line with national guidance. Regulation 12(2)(a): Safe care and treatment.

- The service must ensure that the five steps to safer surgery checklist is completed fully and signed and date by relevant staff. Regulation 12(2)(a): Safe care and treatment.

- The service must ensure that staff are implementing the sepsis recognition and management form and stop the clock actions are completed within the hour in line with trust policy and care plan. Regulation 12(2)(a): Safe care and treatment.

- The service must ensure all staff who provide care and treatment to young people under 18 years have received the appropriate level of safeguarding training as outlined in the intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (Fourth edition: January 2019). Regulation 13: Safeguarding people from abuse and improper treatment.

- The service must ensure all risks are assessed, monitored, mitigated and the risk register is routinely reviewed. Regulation 17(2)(b): Good governance.

- The service must ensure patient records when not in use are stored securely. Regulation 17(2)(c): Good governance.

- The service must ensure all staff have completed mandatory training in key skills and other training specific to their roles including Mental Capacity Act and deprivation of liberty safeguards. Regulation 18(2)(a)(b): Staffing.

- The service must ensure that all clinical areas are adequately staffed to ensure safe patient care. Regulation 18 (1): Staffing.

- The service must ensure that sufficient staff are trained and available in advanced paediatric life support. Regulation 18 (2): Staffing.

In End of life care at RSH:

The service MUST take action to:

- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.

- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing

- The service must ensure it fully completes do not attempt cardiopulmonary resuscitation (DNACPR) and ReSPECT forms. Regulation 11: Need for consent.

Summary of findings

- The service must ensure it staff carry out and complete mental capacity act assessments for all patients who are deemed to not have capacity. Regulation 11: Need for consent.

- The trust must ensure it had full oversight of end of life care services and fully embeds the end of life care team into the scheduled care group governance processes. Regulation 17(2)(a): Good Governance.

- The service must have an electronic system which accurately identifies and tracks end of life and palliative care patients. Regulation 12 (2)(a): Safe Care and Treatment.

In Outpatients at RSH:

The service MUST take action to:

- The trust must address the low lighting levels in parts of the Eye Clinic in order to keep patients with poor sight safe from falling. Regulation 12(2)(d) : Safe care and treatment.

- The trust must ensure that the plans it has to make vision assessment rooms safer in the Eye Clinic through the introduction of new light boxes are implemented. Regulation 12(2)(d): Safe care and treatment.

Actions the trust should take to improve:

At trust well led level:

The trust SHOULD take action to:

- Progress the plans to review the vision, strategy and values to promote high quality care.

- Consider how leaders can be more visible to staff, with recognition from staff of this visibility.

- Develop and support a culture in which staff feel supported, respected and valued.

- Finalise and implement the digital strategy so that information technology systems are used effectively to accurately monitor and improve the quality of care.

In Urgent and emergency care at PRH:

The service SHOULD take action to:

- Review all policies regarding managing deteriorating patients.

- Review departmental risk registers to ensure actions are updated in a timely manner.

- The service should review staff understanding of assessing and responding to patient at risk of mental health deterioration and seek guidance or support from other mental health services available.

- The service should obtain an observation policy and a robust restraint policy in place.

In Medical care at PRH:

The service SHOULD take action to

- The trust should ensure that all staff responsible for the delivery of thrombolysis are trained and competent to do so. Regulation 18 (2): Staffing.

- The trust should ensure that nursing staff within medical services at The Princess Royal Hospital complete the mandatory training assigned to them Regulation 18 (2): Staffing.

- The trust should ensure active recruitment into medical and nursing posts within medical services at the Princess Royal Hospital continues. Regulation 18 (1): Staffing.

Summary of findings

In Surgery at PRH:

The service SHOULD take action to:

- Summary of findings 12 Shrewsbury and Telford Hospital NHS Trust Inspection report April 2020
- Ensure staff comply with infection control practice. Regulation 12 (2) (h): Safe care and treatment.
- Ensure all staff complete their mandatory training including safeguarding, MCA and DOLS. Regulation 18 (2): Staffing.
- Continue to try and improve flow through theatre and reduce the number of cancelled operations.
- Continue to try and improve the admitted pathway referral to treatment times.
- Ensure accurate marking of surgical site and recording on operating lists and consent forms. Regulation 12 (1)(a): Safe care and treatment.
- Make improvements in the National Hip Fracture Database audits outcomes.

In Maternity care at PRH:

The service SHOULD take action to:

- The trust should ensure the maternity dashboard is colour coded in line with national guidance.
- The trust should ensure all staff complete accurate documentation around CTG monitoring.
- The trust should ensure women are not identifiable by name on the board at the midwives' station on the postnatal ward.
- The trust should ensure that all midwives have an annual appraisal.

In Children and Young People care at PRH:

The service SHOULD take action to:

- The service should ensure they have appropriate systems in place to support the transition of children and young people to adult services. Regulation 9: Person Centred Care.
- The service should consider providing an appropriate environment and facilities for children and young people with learning disabilities and autism.

In End of life care at PRH:

The service SHOULD take action to:

- The trust should continue to participate in an external review of the chaplaincy service to ensure this service meets individual need.
- The service should provide it provides key specialist palliative care services seven days week in line with National Institute of Health and Care Excellence.
- The service should ensure all risks are recorded appropriately on the risk register.
- The service should have a service level agreement in place in place to ensure the continuation of the out of hours service.
- The service should undertake audits of end of life care patients preferred place of care or death. The service should undertake audits for pain or symptom control for end of life care patients.

In Outpatients at PRH:

Summary of findings

The service SHOULD take action to:

- Monitor that all staff have access to appropriate mental capacity act (MCA) training and updates.

- Monitor that staff understand how and when to conduct a mental capacity act (MCA) assessment.

- Monitor that medical staff complete patient records in a clear and legible way.

- Consider ways to improve access to timely appointments for people with cancer in line with national guidelines.

- Consider ways to improve staff engagement with senior leaders and the executive team.

- Monitor that the flooring and chairs in the phlebotomy room comply with infection prevention and control guidelines.

In Urgent and emergency care at RSH:

The trust SHOULD take action to:

- The service should consider how cleanliness within the ED can be consistently maintained and embed safe infection prevention and control practice within the ED.

- The service should review the systems in place to access hoists promptly in the event of the ED hoist being unavailable.

- The service should continue to explore the options available to ensure that facilities are consistently available for the relatives of ED patients who are seriously ill.

- The service should continue to work with commissioners to improve ambulance handover times.

- The service should continue to embed local initiatives aimed to improve sepsis care.

- The service should consider how to improve the accuracy of the information that is recorded on the ED patient board.

- The service should continue to make progress with the ED's long term recruitment plan for nursing and medical staff. This includes the recruitment and retention of children's nurses and a paediatric emergency medicine consultant.

- The service should consider reviewing how the use of rapid tranquilisation medicines is recorded when the medicines used fall outside of the rapid tranquilisation policy.

- The service should review medicines refrigeration capacity to ensure medicines are consistently stored safely in the event of a refrigerator breakdown.

- The service should review the controlled drugs books to ensure they can clearly record the level of detail required.

- The service should explore the staff feedback about how pharmacy staff could be utilised to improve medicines management in the ED.

- The service should explore how to effectively display patient safety information within the ED.

- The service should review the clinical policies and pathways that relate to ED care and reference the best practice and national guidance that they are based upon.

- The service should ensure that patients who require food and drink within the ED have their dietary needs assessed and planned for. Regulation (1)(2)(a)(ii)(4)(a)(c)(d).

- The service should review the content of the action plans in place in response to the RCEM audits to check they will be effective in driving improvements and better patient outcomes.

- The service should continue to aim towards consistently achieving their 90% appraisal compliance rate for staff working in the ED.

Summary of findings

- The service should continue with the implementation of a suitable competency tool for staff working.

In Medical care at RSH:

The service SHOULD take action to

- The service should ensure there are enough therapy staff. Regulation 18(1): Staffing.

- The service should ensure patients are reviewed by doctors during weekends. Regulation 18(1): Staffing.

In Surgery at RSH:

The service SHOULD take action to:

- The service should ensure that appropriate spaces are made available within the surgical assessment unit when delivering patient care to ensure patient privacy and dignity is maintained and that all staff respect patient privacy and dignity at all times. Regulation 10: Dignity and respect.

- The service should ensure anaesthetic machine safety checks are completed daily and are dated and signed. Regulation 12(2)(e): Safe care and treatment.

- The service should ensure all clinical waste is disposed of correctly. Regulation 12(2)(h): Safe care and treatment.

- The service should ensure that all areas use to temporarily escalate patients have undergone a robust risk assessment and are safe to use for the intended purpose. Regulation 12(2)(d): Safe care and treatment.

- The service should ensure all staff have received sepsis training. Regulation 18(2): Staffing.

- The service should consider reviewing its complaints process so that complaints are investigated and responded to in a timely manner.

- The service should consider implementing a consistent approach to theatre and ward-based team meeting content and documentation.

- The service should consider reviewing its process for discussing sensitive information and delivering bad news to patients admitted to surgical wards.

- The service should consider implementing a consistent multi-disciplinary team meeting approach across all surgical specialities.

- The service should consider reviewing management staffing out of hours to support the provision of seven day working.

- The service should review the process for providing agency staff with immediate access to electronic records and systems.

In End of life care at RSH:

The service SHOULD take action to:

- The trust should continue to participate in an external review of the chaplaincy service to ensure this service meets individual need.

- The service should provide it provides key specialist palliative care services seven days week in line with National Institute of Health and Care Excellence.

- The service should ensure all risks are recorded appropriately on the risk register.

Summary of findings

- The service should have a service level agreement in place in place to ensure the continuation of the out of hours service.

- The service should undertake audits of end of life care patients preferred place of care or death.

- The service should undertake audits for pain or symptom control for end of life care patients.

In Outpatients at RSH:

The service SHOULD take action to:

- The trust should ensure that they monitor compliance with mandatory training for fire, infection control, resuscitation and mental capacity. Regulation 12(2)(f): Safe care and treatment.

- The trust should ensure there is a means for staff to positively identify equipment that has been cleaned between patients. Regulation 12(2)(e): Safe care and treatment.

- The trust should ensure that they monitor compliance with national standards for cancer specialities and respond as necessary. Regulation 12(2)(a): Safe care and treatment.

- The trust should monitor that staff consistently follow the trust policy of use of relatives as translators.

- The trust should continue to develop its information systems to minimise the risks associated with duplication of data entry and reliance on paper systems

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well led at the trust as inadequate. This was the same as the previous inspection. We rated it as inadequate because:

- There was a lack of stability in the executive team with several interim members, although to increase stability these individuals had agreed to stay in post until substantive post holders were in place. The board had some knowledge of the current challenges and were acting to address these however this had not made the sustained improvements required to deliver high quality care and in some areas the quality of care had deteriorated. Not all leaders at all levels had the capacity and capability to lead effectively.

- The trust's strategy, vision and values were developed in 2016 and had not delivered on all the objectives set. Progress against delivery of the strategy and plans was not consistently or effectively monitored or reviewed and there was little evidence of progress. Leaders at all levels were not always held to account for the delivery of the strategy. Staff informed us they did not always observe or experience members of the executive team displaying the trust values in their behaviours.

- There was an improving understanding of the importance of culture, however, there were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported or appreciated.

Summary of findings

Staff reported the culture was top-down and directive. Staff told us about high levels of bullying, harassment and discrimination, and the organisation was not taking adequate action to reduce this. When staff raised concerns, they were not treated with respect, or the culture, policies and procedures do not provide adequate support for them to do so. There was improving attention to staff development and improving appraisal rates.

- The arrangements for governance and performance management were not always fully clear and did not always operate effectively. Staff were not always clear about their roles, what they were accountable for, and to whom. Governance systems were ineffective to ensure quality services were provided.

- Although the trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected these were not working effectively.

- The information used in reporting, performance management and delivering quality care was not always accurate, valid, reliable, timely or relevant. Leaders recognised the quality of data was poor however they were relaying on and taking assurance from this data. Information was used mainly for assurance and rarely for improvement. Arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems were not always robust.

- Staff felt they were not listened to and were sometimes fearful to raise concerns or issues, these were issues at the last inspection.

- Improvements were not always sustained. The organisation did not react sufficiently to risks identified through internal processes, but often relied on external parties to identify key risks before they start to be addressed. Where changes were made, the impact on the quality and sustainability of care was not fully understood in advance. Systems lacked maturity and senior leaders recognised this.

However,

- Required data or notifications were submitted to external organisations.

- The trust engaged with patients, staff, the public and local organisations to plan and manage services and collaborated with partner organisations.

Ratings tables

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➜←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or

- we have not inspected it this time or

- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ➜← Apr 2020	Inadequate ↓ Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↓ Apr 2020	Inadequate ➜← Apr 2020	Inadequate ➜← Apr 2020

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Shrewsbury Hospital	Requires improvement ↑ Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↑ Apr 2020	Requires improvement ↑ Apr 2020
Princess Royal Hospital	Inadequate →← Apr 2020	Inadequate ↓ Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↓ Apr 2020	Inadequate →← Apr 2020	Inadequate →← Apr 2020
Overall trust	Inadequate →← Apr 2020	Inadequate ↓ Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↓ Apr 2020	Inadequate →← Apr 2020	Inadequate →← Apr 2020

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Royal Shrewsbury Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate →← Apr 2020	Inadequate ↓ Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↓ Apr 2020	Inadequate →← Apr 2020	Inadequate →← Apr 2020
Medical care (including older people's care)	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020
Surgery	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020
Critical care	Requires improvement Nov 2018	Requires improvement Nov 2018	Good Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018
End of life care	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020	Good →← Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↑ Apr 2020	Requires improvement →← Apr 2020
Outpatients	Requires improvement Apr 2020	Not rated	Good Apr 2020	Requires improvement Apr 2020	Good Apr 2020	Requires improvement Apr 2020
Overall*	Requires improvement ↑ Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↑ Apr 2020	Requires improvement ↑ Apr 2020

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for Princess Royal Hospital.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate →← Apr 2020	Inadequate ↓ Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↓ Apr 2020	Inadequate →← Apr 2020	Inadequate →← Apr 2020
Medical care (including older people's care)	Inadequate ↓ Apr 2020	Inadequate ↓ Apr 2020	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020	Inadequate ↓ Apr 2020	Inadequate ↓ Apr 2020
Surgery	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020	Good →← Apr 2020	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020
Critical care	Requires improvement Nov 2018	Requires improvement Nov 2018	Good Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018
Maternity	Requires improvement ↑ Apr 2020	Good ↑ Apr 2020	Good →← Apr 2020	Good →← Apr 2020	Requires improvement →← Apr	Requires improvement →← Apr
Services for children and young people	Requires improvement ↓ Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↓↓ Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement ↓ Apr 2020
End of life care	Requires improvement →← Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↓ Apr 2020	Requires improvement →← Apr 2020	Requires improvement ↑ Apr 2020	Requires improvement →← Apr 2020
Outpatients	Good Apr 2020	Not rated	Good Apr 2020	Good Apr 2020	Good Apr 2020	Good Apr 2020
Overall*	Inadequate →← Apr 2020	Inadequate ↓ Apr 2020	Requires improvement ↓ Apr 2020	Inadequate ↓ Apr 2020	Inadequate →← Apr 2020	Inadequate →← Apr 2020

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

The Princess Royal Hospital

Grainger Drive
Appley Castle
Telford
Shropshire
TF1 6TF
Tel: 01952641222
www.sath.nhs.uk

Key facts and figures

Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin and mid Wales. The trust has two main hospital sites: Royal Shrewsbury Hospital and Princess Royal Hospital in Telford. The two hospitals have approximately 650 inpatient beds. Princess Royal Hospital has 10 operating theatres. The trust employed 6,146 staff as of July 2019. Princess Royal Hospital is the trust's specialist centre for inpatient head and neck surgery. It includes the Shropshire Women and Children's Centre, the trust's main centre for inpatient women's and children's services. The trust provides acute inpatient care and treatment for specialties including cardiology,

clinical oncology, colorectal surgery, endocrinology, gastroenterology, gynaecology, haematology, head and neck, maternity, neonatology, nephrology, neurology, respiratory medicine, stroke medicine, trauma and orthopaedics, urology and vascular surgery. Both hospitals provide acute hospital inpatient services and outpatient services to Shropshire, Telford and Wrekin and mid Wales.

(Source: Routine Provider Information Request (RPIR) – Context acute tab; trust website)

Summary of services at The Princess Royal Hospital

Inadequate 🔴 ➡️ ⬅️

Our rating of services stayed the same. We rated it them as inadequate because:

- The safe key question remained as inadequate.
- Effective key question went down to inadequate.
- Caring key question went down to requires improvement.
- Responsive went down to inadequate.
- Well led key question remained as inadequate.

Urgent and emergency services

Inadequate 🔴 ➜ ⬅

Key facts and figures

Details of emergency departments and other urgent and emergency care services at this trust:

- Royal Shrewsbury Hospital emergency department.

- Princess Royal Hospital emergency department.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Both emergency departments include a major's unit. Both include a minor injuries unit and walk-in urgent care centre that are co-located with the main department. Royal Shrewsbury Hospital's emergency department is the trust's trauma centre. The emergency department at Princess Royal Hospital is the main receiving unit for paediatrics. The internal layout of the Emergency Department (ED) comprises of a main waiting area. Within this area there were two hatches; one where patients book in and see a streaming nurse (for minor injuries); the other is used for all 'walk in' patients to book in with reception staff. A triage room leads off the main waiting room. Within the treatment areas there were four 'minors' cubicles (for patients with minor injuries and illness), eight 'majors' cubicles (for patients with major illness or injury) and a paediatric treatment room. In addition, there were two 'pit stop' cubicles where rapid assessments took place following triage, and two areas for 'fit to sit' patients. One of these cubicles had chairs where patients who were well enough to sit and wait further assessment. The other 'fit to sit' cubicle was a bed where patients could be examined individually if necessary. There was also a separate treatment room which was used for patients with communicable infections. If this room was in use, infectious patients were transferred to the ED theatre. The ED theatre was otherwise used for procedures such as minor suturing. There was also a plaster room to use when the fracture clinic facilities were not available. A further 'Swan' room was also used to locate patients who were at the end of life in the department.

Summary of this service

Our rating of this service stayed the same. We rated it as inadequate because:

- Managers did not make sure that everyone completed their mandatory training. Not all staff had completed their safeguarding training. The trust's mandatory training target was met by nurses for only three of the 11 mandatory training modules and three of the nine mandatory training modules for medical staff.

- The design and use of facilities for patients were not designed to keep people safe. Streaming and triaging in the department was not managed in a way to keep people safe. Staff did not follow a consistent approach to triage, monitoring and recording of observations. During busy periods we were not assured of the levels of staff were available to manage children and patients safely in the corridor. The service had variable rates around vacancy and bank usage for their staff. The service sometimes had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- Staff sometimes kept detailed records of patients' care and treatment. Records were sometimes clear, up-to-date. The service sometimes used systems and processes to safely prescribe, administer, record and store medicines.

- The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers sometimes ensured that staff followed guidance and were kept up to date on evidence-based practice. Patient outcomes were worse than national averages. The service did not always make sure staff were competent for their roles and managers did not always appraise staff's work performance.

Urgent and emergency services

- Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not always support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Patients were not always respected of their privacy and dignity or considered their individual needs. Staff were not always able to offer emotional support to patients, families and carers to minimise their distress.

- The service sometimes planned and provided care in a way that met the needs of local people and the communities served. The trust sometimes worked with others in the wider system or local organisations to plan care. The service did not always take account of patients' individual needs and preferences. Staff sometimes made reasonable adjustments to help patients access services. Patients could not always access the service when they needed it in a timely way. This meant that patients experienced unacceptable waits to be admitted into the department, receive treatment and be discharged. Waiting times and arrangements to admit, treat and discharge patients were not in line with good practice.

- Leaders did not always understand or manage the priorities and issues the service faced. The trust did not always use a systematic approach to continually improve the quality of its services. Governance was not effective to monitor and manage risks on a regular basis to improve. This placed patients at significant risk of harm. The department did not always have effective systems for identifying risks. The service did not always collect reliable data. Data or notifications were not consistently submitted to external organisations as required.

- The department had not learnt from some of the findings from the last inspection.

Is the service safe?

| Inadequate 🔴 ➡️⬅️ |

Our rating of safe stayed the same. We rated it as inadequate because:

- Streaming and triaging in the department was not managed in a way to keep people safe. Staff did not follow a consistent approach to triage, monitoring and recording of observations. During busy periods we were not assured of the levels of staff were available to manage children and patients safely in the corridor.

- The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and up-to-date. The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

- Managers did not make sure that everyone completed their mandatory training. The trust's mandatory training target was met by nurses for only three of the 11 mandatory training modules and three of the nine mandatory training modules for medical staff.

- Not all staff had completed their safeguarding training.

- The design and use of facilities for patients were not designed to keep people safe.

- Managers investigating incidents did not always share lessons learned with the whole team or the wider service.

However,

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Urgent and emergency services

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- The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. Staff managed clinical waste well.

- Managers reviewed staffing levels and skill mix and gave locum staff a full induction.

- The service had nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- Records were stored securely and easily available to all staff providing care.

- The service managed patient safety incidents. Staff recognised and reported incidents and near misses and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.

- The service used monitoring results to improve safety. Staff collected safety information and shared it with staff.

Is the service effective?

Inadequate 🔴 ↓

Our rating of effective went down. We rated it as inadequate because:

- The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always ensure that staff followed guidance and were kept up to date on evidence-based practice.

- Patient outcomes were worse than national averages.

- The service did not always make sure staff were competent for their roles and managers did not always appraise staff's work performance.

- Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent. They did not always support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

However,

- Staff gave patients enough food and drink to meet their needs and improve their health.

- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements to improve outcomes for patients.

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

- Key services were available seven days a week to support timely patient care.

- Staff gave patients practical support and advice to lead healthier lives.

Is the service caring?

Requires improvement 🟠 ↓

Urgent and emergency services

Our rating of caring went down. We rated it as requires improvement because:

- Patients were not always respected of their privacy and dignity or considered of their individual needs.
- Staff were not always able to offer emotional support to patients, families and carers to minimise their distress.

However,

- Staff treated patients with compassion and kindness.
- Staff understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Inadequate 🔴 ⬇

Our rating of responsive went down. We rated it as inadequate because:

- Patients could not always access the service when they needed it in a timely way. This meant that patients experienced unacceptable waits to be admitted into the department, receive treatment and be discharged. Waiting times and arrangements to admit, treat and discharge patients were not in line with good practice.
- The service did not always plan and provide care in a way that met the needs of local people and the communities served. The trust did not always work with others in the wider system or local organisations to plan care.
- The service did not always take account of patients' individual needs and preferences. Staff sometimes made reasonable adjustments to help patients access services.

However,

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.
- Staff coordinated care with other services and providers.

Is the service well-led?

Inadequate 🔴 ➡⬅

Our rating of well-led stayed the same. We rated it as inadequate because:

- Leaders did not understand or manage the priorities and issues the service faced.
- The trust did not use a systematic approach to continually improve the quality of its services.
- Governance was not effective to monitor and manage risks on a regular basis to improve. This placed patients at significant risk of harm.
- The service did not have effective systems for identifying risks.

Urgent and emergency services

- The service did not always collect reliable data. Data or notifications were not consistently submitted to external organisations as required.

- The service had not learned from some of the findings from the last inspection

However,

- Leaders had the skills and abilities to run the service.

- Local leadership were visible and approachable in the service for patients and staff. Local leadership supported staff to develop their skills and take on more senior roles.

- The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans. Leaders and staff understood and knew how to apply them and monitor progress.

- Staff felt respected, supported and valued by local leaders. They were focused on the needs of patients receiving care. The department provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns.

- Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

- Leaders and staff engaged with patients and staff.

- All staff were committed to continually learning.

Areas for improvement

The service MUST take action to:

- Ensure nurse staffing levels are adequate to keep all patients safe and skill mix must be reviewed to include appropriate cover for paediatric patients. Regulation 18 (1): Staffing.

- Ensure medical staffing levels are adequate to keep all patients safe, especially during the night shifts. Regulation 18 (1): Staffing.

- Ensure provide guidance to enable staff to consistently manage and review deteriorating patients, in line with national guidance. Regulation12 (1) (2) (a) (c): Safe care and treatment.

- Ensure they review its performance against all targets set out in national key performance indicators and in line with the Royal College of Emergency Medicine (RCEM) audits. Regulation 17 (1) (2) (a): Good governance.

- Ensure that all appropriate staff are trained to the required levels in both adult and children's safeguarding. Regulation 18 (1) (2) (a): Safe care and treatment.

- Ensure the emergency department (ED) report the standards around caring for patients promptly; patients must be seen for a face-to-face assessment within the fifteen minutes of registering on arrival to ED. Regulation 12 (1) (2) (a): Safe care and treatment.

- Ensure all PEWS's are escalated appropriately for medical reviews and early intervention as required. Regulation 12 (1) (2) (a) (b): Safe care and treatment.

- Ensure all staff complete risk assessments for each patient on admission / arrival, using a recognised tool, and review this regularly. Staff must complete, or arrange, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Regulation 12 (1) (2) (a) (b): Safe care and treatment.

Urgent and emergency services

- Ensure accurate and complete records of all patient restraint are maintained Regulation 17 (1) (2) (c): Good governance.

- Ensure all staff carrying out patient restraint are trained and competent. Regulation 12 (1) (2) (c) Safe care and treatment.

The service SHOULD take action to:

- Review all policies regarding managing deteriorating patients.

- Review departmental risk registers to ensure actions are updated in a timely manner.

- The service should review staff understanding of assessing and responding to patient at risk of mental health deterioration and seek guidance or support from other mental health services available.

- The service should obtain an observation policy and a robust restraint policy in place.

Medical care (including older people's care)

Inadequate 🔴 ⬇

Key facts and figures

The trust's medical care service provides care and treatment for specialties including cardiology, gastroenterology, neurology, oncology, respiratory medicine and stroke medicine.

(Source: Routine Provider Information Request AC1 - Acute context)

The medical care service at Princess Royal Hospital provides care and treatment for specialties including cardiology, gastroenterology, neurology, respiratory medicine and stroke medicine.

The hospital has 211 medical inpatient beds located across 11 wards and units:

The trust had 77,043 medical admissions from March 2018 to February 2019. Emergency admissions accounted for 30,006 (38.9%), 571 (0.7%) were elective, and the remaining 46,466 (60.3%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 27,878

- Gastroenterology: 20,301

- Clinical oncology: 12,649

(Source: Hospital Episode Statistics)

Our inspection of this service was unannounced (the trust did not know we were coming). During our inspection we visited all areas where medical services were delivered from. We spoke with staff of all levels including health care assistants, nurses, ward manager, matrons, junior doctors, registrars and consultants. We spoke with patients and their families about the care and treatment they had received at the trust. During our inspection we also reviewed patient documentation and requested further evidence from the trust.

Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection.

- Staff did not always complete or update risk assessments for each patient that removed or minimised risks. Staff did not always identify or quickly act upon patients at risk of deterioration.

- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up-to-date.

- We had concerns about the administration of rapid tranquilization.

- Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005. We were not assured that staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

- Staff did not always report incidents.

Medical care (including older people's care)

- Distress in the open environment was not always handled discreetly.

- The service did not always consider of patients' individual needs and preferences.

- Not all staff felt respected, supported and valued.

- The service did not always use a systematic approach to continually improve the quality of its services, safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

However:

- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were mostly in line with national standards.

- It was easy for people to give feedback and raise concerns about care received.

Is the service safe?

Inadequate 🔴 ⬇

Our rating of safe went down. We rated it as inadequate because:

- The service provided mandatory training in key skills to all staff. However, not everyone had completed it.

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had received training on how to recognise and report abuse.

- The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection.

- Not all equipment was well maintained and ready for use or used safely.

- Staff did not always complete or update risk assessments for each patient that removed or minimised risks. Staff did not always identify or quickly act upon patients at risk of deterioration.

- The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up-to-date.

- We had concerns about the administration of rapid tranquilisation.

Is the service effective?

Inadequate 🔴 ⬇

Our rating of effective went down. We rated it as inadequate because:

- The service did not always provide care and treatment based on national guidance and evidence-based practice. Staff did not always protect the rights of patients subject to the Mental Health Act 1983.

Medical care (including older people's care)

- The service did not make sure all staff were competent for their roles.

- Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005. We were not assured that staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

- Staff monitored the effectiveness of care and treatment. However, they did not always use the findings to make improvements and achieved good outcomes for patients.

- Not all key services were available seven days a week to support timely patient care.

However:

- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Is the service caring?

Requires improvement 🟠 ➡ ⬅

Our rating of caring stayed the same. We rated it as requires improvement because:

- Staff did not always treat patients with compassion and kindness or respect their privacy and dignity.

- Distress in the open environment was not always handled discreetly.

However:

- Staff provided emotional support to patients, families and carers.

- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement 🟠 ➡ ⬅

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The service did not always consider of patients' individual needs and preferences.

However:

- The service planned and provided care in a way that mostly met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

- Most people could access the service when they needed it and received the right care promptly.

- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were mostly in line with national standards.

- It was easy for people to give feedback and raise concerns about care received.

Medical care (including older people's care)

Is the service well-led?

Inadequate 🔴 ⬇

Our rating of well-led went down. We rated it as inadequate because:

- Not all issues and priorities to the service were understood.

- Not all staff felt respected, supported and valued. Staff told us the culture was not always supportive of raising concerns without fear.

- Although there were governance systems in place these were not operating effectively to improve the quality of services.

- Although there were systems in place to mitigate risks, these were not working effectively. Not all risks to the service had been identified and escalated with actions to reduce their impact, risk identified at previous inspections had not been resolved.

- All staff were committed to continually learning and improving services however not all actions taken had improved patient care.

However:

- Leaders had the integrity, skills and abilities to run the service.

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services

Areas for improvement

The service Must take action to:

- The trust must ensure that medical staff within medical services at the Princess Royal Hospital complete the mandatory training assigned to them. Regulation 18 (2): Staffing.

- The trust must ensure that medical staff within medical services at the Princess Royal Hospital complete the mandatory safeguarding training assigned to them Regulation 13: Safeguarding.

- The trust must ensure that policies and procedures in place to prevent the spread of infection are adhered to in medical services at the Princess Royal Hospital. Regulation 12 (2)(h): Safe care and treatment.

- The trust must ensure that equipment is used in a safe manner to protect patients from the risk of injury or harm. Regulation 12 (2)(e): Safe care and treatment.

- The trust must ensure that deteriorating patients are identified and escalated in line with trust policy within medical care at the Princess Royal Hospital. Regulation 12 (2)(a): Safe care and treatment.

- The trust must ensure that medical patients at the Princess Royal Hospital have their individual needs assessed and planned for. Regulation 9: Person-centred care.

- The trust must ensure that policies and procedures in place surrounding the mental Capacity Act 2005 and Mental health Act 1983 are understood and correctly and consistently applied. Regulation 13: safeguarding.

Medical care (including older people's care)

- The trust must ensure that ward moves per admission and ward moves at night are recorded so that individual needs are accounted for. Regulation 9: Person-centred care.

- The trust must ensure that effective governance systems and process are in place to assess, monitor and improve all aspects of care delivered. Regulation 17 (1)(2)(a): Good governance.

The service Should take action to:

- The trust should ensure that all staff responsible for the delivery of thrombolysis are trained and competent to do so. Regulation 18 (2): Staffing.

- The trust should ensure that nursing staff within medical services at The Princess Royal Hospital complete the mandatory training assigned to them Regulation 18 (2): Staffing.

- The trust should ensure active recruitment into medical and nursing posts within medical services at the Princess Royal Hospital continues. Regulation 18 (1): Staffing.

Surgery

Requires improvement 🟠 ➔ ⬅

Key facts and figures

Surgery services provided by Shrewsbury and Telford NHS trust are located on two hospital sites which provide both elective and emergency surgery to the population of Shrewsbury, Telford, Wrekin and the wider areas. Royal Shrewsbury Hospital, Shrewsbury and The Princess Royal Hospital, Telford were visited as part of the inspection process and each location has a separate evidence appendix. Surgical specialists were managed by the scheduled care group across both hospitals with the same clinical directors. For this reason, there may be some duplication contained within the two evidence appendices.

The surgery core service at Princess Royal Hospital includes breast surgery, ENT, maxillofacial surgery and planned and emergency orthopaedics. In addition, the hospital accepts all head and neck emergency patients referred by GPs and admitted from the emergency departments at both the trust's acute sites.

Princess Royal Hospital has eight operating theatres (excluding the two maternity operating theatres which are not relevant to this core service) and 106 surgical inpatient beds and day case trollies located across four wards and units.

The trust had 31,414 surgical admissions from March 2018 to February 2019. Emergency admissions accounted for 12,930 (41.2%), 3329 (10.6%) were elective, and the remaining 15,155 (48.2%) were day case.

We inspected the service from the 18 to 20 of December 2019. As part of the inspection we visited the following areas:

- Day Surgery Unit
- Ward 4 (trauma and orthopaedics)
- Ward 8 (trauma and orthopaedics)
- Ward 17 (head and neck/elective orthopaedics)
- Day surgery theatres
- Main theatres
- Theatre recovery

During the inspection we spoke with 14 patients, 51 staff and reviewed 12 patient records and 17 prescription charts. We reviewed policies, performance information and data about the surgical service.

The service was last inspected in 2018. At the last inspection it was rated as requires improvement overall and for safe, effective, responsive and well led. Caring was rated as good.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service had not ensured all staff had completed mandatory training in key skills and safeguarding training.
- There were inconsistent infection control practices across the service. A patient in isolation had their side room door left open on two consecutive days.

Surgery

- There were some wrong site of surgery marked on patients and within the operating list and consent forms. (These were highlighted during the World Health Organisation (WHO) surgical checks.)

- Medical outliers in the day surgery unit blocked beds causing cancellation of operations.

- From August 2018 to July 2019 the trust's referral to treatment time for admitted pathways for surgery was lower than the England average in 10 out of 12 months. From March 2019, fewer than 50% of patients were admitted within 18 weeks of referral each month.

- We were not assured the service had robust systems in place to include all relevant risks on the risk register and proactively manage and mitigate risks.

However,

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires improvement 🟠 ➜ ⬅

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service had not ensured all staff had completed mandatory training in key skills and safeguarding training.

- There were inconsistent infection control practices across the service. A patient in isolation had their side room door left open on two consecutive days.

- There were some wrong site of surgery marked on patients and within the operating list and consent forms. (These were highlighted during the World Health Organisation (WHO) surgical checks.)

- Prescribers did not always write separate prescriptions for medicines (paracetamol) that could be given by either the oral or intravenous route. Nurses sometimes failed to record the actual dose administered for pain relief medicines when they were prescribed as a variable dose.

Surgery

However,

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

- The service mainly controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

- The service used systems and processes to safely prescribe, administer, record and store medicines.

- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Requires improvement 🟠 ➔ ⬅

Our rating of effective stayed the same. We rated it as requires improvement because:

- Although there were examples of using the findings to make improvements this was not consistent in all audits and in the National Hip Fracture Database showed a deterioration.

However,

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

- Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Surgery

- Staff monitored the effectiveness of care and treatment.

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

- Key services were available seven days a week to support timely patient care.

- Staff gave patients practical support and advice to lead healthier lives.

- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Is the service caring?

Good 🟢 ➔ ⬅

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement 🟠 ➔ ⬅

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Medical outliers in the day surgery unit blocked beds causing cancellation of operations.

- From August 2018 to July 2019, the trust's referral to treatment time for admitted pathways for surgery was lower than the England average in 10 out of 12 months. From March 2019, fewer than 50% of patients were admitted within 18 weeks of referral each month.

However,

- The service planned and provided care in a way that met the needs of local people and the communities served.

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Surgery

Is the service well-led?

Requires improvement 🟠 ➔ ⬅

Our rating of well-led stayed the same. We rated it as requires improvement because:

- We were not assured the service had robust systems in place to include all relevant risks on the risk register and proactively manage and mitigate risks.

- Inaccurate marking of surgical sites and inaccurate recording on consent forms and theatre lists was not on the risk register. Although the head of quality and safety was aware of the issue, we were not assured that this risk had senior management oversight and regular review.

However,

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

- Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

- Leaders and staff actively and openly engaged with patients, staff, and the public to plan and manage services.

- All staff were committed to continually learning and improving services.

Areas for improvement

The service should take action to:

- Ensure staff comply with infection control practice. Regulation 12 (2) (h): Safe care and treatment.

- Ensure all staff complete their mandatory training including safeguarding, MCA and DOLS. Regulation 18 (2): Staffing.

- Continue to try and improve flow through theatre and reduce the number of cancelled operations.

- Continue to try and improve the admitted pathway referral to treatment times.

- Ensure accurate marking of surgical site and recording on operating lists and consent forms. Regulation 12 (1)(a): Safe care and treatment.

- Make improvements in the National Hip Fracture Database audits outcomes.

Maternity

Requires improvement 🟠 ➔ ⬅

Key facts and figures

The trust has 70 maternity beds. Of these beds 53 are located within the consultant-led maternity unit at Princess Royal Hospital:

Ward/unit	Specialty or description	Inpatient beds
Ward 21	Postnatal	23
Ward 22	Antenatal	13 inpatient and 4 triage beds
Ward 24	Delivery suite	13 *en-suite* delivery rooms

The delivery suite has a pool room and includes the two maternity theatres and recovery area.

The Wrekin midwife-led unit is situated in the grounds of the Princess Royal Hospital. The unit has 17 beds. These include four birthing rooms, one with a birthing pool. Postnatal care is provided in four bed bays. Many women who have had a baby in the consultant unit transfer to the Wrekin Unit for postnatal care.

We spoke with 46 members of staff including midwives, doctors, maternity support workers, sonographers, ward clerks and housekeepers. We also spoke with seven women and four of their relatives. We observed interactions between women and staff, considered the environment and looked at 36 women's care records and six prescription records. We also reviewed other documentation from stakeholders and nationally published data for the trust.

The midwife-led unit at Royal Shrewsbury Hospital is currently closed to inpatients, because of non-compliance with building regulations. The midwife-led units at Bridgnorth, Ludlow and Oswestry are currently closed due to staffing. This is subject to the ongoing review of the Midwifery Led maternity services, commissioned by the Shropshire and Telford CCGs, and the awaited public consultation.

The trust also provides antenatal and postnatal care from community bases at Whitchurch and Market Drayton.

The trust's maternity service provides antenatal, postnatal and intrapartum obstetric and maternity care that includes scanning, early pregnancy assessment and triage.

The trust noted that midwifery-led care in the area is currently being reviewed by Shropshire, Telford & Wrekin Clinical Commissioning Group in line with the National Maternity Review (Better Births) 2016.

(Source: Trust Provider Information Request – Sites tab and Acute context; trust website)

From January 2018 to December 2018 there were 4,350 deliveries at the Trust.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

We rated effective, caring and responsive as good. Safe and well led were rated as requires improvement.

Maternity

- Staff did not always complete training in key skills. Staff did not protect patients from abuse in line with trust policy staff were not asking about domestic abuse in line with trust policy. Safety incidents were not always graded and reported incidents correctly according to harm. Staff did not always ensure medical staff assessed risks to patients. The service did not always ensure women received one to one care in labour. Staff did not always complete all risk assessments.

- Some leaders did not have the skills and abilities to effectively lead the service and did not operate effective governance processes throughout the service. Leaders and teams did not always use systems to manage performance effectively. Not all performance data was formatted in line with national guidance. Leaders did not always operate effective governance processes, throughout the service and with partner organisations.

However,

- They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service

- Staff provided good care and treatment, gave women enough to eat and drink, and gave them pain relief when they needed it. Managers mostly monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

- Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.

- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

> **Requires improvement** 🟠 ⬆️

Our rating of safe improved. We rated it as requires improvement because:

- The service provided mandatory training in key skills to all staff, however the trust target for attendance at training was not met by the service. Midwifery staff were not compliant with all mandatory update requirements.

- Staff mostly completed and updated risk assessments for each woman and took action to remove or minimise risks. However, not all staff identified and quickly acted upon women and their babies at risk of deterioration.

- The service made sure staff were competent for their roles. Managers held supervision meetings with them to provide support and development. However, managers did not appraise all staff's work performance.

- Eligibility of medical staff for safeguarding children level 3 training was low.

However:

Maternity

- Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it.

- The service mostly controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean, however we found minute traces of body fluids were evident on one chair and a bed.

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

- The service had enough maternity staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.

- Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

- The service used systems and processes to safely prescribe, administer, record and store medicines.

- The service mostly managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service, however incidents were not always graded correctly according to the level of harm. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

Is the service effective?

Good 🟢 ⬆

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

- Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.

- Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

- Doctors, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

- Key services were available seven days a week to support timely patient care.

- Staff gave women practical support and advice to lead healthier lives.

Maternity

- Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

- However, managers did not appraise all staff's work performance.

However,

- The service generally made sure staff were competent for their roles. Managers held supervision meetings with them to provide support and development.

Is the service caring?

Good 🟢 ➡️ ⬅️

Our rating of caring stayed the same. We rated it as good because:

- Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way.

- Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

- Staff supported women, families and carers to understand their condition and make decisions about their care and treatment. Women and their families could give feedback on the service and their treatment and staff supported them to do this.

Is the service responsive?

Good 🟢 ⬆️

Our rating of responsive improved. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

- The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

- Women could usually access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards. However, discharge from the triage unit was not always in line women's care plans.

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Maternity

Is the service well-led?

Requires improvement ● → ←

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Some leaders did not have the skills and abilities to effectively lead the service and did not always operate effective governance processes throughout the service and with partner organisations.

- Leaders did not have full oversight of the risks that were identified during the inspection with regard to poor risk assessments, one to one care, domestic abuse, carbon monoxide screening.

- Leaders and teams did not always identify relevant risks within the service and therefore did not identify actions to reduce their impact.

However,

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.

- The maternity service collected, analysed, managed, and used information well to support all its activities, using secure electronic systems with security safeguards. Staff understood their responsibilities regarding accessing and storing confidential information

- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

- Leaders and staff actively and openly engaged with women, staff, equality groups, the public and local organisations to plan and manage services.

- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

Areas for improvement

The service MUST take action to:

- The trust must ensure staff complete mandatory training, including training on safeguarding of vulnerable children and adults, in line with the trust target. Regulation 12 (1)(2)(c): Safe care and treatment.

- The trust must ensure high risk women are reviewed in the appropriate environment by the correct member of staff. Regulation 12 (1)(2a,b,h): Safe care and treatment.

- The trust must ensure grading of incidents reflects the level of harm, to make sure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance. Regulation 20: Duty of candour.

- The trust must ensure all women receive one to one care when in established labour. Regulation 12(1)(2a, b): Safe care and treatment.

Maternity

- The trust must ensure that carbon monoxide monitoring assessments and records are in line with trust policy. Regulation 12 (1)(2a,b): Safe care and treatment.

- The trust must ensure that women are asked about domestic violence in line with trust policy. Regulation 12 (1)(2a,b): Safe care and treatment.

- The trust must ensure ward level safety huddles are performed in all areas to ensure information is shared with all staff. Regulation 17 (1)(2): Good governance.

- The trust must ensure that the senior leadership team has processes for governance and oversight of risk and quality improvement. Regulation 17(1)(2): Good governance.

The service should take action to:

- The trust should ensure the maternity dashboard is colour coded in line with national guidance.

- The trust should ensure all staff complete accurate documentation around CTG monitoring.

- The trust should ensure women are not identifiable by name on the board at the midwives' station on the postnatal ward.

- The trust should ensure that all midwives have an annual appraisal.

Services for children and young people

Requires improvement 🟠 ⬇

Key facts and figures

The trust has 36 paediatric inpatient beds located on Ward 19 at Princess Royal Hospital. Children up to the age of 16 years can be admitted to the children's ward. Once a patient reaches their sixteenth birthday they will be admitted to an adult ward.

The hospital also has a children's assessment unit consisting of eight assessment beds where children are assessed to determine if they require admission to the children's ward or treatment prior to discharge home. The unit is open 24 hours seven days a week.

The hospital's neonatal unit (Ward 23) is commissioned to provide 22 cots, however when in periods when demand is high the trust can increase this to 23 cots.

There is a medical day unit at Royal Shrewsbury Hospital for children with long term conditions requiring outpatient assessment and diagnostics. This service is open from 9am to 5pm Monday to Friday.

The trust had 9,068 spells in its services for children and young people from March 2018 to February 2019.

Emergency spells accounted for 91% (8,275), 7% (620) were day case and the remaining 2% (173) were elective

During our inspection we spoke with seven patients and their families, we checked 10 pieces of equipment, seven sets of patient records and seven prescription charts.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep providing the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and had recruited some new staff with more expected in the coming months.

- The service provided mandatory training in key skills to all staff and made sure most staff completed it, however medical staff were not consistently compliant.

- Staff had safeguarding training on how to recognise and report abuse and they knew how to apply it, however medical staff were not consistently compliant.

- The design, maintenance and use of facilities, premises and equipment kept people safe, however some environments did not follow national guidance. Children and young people were not separated from adults in the day surgery and the main theatre recovery areas.

- The service did not always make sure staff were competent for their roles. Staff were not trained to care for children and young people with mental health needs, learning disabilities or autism.

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff did not always protect the rights of children and young people subject to the Mental Health Act 1983. Staff were not trained or have the required competencies to care for children and young people with mental health needs, learning disabilities or autism.

Services for children and young people

- The service did not always plan and provide care in a way that met the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care. The service did not have a transition lead nor a transition policy to support children and young people moving into adult services. There were very limited facilities to support the needs of children and young people with additional needs.

- There were no systems in place across the service to support children and young people who were transitioning to adult services and no transition lead.

However,

- The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

- Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

- Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Is the service safe?

Requires improvement 🟠 ⬇

Our rating of safe went down. We rated it as requires improvement because:

- The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep providing the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and had recruited some new staff with more expected in the coming months.

- The service provided mandatory training in key skills to all staff and made sure most staff completed it, however medical staff were not consistently compliant.

- Staff had safeguarding training on how to recognise and report abuse and they knew how to apply it, however medical staff were not consistently compliant.

However,

- The design of the environment, maintenance and use of facilities, premises and equipment kept people safe.

- Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so.

Services for children and young people

- The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

- Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

- The service had enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

- Staff kept detailed records of children and young people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

- The service used systems and processes to safely prescribe, administer, record and store medicines.

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Requires improvement 🟠 ⬇

Our rating of effective went down. We rated it as requires improvement because:

- The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff did not always protect the rights of children and young people subject to the Mental Health Act 1983. Staff were not trained or have the required competencies to care for children and young people with mental health needs, learning disabilities or autism.

However,

- Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for children, young people and their families' religious, cultural and other needs.

- Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

- Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

- Key services were available seven days a week to support timely patient care.

- Staff gave children, young people and their families practical support and advice to lead healthier lives.

Services for children and young people

- Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions.

Is the service caring?

Requires improvement 🟠 ⬇

Our rating of caring went down. We rated it as requires improvement because:

- Patients with additional needs including mental health, learning disabilities and autism were not always treated equally. For example, we saw and were told patients with mental ill health were not permitted to mix.

However,

- Staff provided emotional support to children, young people and their families to minimise their distress.

- Staff supported and involved most children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

- Staff treated most children, young people and their families with compassion and kindness.

Is the service responsive?

Inadequate 🔴 ⬇⬇

Our rating of responsive went down. We rated it as inadequate because:

- The service did not always plan and provide care in a way that met the needs of local people and the communities served.

- Staff did not always make reasonable adjustments to help children, young people and their families access services or coordinate care with other services and providers. Young people over 16 were not generally offered access to children and young people's wards.

- The service did not have training and systems in place to respond to a gap in CAMHS support at weekends and evenings.

- The service did not have a transition lead nor a transition policy to support children and young people moving into adult services.

- There were very limited facilities to support the needs of children and young people with additional needs.

However,

- The service was mostly inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

Services for children and young people

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

Is the service well-led?

Requires improvement 🟠 ⬇

Our rating of well-led went down. We rated it as requires improvement because:

- There were no systems in place across the service to support children and young people who were transitioning to adult services and no transition lead.

- The service did not always promote equality and diversity in daily work and provide opportunities for career development. The service leads had not sought further development for staff working with patient with additional needs such as mental health, autism or learning disabilities, therefore did not always promote equality and diversity.

- Staff were unaware of the service vision and strategy and were not involved in the creation of them.

- Leaders operated governance processes throughout the service and with partner organisations, however they were not all effective as they were not yet embedded. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

However,

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress.

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

- Systems that managed performance were effective. Leaders and teams had identified and escalated most relevant risks and issues and identified actions to reduce their impact. Leaders and teams had plans to cope with unexpected events.

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated, and all patient records were stored securely.

- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Areas for improvement

The service Must take action to:

Services for children and young people

- The service must provide enough nursing staff with the right qualifications, skills, training and experience to keep providing the right care and treatment. Regulations 2014: Regulation 18 (1): Staffing.

- The service must ensure relevant staff are competent in their roles to care for children and young people with mental health needs, learning disabilities and autism. Regulation 18 (2): Staffing.

- The trust must provide a dedicated recovery area for paediatrics and ensure children and young people attending the day surgery unit do not mix with adult patients on the ward. Regulation 12 (d): Safe Care and Treatment.

The service should take action to:

- The service should ensure they have appropriate systems in place to support the transition of children and young people to adult services. Regulation 9: Person Centred Care.

- The service should consider providing an appropriate environment and facilities for children and young people with learning disabilities and autism.

End of life care

Requires improvement ● ➔ ⬅

Key facts and figures

The trust provides end of life care at two of its sites. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 1,641 deaths from March 2018 to February 2019.

This inspection took place as part of the routine inspection schedule. Our inspection was unannounced to enable us to observe routine activity.

During this inspection we spoke with one scheduled care group lead, three end of life care leads, three specialist palliative care nurses, three consultants, two junior doctors, three ward managers, five ward sisters, four nurses, two healthcare assistants, the head of pathology, the mortuary manager, the bereavement manager, the chaplain, two administrators, three porters, three patients and four family members. We also reviewed 11 care records.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and up-to-date.

- It was possible that palliative and end of life care patients could be missed due to the lack of system which identifies patients.

However,

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

- Staff used infection control measures when visiting patients on wards and transporting patients after death.

- Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

- Records were stored securely and easily available to all staff providing care.

- The service used systems and processes to safely prescribe, administer, record and store medicines.

End of life care

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Is the service safe?

Requires improvement 🟠 ➜ ⬅

Our rating of effective stayed the same. We rated it as requires improvement because:

- Key services were not available seven days a week to support timely patient care.
- Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent.
- The service did not monitor the effectiveness of care and treatment.

However,

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff gave patients practical support to help them live well until they died.

Is the service effective?

Requires improvement 🟠 ➜ ⬅

Our rating of effective stayed the same. We rated it as requires improvement because:

- The service did not audit pain and symptom control, or time taken for fast track audits.
- Key services were not available seven days a week to support timely patient care.
- Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent.
- The service did not monitor the effectiveness of care and treatment.

However:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patient's subject to the Mental Health Act 1983.

End of life care

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

- Staff gave patients practical support to help them live well until they died.

Is the service caring?

Requires improvement 🟠 ⬇

Our rating of caring went down. We rated it as requires improvement because:

- We found in the children's viewing room the bedding for the children's cot and the teddy bear placed in the viewing cot were visibly dirty. There were also two bassinets of different sizes for the viewing of babies. Each bassinet had a silk lining, both bassinettes' linings were dirty. One of the bassinet's silk lining had what appeared to be a large dried liquid stain. We asked the mortuary staff member when the bedding was last cleaned, we were advised that it was not known if the bedding had ever been cleaned. We escalated this to the trust, who immediately replaced the bedding in the viewing cot and bassinets

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement 🟠 ➡ ⬅

Our rating of responsive improved. We rated it as requires improvement because:

- The service did not audit waiting times from referral to achievement of preferred place of care and death.

However;

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint

End of life care

Is the service well-led?

Requires improvement 🟠 ⬆

Our rating of well-led improved. We rated it as requires improvement because:

- Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities.

- They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact.

- Staff could not always find the data on patients they needed, in easily accessible formats to make decisions. The information systems were not integrated to allow this.

However,

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

- Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events.

Areas for improvement

The service Must take action to:

- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.

- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing.

- The service must ensure it fully completes do not attempt cardiopulmonary resuscitation (DNACPR) and ReSPECT forms. Regulation 11: Need for Consent.

- The service must ensure it staff carry out and complete mental capacity act assessments for all patients who are deemed to not have capacity. Regulation 11: Need for Consent.

- The trust must ensure it had full oversight of end of life care services and fully embeds the end of life care team into the scheduled care group governance processes. Regulation 17(1)(2)(a): Good Governance.

- The service must have an electronic system which accurately identifies and tracks end of life and palliative care patients. Regulation 12(2)(a): Safe Care and Treatment.

The service should take action to:

- The trust should continue to participate in an external review of the chaplaincy service to ensure this service meets individual need.

End of life care

- The service should ensure it provides key specialist palliative care services seven days week in line with National Institute of Health and Care Excellence.

- The service should ensure all risks are recorded appropriately on the risk register.

- The service should have a service level agreement in place in place to ensure the continuation of the out of hours service.

- The service should undertake audits of end of life care patients preferred place of care or death.

- The service should undertake audits for pain or symptom control for end of life care patients.

Outpatients

Good 🟢

Key facts and figures

Outpatient services at Shrewsbury and Telford NHS Trust are provided mainly at The Princess Royal hospital and the Royal Shrewsbury hospital sites, with a small number of services within the community. Across the trust, outpatients services is managed by scheduled and unscheduled care groups and various specialties. The Scheduled Care Group manages a large proportion of the outpatient activity and associated nursing support across both main trust sites and also at the satellite sites. The Scheduled Care Group manages all the musculoskeletal services which provides outpatients appointments for the fracture clinic and plaster room. The service is for men, women and children of all ages. Most children's outpatients appointments take place in an area attached to the children's wards which is separate to the main outpatients department. Children are seen alongside adults for the specialities of ear, nose and throat (ENT) and fracture clinics which are located in the main outpatients areas. Specialties using main outpatients include respiratory, renal, cardiology, vascular, urology, breast, gastroenterology, general surgery, medicine and medical specialties. All other outpatient departments are specialty managed. These include:

- Ophthalmology.

- Ear, nose and throat (ENT).

- Maternity.

- Dental.

- Endoscopy.

There is a centralised patient access function that deals with the management of all referrals and outpatient booking for about 70% of the Trust's activity through the main outpatients department. The remainder of the activity is managed through individual specialities and satellite outpatient areas such as audiology, provided at community hospital locations. The bookings contact centre is based at the Royal Shrewsbury hospital. All patient cancellations and re-bookings come through this centralised standardised service along with a large amount of follow up bookings. Outpatients is managed by the outpatients matron, outpatients manager and sisters.

During our inspection we:

- visited the main outpatient departments, phlebotomy, pre-operative assessment service, audiology, and the outpatient therapy clinics including physiotherapy and occupational therapy.

- spoke with 12 relatives and 18 patients.

- spoke with 42 members of staff including, nurses and health care assistants, specialist nurses, receptionists, consultants, doctors, matrons and triumvirate managers.

- looked at six sets of patient records in detail and observed several more.

- observed interactions between patients, relatives and staff.

- observed four patient consultations.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

Outpatients

Summary of this service

This is the first time we have rated outpatients separately from diagnostic imaging. We rated it as good because:

- The service had enough nursing staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed most risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. Staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. Most people could access the service when they needed it and did not have to wait too long for treatment.

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's values, and how to apply them in their work. Staff felt respected, supported and valued by their immediate managers. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However,

- The service did not always have enough medical staff provided clinic appointments for some specialities quickly enough.

- The phlebotomy room used chairs which were in a poor state of repair and not compliant with infection prevention and control guidelines. Remedial action for this was in progress. The service controlled infection risk well in all other areas.

- Not all patient consultation records were clear and fully legible.

- Nursing staff did not always complete mental capacity act (MCA) assessments. Nurses relied on medical staff conducting MCA assessments. Staff were not up to date with (MCA) training. The trust had a plan to remedy this.

- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not consistently in line with national standards for some cancer specialities.

Is the service safe?

Good ●

This is the first time we have rated outpatients separately from diagnostic imaging. We rated it as good because:

Outpatients

- The service provided mandatory training in most key skills to all staff and made sure everyone completed it. This was an improvement since our last inspection.

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

- The service controlled infection risk well in almost all areas. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

- Staff identified and quickly acted upon patients at risk of deterioration.

- The service had enough nursing, medical and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. This was an improvement since our last inspection. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

- Staff kept detailed records of patients' care and treatment. Records were up-to-date, stored securely and easily available to all staff providing care.

- The service used systems and processes to safely prescribe, administer, record and store medicines.

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

However,

- Staff were not up to date with mental capacity act (MCA) training. The trust had a plan to remedy this. Nursing staff did not always complete mental capacity act (MCA) assessments. Nurses relied on medical staff to conduct MCA assessments during the consultation.

- The phlebotomy room used chairs which were in a poor state of repair and not compliant with infection prevention and control guidelines. However, the service controlled infection risk well in all other areas.

- Not all handwritten patient records were clear and legible. However, detailed consultation outcomes were typed and added to the record after the appointment.

Is the service effective?

Not sufficient evidence to rate ●

We do not currently provide a rating for Effective. We found that:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

- Staff gave patients enough food and drink to meet their needs and when they were delayed for a long time in the department.

- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Outpatients

- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

- Staff gave patients practical support and advice to lead healthier lives.

- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

- Most staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment.

However,

- Key services were not available seven days a week to support timely patient care. However, some clinics were provided at weekends to meet patient needs.

- Staff did not always fully support patients to make informed decisions about their care and treatment. Not all staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, they followed national guidance to gain patients' consent.

Is the service caring?

Good 🟢

This is the first time we have rated outpatients separately from diagnostic imaging. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Good 🟢

This is the first time we have rated outpatients separately from diagnostic imaging.

We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers

Outpatients

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

However,

- People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not consistently in line with national standards for some cancer specialities.

Is the service well-led?

Good 🟢

This is the first time we have rated outpatients separately from diagnostic imaging. We rated it as good because:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

- The service had a strategy developed with all relevant stakeholders. The strategy was focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress

- Staff felt respected, supported and valued by their immediate managers. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

- Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

- Leaders and teams had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

- The service collected reliable data and analysed it. Most staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

- Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- Most staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

However,

- Staff did not feel valued or respected by senior leaders in the trust's executive team.

Outstanding practice

We found areas of outstanding practice;

Outpatients

- The service implemented a nurse-led wound clinic to provide continuity of care for patients and free up space in other clinics.

- The service were currently trialling a virtual fracture clinic to reduce unnecessary visits for patients.

Areas for improvement

The service SHOULD take action to:

- Monitor that all staff have access to appropriate mental capacity act (MCA) training and updates.

- Monitor that staff understand how and when to conduct a mental capacity act (MCA) assessment.

- Monitor that the flooring and chairs in the phlebotomy room comply with infection prevention and control guidelines.

- Monitor that medical staff complete patient records in a clear and legible way.

- Consider ways to improve access to timely appointments for people with cancer in line with national guidelines.

- Consider ways to improve staff engagement with senior leaders and the executive team.

Royal Shrewsbury Hospital

Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XQ
Tel: 01743261000
www.sath.nhs.uk

Key facts and figures

Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin and mid Wales. The trust has two main hospital sites: Royal Shrewsbury Hospital and Princess Royal Hospital in Telford. The two hospitals have approximately 650 inpatient beds. Royal Shrewsbury Hospital has nine operating theatres. The trust employed 6,146 staff as of July 2019. The trust provides acute inpatient care and treatment for specialties including cardiology, clinical oncology, colorectal surgery, endocrinology, gastroenterology, gynaecology, haematology, head and neck, maternity, neonatology, nephrology, neurology, respiratory medicine, stroke medicine, trauma and orthopaedics, urology and vascular surgery. Both hospitals provide acute hospital inpatient services and outpatient services to Shropshire, Telford and Wrekin and mid Wales.

(Source: Routine Provider Information Request (RPIR) – Context acute tab; trust website)

Summary of services at Royal Shrewsbury Hospital

Requires improvement 🟠 ⬆

Our rating of services improved. We rated it them as requires improvement because:

- The safe key question improved to requires improvement.

- Effective key question remained as requires improvement.

- Caring key question went down to requires improvement.

- Responsive remained as requires improvement.

- Well led key question improved to requires improvement.

Urgent and emergency services

Inadequate 🔴 ➔ ⬅

Key facts and figures

Urgent and emergency care services are provided from the Royal Shrewsbury Hospital (RSH) emergency department and the Princess Royal Hospital (PRH) emergency department.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Both emergency departments include a majors unit. Both include a minor injuries unit and walk-in urgent care centre that are co-located with the main department.

Royal Shrewsbury Hospital's emergency department is the trust's trauma centre. The emergency department at Princess Royal Hospital is the main receiving unit for paediatrics.

(Source: Routine Provider Information Request (RPIR) – Acute context tab)

From March 2018 to February 2019, there were 121,442 attendances at the trust's urgent and emergency care services.

(Source: Hospital Episode Statistics)

The emergency department (ED) at RSH provides services 24 hours a day, seven days a week. At the time of this inspection, the ED at RSH consisted of:

- A booking in and streaming area. Streaming at this ED involved identifying if a patient required assessment and treatment within the ED or within the urgent care centre which was operated by another provider on site.

- A main waiting area.

- A children's waiting area.

- A triage room.

- A four bedded resuscitation bay. The resuscitation area was used for the treatment of trauma, those requiring treatment for life threatening illness or injury and those who require direct monitoring and immediate life/limb saving interventions.

- 12 majors' cubicles. Patients who were referred to this area of care could be unstable in their presentation, unable to mobilise and require immediate treatment or medication

- A 'pit stop'. This is where most patients who attended the department by ambulance received their initial assessment.

- A Clinical Decisions Unit (CDU) that could accommodate up to 10 patients. The CDU was a short stay inpatient area for ED patients only who require on-going observations, treatments and reviews where the main outcome is discharge from hospital within a 36-hour period.

- Three minors' cubicles providing care to patients who presented with minor injuries.

- A fit to sit area that could accommodate up to four patients who were well enough to sit and await discharge or further assessment.

- A relatives' room.

Urgent and emergency services

- Two rooms that could be specifically utilised for the assessment and treatment of children.

There was also an urgent care centre located adjacent to the main waiting area. This was managed separately by another provider.

At the time of our inspection, work was in progress to build a room that could be used by patients who presented with acute mental health concerns.

Urgent and emergency care at RSH was previously inspected by the Care Quality Commission in August 2018. The service was rated as inadequate. A focussed inspection was also completed in April 2019. However, a rating was not awarded to the service due to the focussed nature of the inspection.

We carried out an unannounced inspection of the RSH emergency department from 18 to 20 November 2019 and 26 November 2019. We reviewed 29 patient care records and spoke with 12 patients and four relatives. We also spoke with 47 members of staff including, nurses, doctors, emergency nurse practitioners, therapists, healthcare assistants, receptionists, pharmacists, an associate nurse, a member of security staff, the ward manager, the matron, the head of nursing, the sepsis nurse, the audit manager, the quality improvement lead, the governance lead, and a dementia support worker. We also spoke with three staff who worked alongside the trust within the ED. This included paramedics and a member of staff from the mental health liaison team.

Summary of this service

Our rating of this service stayed the same. We rated it as inadequate because:

- The service did not have enough permanent staff to care for patients and keep them safe. Staff were not always up to date with mandatory training. This included the training required to ensure staff knew how to protect patients from abuse. Staff did not always assess and manage safety risks well and lessons were not always learned following incidents. Emergency medicines were not always available, and medicines were not always stored securely. Accurate and detailed records were not always maintained or stored securely. Safety performance data was not clearly displayed for patients and staff to view.

- We could not be assured that clinical policies and pathways were based on national guidance and best practice. Managers monitored the effectiveness of the service, but appropriate and timely action was not always taken in response to poor audit findings. Managers did not always complete timely appraisals of staff's work performance and ongoing professional development and support was not consistently available to all staff. Effective systems were not in place to ensure people's dietary requirements were met and staff did not always give patients practical support and advice to lead healthier lives. Staff did not protect the rights of patients' subject to the Mental Health Act 1983 and they did not support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance.

- The service was not designed or delivered in a manner that respected patients' privacy and dignity. Staff did not always support people to understand the waiting times for assessment and treatment in the ED.

- The service did not plan care to consistently meet the needs of local people and the individual needs of patients. People could not always access the service when they needed it and they frequently had lengthy waits for treatment. Complaints were not always managed in accordance with trust policy.

Urgent and emergency services

- The service was not well-led. The required improvements from previous inspection had not been made. We identified ongoing and new Regulatory breaches. There was no ED specific vision or strategy and staff did not always feel respected, supported and valued. Information and governance systems were not effective. The service did not engage well with patients and the community to plan and manage services and the services approach to driving improvement was reactive rather than proactive.

However,

- The service mostly controlled infection risk well and managed clinical waste safely. Staffing gaps were filled with temporary staff. The majority of medicines were prescribed, administered and recorded appropriately and when things went wrong, staff apologised to patients and their relatives.

- Staff worked well as a team to benefit patients and some competency checks were in place to confirm that staff had the skills they needed to provide effective care. Staff sought verbal consent from patient's who could make decisions about their care and they gave pain relief when needed. Most ED services were available seven days a week.

- Individual staff members treated patients with compassion and kindness and provided emotional support to patients, families and carers.

- Managers and staff worked with others in the wider system and local organisations to plan care. Reasonable adjustments were made to help patients access the service.

Is the service safe?

Inadequate 🔴 ➔ ⬅

Our rating of safe stayed the same. We rated it as inadequate because:

- The service provided mandatory training in key skills. However, not all staff were up to date with this training.

- Staff were not always up to date with the safeguarding training that would enable them to consistently recognise and report abuse.

- Staff did not always keep equipment and the premises visibly clean.

- The design, maintenance and use of facilities, premises and equipment did not kept people safe.

- Staff did not always promptly identify and quickly act upon patients at risk of deterioration.

- Staff did not always complete risk assessments for each patient in a prompt manner.

- Staff did not always act to remove or minimise risks or update the assessments when risks changed.

- The service did not have enough permanent nursing or medical staff with the right qualifications, skills, training and experience to consistently keep patients safe from avoidable harm and to provide the right care and treatment.

- Detailed records of patients' care and treatment were not maintained within the ED. Records were not always clear, up-to-date or stored securely.

- The service did not have effective systems in place to ensure all medicines were stored securely and in line with manufacturers guidance.

- Emergency medicines were not always available.

- The service did not manage patient safety incidents well. Staff did not always recognise and report incidents and near misses.

Urgent and emergency services

- Systems were in place to support managers to investigate incidents and share lessons learned with the whole team and the wider service. However, incidents were not always effectively investigated in a timely manner to reduce the risk of potential harm from similar or repeated incidents.

- The service collected patient safety data. However, this information was not always up to date or clearly displayed for patients and staff to view.

However,

- The service mostly controlled infection risk well. Staff mostly used equipment and control measures to protect patients, themselves and others from infection.

- Staff managed clinical waste well.

- Staffing gaps were filled with temporary bank and agency staff. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

- Systems were in place to ensure that the majority of medicines were prescribed, administered and recorded appropriately.

- When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Inadequate 🔴 ⬇

Our rating of effective went down. We rated it as inadequate because:

- We could not be assured that clinical policies and pathways were based on national guidance and best practice.

- Managers completed some checks to make sure staff followed guidance. However appropriate and timely action was not always taken in response to poor findings.

- Staff did not protect the rights of patients' subject to the Mental Health Act 1983.

- We could not be assured that staff gave patients enough food and drink to meet their needs and improve their health as care records did not always evidence this.

- Effective systems were not in place to ensure that dietary adjustments could be made for patients' religious, cultural and medical needs. No formal nutritional assessments were in place to enable staff to assess and meet patient's individual dietary needs.

- Appropriate action was not always taken in response to poor findings from clinical audits, to make the required improvements and achieve consistent good outcomes for patients.

- Managers did not always complete timely appraisals of staff's work performance.

- Ongoing professional development and support was not consistently available to all staff.

- Staff did not always give patients practical support and advice to lead healthier lives.

- Staff did not support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance.

However:

- Staff monitored the effectiveness of care and treatment.

Urgent and emergency services

- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

- Some systems were in place to check that staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide patient care.

- Most emergency department services were available seven days a week to support timely patient care.

- Staff sought the verbal consent of patients who were able to make decisions about their care and treatment.

Is the service caring?

Requires improvement 🟠 ⬇

Our rating of caring went down. We rated it as requires improvement because:

- The service was not designed or delivered in a manner that respected patients' privacy and dignity.

- Staff did not always have the time to interact with people in a meaningful way.

- Staff did not always support people to understand the waiting times for assessment and treatment in the emergency department (ED).

- Patients were not consistently supported to feedback their experiences of care in the ED through the completion of the Patient Friends and Family Test.

However,

- Individual staff members treated patients with compassion and kindness.

- Staff provided emotional support to patients, families and carers to minimise their distress.

- Staff understood patients' personal, cultural and religious needs.

- When staff communicated with patients and their relatives, they did this in a manner that reflected peoples individual communication needs.

Is the service responsive?

Inadequate 🔴 ⬇

Our rating of responsive went down. We rated it as inadequate because:

- The service was not designed to provide care in a way that consistently met the needs of local people and the communities served.

- The service and staff did not always meet the individual needs of patients, such as the specific needs of patients living with dementia.

- People could not always access the service when they needed to and they did not always receive the right care promptly.

Urgent and emergency services

- Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients fell well below national standards.

- Complaints were not always managed in accordance with trust policy.

However,

- Managers and staff worked with others in the wider system and local organisations to plan care.

- Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers when required.

- Systems were in place to enable people to give feedback and raise concerns about care received.

Is the service well-led?

Inadequate 🔴 ➜ ⬅

Our rating of well-led stayed the same. We rated it as inadequate because:

- Leaders did not have the skills and abilities to run the service in a safe and effective manner.

- Leaders did not understand and manage the priorities and issues the service faced.

- Senior leaders were not always visible and approachable in the service for patients and staff.

- The emergency department (ED) service did not have a clear vision for what it wanted to achieve or an effective strategy to turn it into action.

- Staff did not always feel respected, supported and valued. Some staff reported a bullying culture within the ED and the wider trust and not all staff felt able to report incidents of alleged bullying.

- Leaders in the ED did not operate effective governance processes throughout the service and with partner organisations.

- Work pressures sometimes impacted on the staffs' capacity to regularly meet to, discuss and learn from the performance of the service.

- The service did not always identify, escalate and mitigate relevant risks and issues.

- The information systems were not integrated which meant staff could not always access patient data when they needed it.

- Some performance data was not shared accurately with other organisations.

- Leaders did not always actively and openly engage with staff and patient groups to plan and manage services.

- Increased patient demand in the ED prevented staff from continually learning and improving services.

- Staff told us leaders did not actively encourage innovation or participation in research.

However,

- Changes had been made that supported nursing staff to take on more senior roles within the ED.

- Staff at all levels were clear about their roles and accountabilities.

- The service collected some pertinent data and analysed it.

Urgent and emergency services

- Senior leaders engaged with stakeholders regarding the planning of future ED services.

Areas for improvement

The service MUST take action to:

- The service must ensure the emergency department (ED) nursing and medical staff consistently complete mandatory training, including safeguarding training in line with trust compliance rates. Regulation 18 (1)(2)(a): Staffing.

- The service must provide safe and appropriate facilities for the assessment of patients who present at the ED with acute mental health concerns that conform with national guidance. Regulation 15 (1)(c)(d)(e) and (f): Premises and equipment.

- The service must ensure that they are assessing their performance against the Royal College of Paediatrics and Child Health (RCPCH) emergency care standards and that effective action plans are in place to ensure where possible action is taken to meet these standards. Regulation 17 (1)(2)(a) and (b): Good governance.

- The service must ensure that effective systems are in place to ensure emergency equipment in the ED is in date and available for use. Regulation 12 (1)(2)(e) and (f): Safe care and treatment.

- The service must ensure the premises are secure to protect patients from the risk of harm and to mitigate the risk of equipment from being tampered with or missed. Regulation 15 (1)(b): Premises and equipment.

- The service must ensure that equipment that could be used for self-harm or harm to others is stored securely. Regulation 15 (1)(b): Premises and equipment.

- The service must ensure that all patients are triaged within 15 minutes of arrival to the ED. Regulation 12 (1)(2)(a): Safe care and treatment.

- The service must ensure that nationally recognised tools are used within the ED, in line with guidance to identify and escalate deteriorating patients. Regulation 12 (1)(2)(a)(c) Safe care and treatment.

- The service must ensure that national guidance is followed in the ED with regards to the prompt treatment of suspected sepsis. Regulation 12 (1)(2)(a)(c) Safe care and treatment.

- The service must ensure the risk associated with falling and developing pressure ulcers are promptly assessed on arrival to the ED and ensure appropriate action is taken to mitigate these risks. Regulation 12 (1)(2)(a) Safe care and treatment.

- The service must formally assess and record individual patients' suitability to use bed/trolley rails. Regulation 12 (1)(2)(a) Safe care and treatment.

- The service must formally assess the risks associated with patients who present at the ED with acute mental health conditions. Appropriate action must be taken to mitigate these risks. Regulation 12 (1)(2)(a): Safe care and treatment.

- The service must ensure that ED records are stored securely and contain a clear and contemporaneous account of the care and treatment provided. Regulation 17(1)(2)(c): Good governance.

- The service must ensure that all medicines are stored securely and correctly with restricted access to authorised staff. Regulation 12 (1)(2)(g) Safe care and treatment.

- The service must ensure that emergency medicines are always available within the ED. Regulation 12 (1)(2)(f) Safe care and treatment.

- The service must ensure that effective systems are in place to enable managers to take prompt and immediate action to reduce the risk of avoidable incidents from reoccurring in the ED. Regulation 17 (1)(2)(b): Good governance.

Urgent and emergency services

- The service must ensure that the incident reporting systems in place supports ED staff to consistently identify and report safety incidents and near misses. Regulation 17 (1)(2)(b): Good governance.

- The service must ensure national and local guidance is followed with regards to the practice of physical restraint within the ED. Regulation 13 (1)(4)(b): Safeguarding service users from abuse and improper treatment.

- The service must ensure that the rights of patients who present in the ED under the Mental Health Act 1983 are consistently protected. Regulation 13 (1)(5) Safeguarding service users from abuse and improper treatment.

- The service must ensure that clinical staff in the ED understand and can apply the requirements of the Mental Capacity Act 2005. Regulation 11 (1)(3): Need for consent.

- The service must ensure that patients in the ED are only deprived of their liberty when it is lawful to do so in accordance with the Mental Capacity Act 2005. Regulation 13 (1)(5): Safeguarding service users from abuse and improper treatment.

- The service must ensure that patients within all areas of the ED consistently have their right to privacy respected. Regulation 10 (1)(2)(a): Dignity and respect.

- The service must ensure all complaints are managed in accordance with trust policy. Regulation 16 (2): Complaints.

- The service must ensure that an effective leaders are in place to design and action an improvement plan within the ED to improve the safety, effectiveness and responsiveness of the service and to ensure improved standards of care are consistently achieved. Regulation 17 (1)(2)(a)(b): Good governance.

- The service must ensure that all relevant risks within the ED are included and planned for in the service's risk register. Regulation 17 (1)(2)(b): Good governance.

- The service must ensure patients are consistently involved in plans to improve ED services. Regulation 17 (1)(2)(e). Good governance.

The service SHOULD take action to:

- The service should consider how cleanliness within the ED can be consistently maintained and embed safe infection prevention and control practice within the ED.

- The service should review the systems in place to access hoists promptly in the event of the ED hoist being unavailable.

- The service should continue to explore the options available to ensure that facilities are consistently available for the relatives of ED patients who are seriously ill.

- The service should continue to work with commissioners to improve ambulance handover times.

- The service should continue to embed local initiatives aimed to improve sepsis care.

- The service should consider how to improve the accuracy of the information that is recorded on the ED patient board.

- The service should continue to make progress with the ED's long term recruitment plan for nursing and medical staff. This includes the recruitment and retention of children's nurses and a paediatric emergency medicine consultant.

- The service should consider reviewing how the use of rapid tranquilisation medicines is recorded when the medicines used fall outside of the rapid tranquilisation policy.

- The service should review medicines refrigeration capacity to ensure medicines are consistently stored safely in the event of a refrigerator breakdown.

- The service should review the controlled drugs books to ensure they can clearly record the level of detail required.

Urgent and emergency services

- The service should explore the staff feedback about how pharmacy staff could be utilised to improve medicines management in the ED.

- The service should explore how to effectively display patient safety information within the ED.

- The service should review the clinical policies and pathways that relate to ED care and reference the best practice and national guidance that they are based upon.

- The service should ensure that patients who require food and drink within the ED have their dietary needs assessed and planned for. Regulation (1)(2)(a)(ii)(4)(a)(c)(d).

- The service should review the content of the action plans in place in response to the RCEM audits to check they will be effective in driving improvements and better patient outcomes.

- The service should continue to aim towards consistently achieving their 90% appraisal compliance rate for staff working in the ED.

- The service should continue with the implementation of a suitable competency tool for staff working in the ED.

- The service should explore how to improve the training and development opportunities for middle grade medical staff.

- The service should continue to explore how allied health professions could provide a consistent seven-day service within the ED.

- The service should explore how they can make every contact count by offering health promotion advice and support to patients with risks that may affect their long term health and wellbeing.

- The service should consider how to evidence that consent has been sought and gained from patients within the ED.

- The service should consider how they can give accurate and up to date waiting time information to patients and their relatives within the ED.

- The service should explore how to improve patient participation in the Patient Friends and Family Test.

- The service should explore how they can make the ED more user friendly for all patients. This should include a review of the signage within the ED.

- The service should explore how the individual needs of people living with dementia could be met within the ED.

- The service should review the systems in place to improve the availability of information leaflets. This should include reviewing if there is a need to have information leaflets readily available in other appropriate languages and formats within the ED.

- The service should accurately report the numbers of patients leaving before being treated.

- The service should consider introducing a system to effectively monitor the time taken from referral to assessment in regard to the use of the mental health liaison team in the ED.

- The senior leadership team in the ED should explore how to improve their visibility and accessibility to staff and patients.

- The service should explore how the role of the band seven nurse within the ED can be improved to provide a consistent approach to the day to day co ordination the ED.

- The service should consider designing an ED specific vision and strategy outlining short and long term goals whilst the future fit project is in progress.

Urgent and emergency services

- The service should review the 2018 staff survey results and devise an appropriate action plan to address the alleged bullying culture within the ED and wider trust.

- The service should consider how they can evidence that the trust's major incident plan is well rehearsed by staff.

- The service should review the processes in place to enable them to send accurate information with other organisations as required.

Medical care (including older people's care)

Inadequate 🔴 ➙ ⬅

Key facts and figures

Medical care is provided on both the Royal Shrewsbury Hospital (RSH) and Princess Royal Hospital Sites. Services provided on RSH site include: Nephrology (including Renal Dialysis unit), Respiratory, Cardiology, Endocrinology, Care of the Elderly (and Rehabilitation) as well as inpatient Neurology support and speciality outpatient clinics held in the Outpatients department, including Movement Disorders, Neurology, Dermatology and Diabetes.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During our inspection we visited areas providing medical care in the service including: haematology and oncology, short stay unit, endocrinology, nephrology, general medicine, respiratory, the acute medical unit, the discharge lounge, coronary care unit, the renal unit, the frailty unit, acute medical unit and endoscopy. On our inspection we spoke with 33 members of staff including registered nurses, doctors, allied health professionals, pharmacists, healthcare assistants and the services leadership team. We spoke with nine patients and three relatives.

The care quality commission last inspected the service in September 2018 and rated the service as requires improvement overall. Safe, effective, responsive and well led were rated as requires improvement and caring was rated as good.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- Staff completion data for mandatory training did not meet the trust targets.

- Infection prevention and control practices were not consistently adhered to within the hospital. Staff did not always wear appropriate personal protective equipment (PPE) and did not always wash their hands between patients.

- Staff completed venous thromboembolism risk assessments for each patient on admission but did not always review this regularly. We were not assured that risks to patients had been managed appropriately.

- Staff did not always follow systems and processes when safely prescribing medicines. We could not be assured that patients received the accurate drug dosing due to the weight not being recorded on medicine charts and the trust's electronic recording system.

- We were not assured staff used measures that limited patients' liberty appropriately and always knew how to support patients who lacked capacity, or who were experiencing mental ill health.

- Facilities and premises were not always appropriate for the services being delivered. The lack of appropriate facilities within the renal unit meant privacy and dignity could not always be maintained.

- We were not assured that the staff moved to other ward areas including escalation areas had necessary competencies to enable them practice safely.

- Governance systems were in place to monitor and assess risk but did not ensure risks such as compliance with mandatory training and infection prevention and control which had been identified during our inspection in September 2018 had been rectified.

Medical care (including older people's care)

Is the service safe?

Requires improvement 🟠 ➔ ←

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service provided mandatory training in key skills to staff, compliance was monitored but consistently did not meet the trust target.

- The service did not always control infection risk well. We could not be fully assured that infection prevention and control (IPC) practices were consistently adhered to. However, staff kept the premises visibly clean.

- Whilst staff assessed risks to patients and monitored their safety, they were not always completed for every patient when required. However, staff identified and acted upon patients at risk of deterioration.

- We were not assured that risk assessments were carried out for patients living with mental health conditions and attending the renal unit.

- The service did not always use systems and processes to safely prescribe medicines. However, they administered, recorded and stored medicines safely.

- The service did not have enough permanent medical, nursing, therapy and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

However,

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had training on how to recognise and report abuse.

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

- Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care. This had improved since our last inspection.

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

Requires improvement 🟠 ➔ ←

Our rating of effective stayed the same. We rated it as requires improvement because:

Medical care (including older people's care)

- Staff did not always know how to support patients who lacked capacity, or who were experiencing mental ill health to make their own decisions and did not always use measures that limited patients' liberty appropriately. However, staff supported patients to make informed decisions about their care and treatment.

- The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance. However, staff protected the rights of patients' subject to the Mental Health Act 1983.

- Some key services were available seven days a week to support timely patient care. However, patients were not routinely reviewed by doctors at weekends.

However,

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for patients' religious, cultural and other needs.

- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

- Staff mostly monitored the effectiveness of care and treatment. They used the findings to make improvements and mostly achieved good outcomes for patients.

- The service made sure most staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

- Staff gave patients practical support and advice to lead healthier lives.

Is the service caring?

Requires improvement 🟠 ⬇

Our rating of caring went down. We rated it as requires improvement because:

- Staff did not always take patients individual needs into account and did not ensure patients' privacy and dignity was always maintained. However, they treated patients with compassion and kindness.

However,

- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement 🟠 ⬇

Our rating of responsive went down. We rated it as requires improvement because:

Medical care (including older people's care)

- The service mostly planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. However, facilities and premises were not always appropriate for the services being delivered.

- Staff did not respond to complaints in a timely manner.

- Staff moved patients between wards at night and did not justify if the bed moves were for clinical or non-clinical reasons.

However,

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Requires improvement ● → ←

Our rating of well-led stayed the same. We rated it as requires improvement because:

- The service did not always use a systematic approach to continually improve the quality of its services, safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. Governance processes in some areas were not embedded to ensure consistency across the service.

- The service did not have effective systems for planning to eliminate or reduce risks and coping with both the expected and unexpected.

- Most managers had the right skills and abilities to run the service providing high-quality sustainable care. However, new changes required after a death on the renal unit had not always been implemented.

However,

- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff and patients.

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. However, staff morale was sometimes low due to being moved to provide cover during staff shortages.

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems.

- The service engaged well with patients and their relatives to plan and manage appropriate services.

- The service was committed to improving services by learning from when things went well and when they went wrong and promoting innovation.

Medical care (including older people's care)

Areas for improvement

The service MUST take action to:

- The service must ensure that the mandatory training rates meet the trust target. Regulation 18 (2): Staffing.

- The service must ensure venous thromboembolism assessments are consistently carried out. Regulation 12 (2)(a): Safe care and treatment.

- The service must ensure risk assessments are carried out for patients in side rooms living with mental health conditions. Regulation 12 (2)(a): Safe care and treatment.

- The service must ensure deprivation of liberty safeguards reassessments are carried out. Regulation 13: Safeguarding service users from abuse and improper treatment.

- The service must ensure weight, height and body mass index are consistently recorded. Regulation 12 (2)(a): Safe care and treatment.

- The service must ensure that staff consistently adhere to infection prevention and control practices. Regulation 12 (2)(h): Safe care and treatment.

- The service must ensure all staff moved to other ward areas/escalation areas practice within their competencies. Regulation 18(2): Staffing.

- The service must ensure that privacy and dignity of patients attending the renal unit is maintained. Regulation 10: Privacy and dignity.

- The service must ensure that concerns identified during our inspection are addressed. Regulation 17(2)(b): Good governance.

The service SHOULD take action to:

- The service should ensure there are enough therapy staff. Regulation 18(1): Staffing.

- The service should ensure patients are reviewed by doctors during weekends. Regulation 18(1): Staffing.

Surgery

Requires improvement 🟠 →←

Key facts and figures

The surgery core service provides care and treatment for specialties including breast surgery, colorectal surgery, ear nose and throat (ENT), head and neck, ophthalmology, upper gastro-intestinal surgery, urology and vascular surgery.

(Source: Routine Provider Information Request AC1 - Acute context)

Surgical services are provided on both the Royal Shrewsbury Hospital (RSH) and The Princess Royal Hospital (PRH) sites.

RSH surgical admissions unit accepts all surgical emergency patients referred by GPs and admitted from the emergency departments at both RSH and PRH sites. RSH is a designated trauma unit.

The surgery core service at this hospital provides care and treatment for specialties including colorectal surgery, upper gastro-intestinal surgery, urology and vascular surgery. In addition, ears, nose and throat (ENT) and ophthalmology day case surgery is carried out at this site.

Royal Shrewsbury Hospital has nine operating theatres and 119 surgical inpatient beds located across four wards and units:

Ward/unit	Specialty or description	Inpatient beds
Day case ward	**General surgery**	**16**
Surgical assessment unit & short stay surgical unit	**General surgery**	**38**
Ward 22	**Trauma & orthopaedics**	**29**
Ward 26	**Vascular and urology**	**36**

(Source: Routine Provider Information Request AC1 - Acute context)

RSH, Shrewsbury and PRH, Telford were visited as part of the inspection process and each location has a separate evidence appendix. Surgical specialists were managed by the same scheduled care group across the hospitals and had the same clinical directors.

This evidence appendix relates to surgery services provided at RSH, Shrewsbury, which provided both elective and emergency surgery.

Surgical services at RSH was previously inspected by the Care Quality Commission in August. The service was rated as requires improvement, although caring was rated as good.

During our unannounced inspection from 18 to 20 November 2019 and 02 December 2019, we visited all areas providing surgery services at the hospital, including the surgical assessment unit and short stay ward, pre-assessment, the day case unit and short stay ward, and two surgical wards, theatres and recovery. We spoke with 11 patients and observed

Surgery

patient care and treatment. We reviewed 18 patient care records and 10 medicine administration records. We spoke with 42 members of staff including nurses, doctors, anaesthetists, surgeons, therapists, healthcare assistants, housekeeping staff, theatre practitioners, ward managers, matrons, pharmacists and dementia care assistants. We also interviewed some members of the senior management team within the scheduled care group.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service did not make sure all staff completed mandatory training in key skills. The number of staff who completed mandatory training did not meet trust targets.

- The service did not make sure all staff completed mandatory safeguarding training. The number of staff who completed it did not meet trust targets. Clinical staff working with children and young people under 18 in theatres, did not have the correct level of safeguarding training.

- Infection prevention and control measures were not consistently followed by staff entering and leaving isolation rooms.

- The maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste well. Staff did not always carry out daily safety checks of specialist equipment.

- Staff did not always complete and update risk assessments for each patient and remove or minimise risks. Staff identified and acted upon patients at risk of deterioration, however, this was not always within timescales outlined in trust policy.

- The service did not always have enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment.

- Records were not always clear and up-to-date and were not always stored securely.

However,

- Staff understood how to protect adult patients from abuse and the service worked well with other agencies to do so.

- The service mostly controlled infection risk well. Staff used equipment to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

- Nursing staff in post had the right qualifications, skills, training and experience. Managers regularly reviewed and adjusted staffing levels and skill mix, using a trust wide approach to ensure safe staffing levels across the trust by prioritising areas of greatest need. Bank and agency staff received a full induction.

- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

- Staff kept detailed records of patients' care and treatment. Records were easily available to staff providing care.

- The service used systems and processes to safely prescribe, administer, record and store medicines.

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured actions from patient safety alerts were implemented and monitored.

Surgery

- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service safe?

Requires improvement 🟠 ➔ ⬅

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not make sure all staff completed mandatory training in key skills. The number of staff who completed it did not meet trust targets.

- The service did not make sure all staff completed mandatory safeguarding training. The number of staff who completed it did not meet trust targets. Clinical staff working with young people under 18 in theatres, did not have the correct level of safeguarding training.

- Infection prevention and control measures were not consistently followed by staff entering and leaving isolation rooms.

- The maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always manage clinical waste well. Staff did not always carry out daily safety checks of specialist equipment.

- The service did not always have enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment.

- Staff did not always complete and update risk assessments for each patient and remove or minimise risks. Staff identified and acted upon patients at risk of deterioration, however, this was not always within timescales outlined in trust policy.

- Records were not always clear and up-to-date and were not always stored securely.

However,

- Staff understood how to protect adult patients from abuse and the service worked well with other agencies to do so.

- The service mostly controlled infection risk well. Staff used equipment to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

- Nursing staff in post had the right qualifications, skills, training and experience. Managers regularly reviewed and adjusted staffing levels and skill mix, using a trust wide approach to ensure safe staffing levels across the trust by prioritising areas of greatest need. Bank and agency staff received a full induction.

- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

- Staff kept detailed records of patients' care and treatment. Records were easily available to staff providing care.

- The service used systems and processes to safely prescribe, administer, record and store medicines.

- The service mostly managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured actions from patient safety alerts were implemented and monitored.

Surgery

- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

Requires improvement 🔴 ➔ ⬅

Our rating of effective stayed the same. We rated it as requires improvement because:

- The service achieved mixed outcomes for patients. Plans were in place to improve this.

- Managers did not hold supervision meetings with staff to provide support and development.

- Appraisal rates did not meet trust targets.

- Multidisciplinary meetings were not consistently held across all specialities.

- There was very low staff compliance with mandatory training in Mental Capacity or Deprivation of Liberty Safeguards.

However,

- Staff monitored the effectiveness of care and treatment.

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients' subject to the Mental Health Act 1983.

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service adjusted for patients' religious, cultural and other needs.

- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

- Key services were available seven days a week to support timely patient care.

- Staff gave patients practical support and advice to lead healthier lives.

- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. Most staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Is the service caring?

Requires improvement 🔴 ⬇

Our rating of caring went down. We rated it as requires improvement because:

- Staff did not always demonstrate they respected the privacy and dignity of patients who stayed overnight in the surgical assessment unit.

- Staff did not always demonstrate empathy in delivering bad news to patients in a private space.

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However,

- Staff treated patients with compassion and kindness and took account of their individual needs.

- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement 🟠 ➜ ⬅

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Capacity did not meet the demand of the service and patients were boarded on the surgical assessment unit to accommodate them.

- People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

- Complaints were not always responded to in a timely manner and the service took longer to investigate than the trust average. The average days it took to investigate was more than our previous inspection in 2018.

However,

- We saw the service planned and, in most cases, provided services in a way that met the needs of local people.

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Requires improvement 🟠 ➜ ⬅

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Managers were not always available out of hours and leaders were not always visible and approachable in the service for patients and staff.

- The strategic priorities of the service did not demonstrate they were aligned to local plans within the wider health economy.

- Not all staff had regular opportunities to meet, discuss and learn from the performance of the service.

- We were not assured the service identified all risks. Risks had been on the risk register for long periods and did not always demonstrate they were being effectively managed to reduce their impact. Not all risks we identified during our inspection were on the service risk register.

Surgery

- The service collected reliable data and analysed it, however, systems did not provide managers with information to assess volume and waiting times of patients attending the surgical assessment unit.

- The service had not made significant improvements within surgical services at the Royal Shrewsbury Hospital following our previous inspection in 2018.

However,

- Most leaders had the skills, knowledge and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles.

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

- Staff felt increasingly respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

- Leaders operated governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities.

- Leaders and teams used systems to manage performance. Systems were in place to identify and escalate risks and issues.

- The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

- Leaders and staff engagement with patients, staff, the public and local organisations to plan and manage services was improving. They collaborated with partner organisations to help improve services for patients.

- All staff were committed to continually learning and improving services. Most staff had a good understanding of quality improvement methods and the skills to use them.

Outstanding practice

We saw examples of excellent support for patients living with dementia on most wards. The hospital had a dementia support team who visited all patients identified as living with dementia. They undertook a review to ensure their needs were being met. The service used 'this is me' forms effectively. We saw transparent stands were provided where this is me forms were placed in the stand at the bedside. This meant staff visiting patients could immediately see the form and understand the patients' specific communication needs. They also supported wards by providing them with resources to support patients and organised finger foods for patients with limited appetite to ensure there was a variety of options. The service also had a dementia café that operated twice a month, where patients living with dementia could take time out of the ward and participate in activities such as singling and quizzes.

Areas for improvement

The service MUST take action to:

- The service must ensure all patients at risk of falls undergo a risk assessment, regular monitoring and management in line with the trust policy and care plan. Regulation 12(2)(a): Safe care and treatment.

Surgery

- The service must ensure that intra-operative temperatures are routines recorded during procedures in line with national guidance. Regulation 12(2)(a): Safe care and treatment.

- The service must ensure that the five steps to safer surgery checklist is completed fully and signed and date by relevant staff. Regulation 12(2)(a): Safe care and treatment.

- The service must ensure that staff are implementing the sepsis recognition and management form and stop the clock actions are completed within the hour in line with trust policy and care plan. Regulation 12(2)(a): Safe care and treatment.

- The service must ensure all staff who provide care and treatment to young people under 18 years have received the appropriate level of safeguarding training as outlined in the intercollegiate guidance: Safeguarding Children and Young People: Roles and competencies for Health Care Staff (Fourth edition: January 2019). Regulation 13: Safeguarding people from abuse and improper treatment.

- The service must ensure all risks are assessed, monitored, mitigated and the risk register is routinely reviewed. Regulation 17(2)(b): Good governance.

- The service must ensure patient records when not in use are stored securely. Regulation 17(2)(c): Good governance.

- The service must ensure all staff have completed mandatory training in key skills and other training specific to their roles including Mental Capacity Act and deprivation of liberty safeguards. Regulation 18(2)(a)(b): Staffing.

- The service must ensure that all clinical areas are adequately staffed to ensure safe patient care. Regulation 18 (1): Staffing.

- The service must ensure that sufficient staff are trained and available in advanced paediatric life support. Regulation 18 (2): Staffing.

The service SHOULD take action to

- The service should ensure that appropriate spaces are made available within the surgical assessment unit when delivering patient care to ensure patient privacy and dignity is maintained and that all staff respect patient privacy and dignity at all times. Regulation 10: Dignity and respect.

- The service should ensure anaesthetic machine safety checks are completed daily and are dated and signed. Regulation 12(2)(e): Safe care and treatment.

- The service should ensure all clinical waste is disposed of correctly. Regulation 12(2)(h): Safe care and treatment.

- The service should ensure that all areas use to temporarily escalate patients have undergone a robust risk assessment and are safe to use for the intended purpose. Regulation 12(2)(d): Safe care and treatment.

- The service should ensure all staff have received sepsis training. Regulation 18(2): Staffing.

- The service should consider reviewing its complaints process so that complaints are investigated and responded to in a timely manner.

- The service should consider implementing a consistent approach to theatre and ward-based team meeting content and documentation.

- The service should consider reviewing its process for discussing sensitive information and delivering bad news to patients admitted to surgical wards.

- The service should consider implementing a consistent multi-disciplinary team meeting approach across all surgical specialities.

Surgery

- The service should consider reviewing management staffing out of hours to support the provision of seven day working.

- The service should review the process for providing agency staff with immediate access to electronic records and systems.

End of life care

Requires improvement 🟠 →←

Key facts and figures

The trust provides end of life care at two of its sites. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 1,641 deaths from March 2018 to February 2019.

This inspection took place as part of the routine inspection schedule. Our inspection was unannounced to enable us to observe routine activity.

During this inspection we spoke with one scheduled care group lead, three end of life care leads, three specialist palliative care nurses, three consultants, two junior doctors, four ward managers, four ward sisters, one staff nurse, one nurse associate, one healthcare assistant, the head of pathology, the mortuary manager, the bereavement manager, three administrators, three porters, one end of life care volunteer, five patients and three family members. We also reviewed ten care records.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service did not have enough staff to care for patients and keep them safe. Staff did not always keep good care records.

- Key services were not available seven days a week. Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent.

- The service did not audit fast track discharges and achievement of preferred place of care and death.

- Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities. They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact. Staff could not always find the data on patients they needed, in easily accessible formats to make decisions. The information systems were not integrated to allow this.

However,

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients and acted on them. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and had access to good information.

End of life care

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Is the service safe?

Requires improvement 🟠 ➔ ⬅

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear and up-to-date.

- It was possible that palliative and end of life care patients could be missed due to the lack of system which identifies patients.

However,

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

- Staff used infection control measures when visiting patients on wards and transporting patients after death.

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

- Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

- Records were stored securely and easily available to all staff providing care.

- The service used systems and processes to safely prescribe, administer, record and store medicines.

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

End of life care

Is the service effective?

Requires improvement 🟠 ➔ ⬅

Our rating of effective stayed the same. We rated it as requires improvement because:

- Key services were not available seven days a week to support timely patient care.

- Staff did not always support patients to make informed decisions about their care and treatment. They did not always follow national guidance to gain patients' consent.

- The service did not monitor the effectiveness of care and treatment.

However,

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

- Staff gave patients practical support to help them live well until they died.

Is the service caring?

Good 🟢 ➔ ⬅

Our rating of caring stayed the same. We rated it as good because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service responsive?

Requires improvement 🟠 ➔ ⬅

Our rating of responsive improved. We rated it as requires improvement because:

End of life care

- The service did not audit fast track discharges and waiting times from referral to achievement of preferred place of care and death.

However;

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Requires improvement 🟠 ⬆

Our rating of well-led improved. We rated it as requires improvement because:

- Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities.

- They did not always identify and escalate relevant risks and issues and identified actions to reduce their impact.

- Staff could not always find the data on patients they needed, in easily accessible formats to make decisions. The information systems were not integrated to allow this.

However,

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

- Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events.

- Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- All staff were committed to continually learning and improving services.

Areas for improvement

The service MUST take action to:

- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.

End of life care

- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing

- The service must ensure it fully completes do not attempt cardiopulmonary resuscitation (DNACPR) and ReSPECT forms. Regulation 11: Need for consent.

- The service must ensure it staff carry out and complete mental capacity act assessments for all patients who are deemed to not have capacity. Regulation 11: Need for consent.

- The trust must ensure it had full oversight of end of life care services and fully embeds the end of life care team into the scheduled care group governance processes. Regulation 17(2)(a): Good Governance.

- The service must have an electronic system which accurately identifies and tracks end of life and palliative care patients. Regulation 12 (2)(a): Safe Care and Treatment.

The service SHOULD take action to:

- The trust should continue to participate in an external review of the chaplaincy service to ensure this service meets individual need.

- The service should provide it provides key specialist palliative care services seven days week in line with National Institute of Health and Care Excellence.

- The service should ensure all risks are recorded appropriately on the risk register.

- The service should have a service level agreement in place in place to ensure the continuation of the out of hours service.

- The service should undertake audits of end of life care patients preferred place of care or death.

- The service should undertake audits for pain or symptom control for end of life care patients.

Outpatients

Requires improvement ●

Key facts and figures

Outpatient services at Shrewsbury and Telford Hospital NHS Trust are provided across two hospital sites, The Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital.

The central outpatient function is managed by the Scheduled Care Group with the exception of the fracture clinic which is managed by the Unscheduled Care Group.

While some outpatient facilities for children are provided alongside those for adults, children's outpatients provision is not included in this section of the report. Similarly, outpatient provision for maternity services is excluded.

At the Royal Shrewsbury Hospital there is a central outpatients facility that covers cardiology, urology, breast, gastroenterology as well as general surgical and medical specialties.

There are separate departments for:

- Ophthalmology (Eye Clinic).

- Surgical Pre Assessment.

- Fracture Clinic.

- Endocrinology.

- Renal.

- Phlebotomy (blood samples).

There is a centralised patient access function that deals with the management of all referrals and outpatient booking for about 70% of the trusts' activity through the main outpatient department. The remainder of the activity is managed through individual specialities and satellite outpatient areas such as audiology, provided at community hospital locations. The bookings contact centre is based at the Royal Shrewsbury Hospital. All patient cancellations and re-bookings come through this centralised standardised service along with a large amount of follow up bookings.

During our inspection we:

- visited the main outpatient department, phlebotomy, surgical pre assessment, the eye clinic, the fracture clinic, the endocrinology clinic and the renal clinic.

- spoke with 4 relatives and 12 patients.

- spoke with 28 members of staff including, nurses and health care assistants, specialist nurses, receptionists, consultants, doctors, matrons and managers.

- looked at 8 sets of patient records.

- observed interactions between patients, relatives and staff.

- observed two patient consultations.

Our inspection was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available.

Outpatients

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

Summary of this service

We rated it as requires improvement because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and usually managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

- Most people could access the service when they needed it and did not wait too long for treatment. The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

- Leaders ran services well and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However,

- There were not enough clinic rooms in some areas and this resulted in patients not being seen.

- In one area assessment rooms were too cramped or poorly lit for safety

- Staff did not have the training they needed to support patients who lacked capacity to make their own decisions.

- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not consistently in line with national standards for some cancer specialities.

- Information system were not integrated with one another relying on duplication of data entry and many systems were paper based.

Is the service safe?

| Requires improvement | 🟠 |

We rated it as requires improvement because:

- There were shortfalls in training for fire safety and infection prevention and control.

Outpatients

- There were concerns in the eye clinic about the suitability of the lighting and the equipment fit in some rooms. There was also an insufficient number of clinic rooms available in some areas to accommodate the demand.

- Equipment, while cleaned between patients, was not always labelled as such.

However

- The service provided mandatory training in key skills to all staff and made sure most staff completed it.

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

- The design, maintenance and use of facilities, premises and equipment usually kept people safe. Staff were trained to use them. Staff managed clinical waste well.

- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

- The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and usually available to all staff providing care. While there were continuing problems with the central records store which caused difficult in finding records, the trust had a costed and approved plan to address them. Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Is the service effective?

We do not currently provide a rating for effective

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

- Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools.

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Outpatients

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

- Staff gave patients practical support and advice to lead healthier lives.

- Staff followed national guidance to gain patients' consent.

However:

- However, because of changes to training arrangements the trust could not be assured that staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Is the service caring?

Good 🟢

We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

However:

- People did not always access the service when they needed it and some patients did not receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards for some cancer specialities.

Is the service responsive?

Requires improvement 🟠

We rated it as requires improvement because:

- People did not always access the service when they needed it and some patients did not receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards for some cancer specialities.

 However:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Outpatients

- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Is the service well-led?

Good ●

Our rating of well-led stayed the same. We rated it as good because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

- Staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and most had regular opportunities to meet, discuss and learn from the performance of the service.

- Leaders and teams managed performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

- The service collected data and analysed it. The information systems were secure.

- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

However:

- However, staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Information systems were not well integrated across the organisation.

Areas for improvement

The service MUST take action to:

- The trust must address the low lighting levels in parts of the Eye Clinic in order to keep patients with poor sight safe from falling. Regulation 12(2)(d) : Safe care and treatment.

- The trust must ensure that the plans it has to make vision assessment rooms safer in the Eye Clinic through the introduction of new light boxes are implemented. Regulation 12(2)(d): Safe care and treatment.

Outpatients

The service SHOULD take action to:

- The trust should ensure that they monitor compliance with mandatory training for fire, infection control, resuscitation and mental capacity. Regulation 12(2)(f): Safe care and treatment.

- The trust should ensure there is a means for staff to positively identify equipment that has been cleaned between patients. Regulation 12(2)(e): Safe care and treatment.

- The trust should ensure that they monitor compliance with national standards for cancer specialities and respond as necessary. Regulation 12(2)(a): Safe care and treatment.

- The trust should monitor that staff consistently follow the trust policy of use of relatives as translators.

- The trust should continue to develop its information systems to minimise the risks associated with duplication of data entry and reliance on paper systems.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Requirement notices

Regulated activity	Regulation
Maternity and midwifery services	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	S29A Warning Notice: quality of healthcare
Diagnostic and screening procedures	
Family planning services	
Management of supply of blood and blood derived products	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	

Regulated activity	Regulation
Treatment of disease, disorder or injury	S31 Urgent variation of a condition

Our inspection team

Bernadette Hanney, Head of Hospitals Inspection, led this inspection. An executive reviewer, Susan Field, Director of Nursing, Gloucestershire Health and Care NHS Foundation Trust, supported our inspection of well-led for the trust overall.

The team included 17 inspectors and 38 specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.

Royal Shrewsbury Hospital

Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XQ
Tel: 01743261000
www.sath.nhs.uk

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Ratings

Overall rating for this hospital	Inadequate ●
Are services safe?	**Inadequate** ●
Are services effective?	**Inadequate** ●
Are services caring?	
Are services responsive?	**Inadequate** ●
Are services well-led?	**Inadequate** ●

Summary of findings

Overall summary of services at Royal Shrewsbury Hospital

Inadequate ● ⬇

Our rating of services went down. We rated them as inadequate because:

During this inspection we used our focused inspection methodology. We did not cover all key lines of enquiry. We have rated the service as inadequate and have taken enforcement action as a result of this inspection to promote patient safety. Our enforcement action included the use of our urgent enforcement powers where we placed conditions on the trust's registration in relation to the assessment and management of risk, care planning, and incident management. We also served two warning notices to the trust requiring them to make improvements in the following areas; end of life care staffing, end of life staff competencies, end of life governance systems and the way the staff support patients in line with their personal preferences and individual needs.

- Staff did not always complete risk assessments for each patient in a prompt manner. Action was not always taken to remove or minimise risks to patient's health and wellbeing. Safety incidents were not always managed well to protect patients from avoidable harm.

- Staff did not always keep detailed records of patients' individual needs, preferences and the care and treatment provided. Person centred care was not always planned for to ensure patient's individual care needs and preferences were met.

- The end of life care service did not ensure that all staff were competent for their roles, placing patients at risk of receiving unsafe and inconsistent care. This had not improved since the last inspection.

- The services did not always provide care and treatment based on national guidance and evidence-based practice.

- Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. At times, patients continued to be unlawfully restricted.

- Leaders did not demonstrate that they had the skills and abilities to run the services. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.

- The culture of the services was not centred on the needs and experience of patients.

- The services did not operate effective governance systems to improve the quality of services. Leaders had not effectively implemented new ways of working to drive improvement and they were not always available to provide day to day support to staff. This had not improved since the last inspection.

- Staff did not keep detailed records of patients' preferences for care and treatment provided at the end of their life. This had not improved since the last inspection.

- The end of life care service did not have the enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. This had not improved since the last inspection and was identified at our inspection in 2018.

- Specialist palliative care services were not available on site seven days a week to support timely patient care. This had not improved since the last inspection.

Summary of findings

- It was possible that palliative and end of life care patients could be missed due to the lack of systems to identify patients. This had not improved since the last inspection.

Medical care (including older people's care)

Inadequate 🔴 ⬇

Summary of this service

Our overall rating of this service went down. We rated it as inadequate because:

- Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed.

- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up-to-date. However, records were stored securely and easily available to all staff providing care.

- The service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

- The service did not ensure that all staff were competent for their roles.

- The trust's policies and procedures were not always based on the most recent national guidance.

- Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. At times, patients continued to be unlawfully restricted.

- The service did not always consider the individual needs and preferences of patients.

- Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff. The culture of the service was not centred on the needs and experience of patients.

- The service did not operate effective governance systems to improve the quality of services.

However:

- Staff on ward 32, identified and acted upon patients at risk of deterioration.

Is the service safe?

Inadequate 🔴 ⬇

Our rating of safe went down. We rated it as inadequate because:

- Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed. This impacted upon the safe care patients received. However, staff on ward 32, identified and acted upon patients at risk of deterioration.

- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up-to-date. This meant that care staff could not easily identify care to be given to individual patients. However, records were stored securely and easily available to all staff providing care.

Medical care (including older people's care)

- Staff did not always report incidents and the service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Inadequate 🔴 ⬇

Our rating of effective went down. We rated it as inadequate because:

- The service did not always provide care and treatment based on national guidance and evidence-based practice.

- The service did not ensure that all staff were competent for their roles.

- Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. At times, patients continued to be unlawfully restricted.

Is the service responsive?

Inadequate 🔴 ⬇

Our rating of responsive went down. We rated it as inadequate because:

- The service did not always take into account the individual needs and preferences of patients.

Is the service well-led?

Inadequate 🔴 ⬇

Our rating of well-led went down. We rated it as inadequate because:

- Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.

- The culture of the service was not centred on the needs and experience of patients.

- The service did not operate effective governance systems to improve the quality of services.

Detailed findings from this inspection

Is the service safe?

Assessing and responding to patient risk

Medical care (including older people's care)

Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed. This impacted upon the safe care patients received. However, staff on ward 32, identified and acted upon patients at risk of deterioration.

Staff should complete risk assessments for each patient on admission, using a recognised tool, but did not always review or complete these regularly. In all 15 records we looked at we saw incomplete risk assessments. Including, falls risk assessments, use of bed rails and skin assessments.

The service continued not to provide assurance that patients were protected from the risk of developing pressure ulcers. Patients with high or very high Waterlow scores, a nationally recognised practice tool was used to assess the risk of developing pressure damage, did not always have further care plans to show what was in place to prevent pressure damage. We saw evidence of this in 11 out of the 15 patient records we looked at. This meant that patients with pressure damage were not appropriately assessed or afforded the correct level of care to minimise the risk of further damage.

We saw that two of the patient records showed poor nutritional intake. There was no nutritional risk assessment recorded to show the risk of malnutrition had been assessed and planned for. We also did not see any heights or weights recorded for these patients. Malnutrition and obesity are risk factors in developing pressure damage to skin. We did not see any height or weights recorded for these patients.

The service continued not to complete holistic and effective falls assessments and falls mitigation plans in line with national guidance which placed patients at serious risk of harm. We saw in one set of patient records that the falls risk assessment on admission stated 'no history of falls'. However, the same patient had been discharged four days before. We saw from the previous admission the falls risk assessment showed the patient did have a history of falls, and one of the reasons for that admission was a fall at home. In another set of patient records the patient was admitted after a fall and a urinary tract infection. The records stated that the patient had fallen at home, however there was no further information given or mitigating risk factors in place.

In a further eight out of 15 patient records we looked at all falls risk assessments were not fully completed, meaning that patients were at risk of potential harm from falling and this had not been identified.

Staff did not manage the risks associated with bed rails which placed people at risk of serious harm. The trusts' own risk assessment for use of bedrails stated that if a patient was restless or confused, staff should not use bedrails. We saw evidence of unsafe and inappropriate use of bedrails on a confused patient. For example, the risk assessment form stated that the patient was restless, confused and was living with dementia. The patient had bedrails in place and there was nothing documented in the risk assessment saying they needed them, except they were confused. This is not a reason to use bedrails.

On ward 32 we saw that there were stickers in place in patients records to highlight to the medical team that the patient was deteriorating. These stickers were red and enabled the nurses to follow a clear check list of when to alert the medical team to assess the patient. Ward 32 had been a pilot for this alerting system, however, they were not recognised or used on the other two medical wards we visited. The plan was to embed this system across the other inpatient wards.

Nursing staff displayed a lack of accountability with regards to their role in assessing and managing patient risk. For example, when we asked a staff member why a patient was not being nursed on a specialist mattress despite having a high risk of developing pressure damage, they could not answer the question. We reframed this question and ask what would trigger a specialist mattress being requested they told us that if the patient developed a pressure ulcer then they would request a specialist mattress. They did not acknowledge that this was potentially too late for the patient as harm to the patient had already been caused.

Records

Medical care (including older people's care)

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up-to-date. This meant that care staff could not easily identify care to be given to individual patients. However, records were stored securely and easily available to all staff providing care.

The service predominately used paper based recording systems. Patients general nursing and medical notes were paper based, and observations were conducted using an electronic device.

Assessments contained in the nursing documentation were not always completed to ascertain patients' individual needs. From the 15 patient records we reviewed, 11 of the nursing documentations contained significant gaps. The gaps included important areas of care, such as; vision, hearing, bowel and urological patterns and history and social history. All of which is essential to provide safe, effective and responsive care. This meant patients were at risk of receiving care and treatment that did not reflect their needs.

The service continued not to provide assurance that the information needed to guide staff in how to provide safe and consistent care was available. The generic care plan options within the nursing documentation were not highlighted to show the care each patient required. None of the 10 patient generic care plans we reviewed highlighted the care and treatment each of these patients required to meet their needs. This meant patients were at risk of receiving unsafe and inconsistent care that was not in line with their individual needs. We reviewed the patient records for a patient who was nil by mouth (NBM) on ward 32. They had a percutaneous endoscopic gastrostomy (PEG) feeding tube in place. Mouth care was inconsistently recorded. Some days it appeared to be on the fluid balance chart, other days showed no evidence of mouth care recorded.

Fluid balance charts were not accurately completed on all five sets of notes reviewed on ward 32. In one set of records the patient was admitted with dehydration. The patient was then considered to be fluid overloaded and a diuretic was prescribed and given. The medical staff had documented in the records that the 'fluid balance was incorrectly recorded', therefore, was not fluid overloaded.

We could not be assured that patients were being supported to change their position at a frequency that was in line with their individual needs and best practice guidance. Patients with high or very high risk of developing pressure damage did not always have their repositioning chart completed accurately, or comprehensively. Mitigations were not always recorded. There was a risk that patients would develop skin damage while awaiting repositioning. Due to the patients' actual position not being recorded before and after repositioning, for example 'back' or 'right side'. There was a risk that patients spent most of their time in the same position.

Daily top to toe skin assessments should be recorded for all patients who received assistance with personal care from staff. However, these assessments were not completed accurately so did not effectively record the condition of individual patient's skin. We saw inconsistences in how the documentation was completed. Some staff stated 'skin intact' and did not complete the whole record, some staff would not physically assess the skin themselves if the patient told them they had no issues. Where wounds were present, there was no further documentation about the size or depth of wound or if any dressing were being used. This meant that a nurse could not assess if patient's skin was improving or deteriorating.

We reviewed in one patient record that the patient had developed a pressure ulcer. The patient was on standard mattress with a Waterlow score of 21 and three red areas marked on their body map on the top to toe assessment. The following day, four red areas were marked on the body map. However, an air mattress was not provided until three days after. This was reported as an incident as a grade 2 pressure ulcer. This was recorded in the patients nursing assessment booklet. However, there was no reference to the grade 2 pressure ulcer on the patient body map. There was no body map completed for two of the days. Changes of patient position were rarely and irregularly recorded on their repositioning chart.

Medical care (including older people's care)

We reviewed the records of a confused patient on ward 22. The falls risk assessment stated that they were of high risk of falls and not able to mobilise independently. They did not have a top to toe assessment carried out but did have a documented Waterlow score of 19. However, there was no record of what mattress this patient was being nursed on.

A patient was admitted with Waterlow score of 10 to ward 32. However, the same patient had been discharged four days ago, and that assessment showed the patient had a Waterlow score of 23. Furthermore, the notes recorded 'pressure areas intact', but the body map indicated a 'red and blanching' area on the buttocks. This patient was obese, with numerous pre-existing medical conditions and was a high risk for developing a pressure ulcer. We discussed this with the ward manager who was confident the bed and mattress were suitable for the patient. However, they requested that the nurse looking after the patient reassessed the Waterlow score.

We found that where catheters were used, catheter care plans or passports were not in place to record when the catheter should be reviewed or changed. We reviewed the records of one patient on ward 21R and one on 22 who had urinary catheters. The reason for the catheter and the review date were left blank. This meant the information needed to guide staff on how to provide safe catheter care was not always available, placing patients at risk of unsafe care.

We found that there was not always an accurate account of the care that patients had received. Records as highlighted above contradicted each other for example, care plans, Top to Toe records and repositioning patients contradicted care that should be given to individual patients. This meant that patients were at risk of harm due to lack of staff knowledge and understanding of the individual patient's needs. For example, we saw in two patient records where falls assessments had been completed to say that a lying and standing blood pressures had been done. However, when we checked the observations this was not the case.

The staff did not always follow the trust and their professional bodies best practice guidance for record keeping. It was not always clear which nursing or medical staff had assessed and treated patients, as records did not always contain a clear record of the staff members name and role who had completed the written entry. Dates and times of written entries were also not consistently recorded to demonstrate an accurate timeline of patients' care.

Records were stored securely. Patient records were stored in locked trolleys in all the ward areas we visited.

Incidents

Staff did not always report incidents and the service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

This inspection was triggered by a never event that had occurred on a medical ward at the Royal Shrewsbury Hospital (RSH) site. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Following the never event, the trust told us that a patient safety alert had been sent to staff to highlight the never event and share learning to prevent a similar incident from reoccurring. We asked 14 members of staff across wards 21R, 22 and 32, if they were aware of the recent never event. Only four of the 14 members of staff were aware of the incident and the learning from it, two of these were the ward manager and the nurse in charge. This meant that the systems in place to manage safety incidents were not always effective.

At RSH, they held a training session in relation to the incident on a piece of equipment, this took place in the canteen. However, if staff were not on duty that day, they did not receive this training.

Medical care (including older people's care)

We found that staff did not identify the safety concerns we identified as incidents. Therefore, these incidents were not reported. For example, the lack of appropriate risk assessment and management plans, the poor record keeping and shortages of staff to provide one to one care for patients at risk of falling were not reported as incidents. This meant learning from these incidents could not take place to improve safety and care.

Is the service effective?

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

We found that the trust's falls and pressure ulcer policy was not based on the most up to date national guidance. The trust's, 'Slips, Trips and Falls Policy' which was last updated and approved in February 2020 continued to reference the National Institute for Health and Care Excellence (NICE) falls guidance for older people from 2004. This guidance has been replaced and the latest NICE guidance recommends that falls prediction tools are no longer used to identify if older people are at risk of falling. These prediction tools should have been replaced with multifactorial assessments for all patients who are 65 and over. We found that this new guidance was not being followed to ensure all patients aged 65 and over had a multifactorial falls assessment and intervention plan.

The trust's, 'Pressure Ulcer Prevention and Management Policy' which was last updated in February 2019 following the February 2019 NICE update. However, we found that this policy did not reflect the need to consider all pressure ulcers as potential serious incidents dependent upon individual circumstances. The policy referred to only reporting grade three and four pressure ulcers as serious incidents. The policy does not reflect that a grade two pressure ulcer could meet the serious incident reporting criteria under certain circumstances. This meant NHS England serious incident guidance was not accurately incorporated into the policy.

Competent staff

The service did not ensure that all staff were competent for their roles.

We were not assured that all staff had completed training in the use of bariatric beds at the time of the serious incident. Out of the nursing staff we spoke with, three of the 14 nurses and healthcare assistants had received formal training prior to the serious incident. The remaining 11 staff told us they learnt from their colleagues, or just 'learnt when the bed was on the ward'. The trust could not provide training records for the compliance of staff. These were held by the external bed company. After the serious incident the trust had arranged training for staff in the use of bariatric beds and mattresses.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. At times, patients continued to be unlawfully restricted.

Staff did not always follow the requirements of the Mental Capacity Act 2005 (MCA) to ensure decisions about care and treatment were made in patient's best interests when they were unable to make these decisions for themselves. This showed no improvement from the last inspection in 2019.

Managers did not monitor the use of Deprivation of Liberty Safeguards (DoLS). Staff continued to inform us they had not completed training in MCA and DoLS. In all the patient records we checked, staff had not carried out daily reassessments

Medical care (including older people's care)

for patients who lacked capacity. On-going assessment of patients with fluctuating capacity, such as when this was likely to improve with medical treatment was not always carried out. There were additional restrictions using close observations, bedrails, physical and chemical restraint. These patients required the protection of the DoLS and early urgent authorisation should have been made.

Managers did not always monitor how well the service followed the Mental Capacity Act and made changes to practice when necessary. When patients could not give consent, it was not always clear that staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Is the service responsive?

Meeting people's individual needs

The service did not always take into account the individual needs and preferences of patients.

Patients continued to be at risk of receiving care and treatment that was not person centred. Patient assessments to ascertain care preferences and individual needs were not completed. None of the 15 care assessment and care plans we reviewed contained any record of patients care preferences or individual care needs. For example, the care records for five patients who were confused or living with dementia contained no information about their likes, interests, what they liked to be called, or what food or drink they normally ate at home.

We reviewed the records of a patient on ward 22, who was admitted with a urinary tract infection and was living with dementia. There was a form from the residential home outlining what they were and were not able to do for themselves. This was not addressed in their care plans on the ward. The form stated that they wake at night to go to the bathroom, the nursing staff documented in their care plans, that the patient did not have the need to frequently go to the toilet. In the residential home they would mobilise with a frame and one carer. In the nursing care plans, it stated that they were not mobile and there was no frame to use and they had the bed rails in place.

Is the service well-led?

Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.

The medical wards were overseen by a matron and each was led by a ward manager. Ward 32 had three junior sisters who provided support to both the ward manager and to junior staff. The manager delegated some tasks to the junior sisters, for example, auditing, training, and staff appraisals. Each junior sister had areas of responsibility specific to them.

An experienced nurse was appointed each day to be the nurse in charge (NIC). Their responsibilities included allocating the daily work, answering telephone enquiries and assisting with patient admissions, transfers and discharges. We were told that the NIC was not normally allocated a group of patients to look after, however this was dependent upon the number of staff working, and the number of patients on the ward at the time. During our inspection, the NIC did not have any patients allocated.

Leaders did not always manage the priorities and the issues the service faced. For example, we found concerns with incomplete patient care plans and risk assessments. Service leaders had not acted to improve patient care records despite carrying out documentation audits and monthly notes audits. This issue was raised as a concern by CQC during the previous inspection.

Medical care (including older people's care)

We were told documentation audits were carried out monthly and that results were used to improve performance. However, each of the patients' notes we reviewed had omissions on care plans and risk assessments which had not been addressed by leaders in the service. We discussed our findings with senior ward staff, and we were told they had found similar issues previously, particularly with regards to accurate recording of fluid balance charts and patient repositioning charts. Despite this, staff did not accurately record this information and we were not assured that the leaders in the service had the necessary skills to challenge bad practice, or to engage with staff in order to make improvements.

We were told that that Covid-19 had increased the workload for staff on the ward, and that caring for infections was often difficult. However, during our inspection there were as many staff as there was patients on ward 32, there were eight members of staff and six patients. We observed that staff would have had time to complete accurate and comprehensive patient care records.

Culture

The culture of the service was not centred on the needs and experience of patients.

We saw that the lack of appropriate risk assessment and care planning had been normalised on the wards we inspected. Staff at all levels did not recognise that this failure to adequately assess and plan patient care led to practice which was unsafe and uncaring. Staff were unable to articulate the impact of inappropriate care documentation, for example around skin damage from pressure, and how this impacted on patients receiving the correct level of care, staff being able to assess whether any interventions were being given or the impact this was having on a patient's health.

We found that there was a normalisation of poor care and a complacency around professional curiosity and challenge. For example, nursing staff and allied healthcare professionals did not challenge medical staff when decisions were made about care or did not contain evidence of patient's individual preferences. Furthermore, we found that staff did not challenge one another when they witnessed poor care or documentation of that care. For example, where body maps, used to highlight areas of pressure damage, were marked with a simple x on the area affected and there was no documentation as to what this meant staff did not challenge their colleagues to complete the document appropriately so that care give n could be assessed for impact.

We interviewed two professional specialist nursing staff about their area of expertise. When we described the concerns, which included those patients at risk of falling who were being managed within their bed to prevent them from falling, we were told that they accepted this was common practice and they were aware this was happening. They acknowledged this was poor nursing care but there was no plan in place to address this. Furthermore, we discussed our concerns around care given to prevent tissue damage from pressure with a senior nurse. We were told that nursing staff used their professional judgement when planning care to relieve tissue damage. However, we found that there was little professional judgement used by ward staff who solely used the chart on the types of mattress to be used to identify when patients required a specialist mattress. Therefore, for a patient who was mobile within the bed a higher-grade pressure relieving mattress was not required unless they developed a grade 3 pressure ulcer. Our discussions with nursing staff supported this position.

Governance

The service did not operate effective governance systems to improve the quality of services.

We saw that there was a lack of learning from previous incidents. We spoke to a specialist nurse about the trust's improvement plan following a prosecution of the trust by the Health and Safety Executive in 2017 in regards to patient falls. We were told that the trust had already provided different beds and therefore there was no improvement plan. Prior to inspecting the trust we reviewed a number of incident reported about falls and found the same issues reported

Medical care (including older people's care)

as had been highlighted in this summary judgement, i.e. lack of staffing poor care risk assessments, and documentation of care and poor management of patients at risk of falling. On this inspection we found the same issues on the medical wards were still evident in the care that was given to patients at risk of falling. This compounded our concerns that the trust failed to learn from significant incidents.

Ward managers completed a programme of internal audit to monitor quality and operational processes. Audits included, for example, documentation, environment, cleanliness, falls, person centred care, and medicine audits. We were told these were reviewed at clinical speciality meetings and divisional quality boards, and that the audits were completed electronically which all staff had access to. However, the audits had not resulted in improvements to the quality of patient risk assessments for pressure ulcers, person centred care, or documentation, in the records we looked at. Issues we had identified in previous inspections had not been rectified. We were not therefore assured that the leaders in the service had identified these key issues in performance and safety.

The service did not have timely and effective actions in place in their improvement plan to appropriately address all previous inspection findings and concerns. For example, our 2018 and 2019 inspections identified a lack of person-centred care planning. The trusts' 2020 action plan recorded an associated action to address this which stated, 'patients must have their individual needs assessed and planned for'. The action plan recorded that this was to be addressed by, 'implementing new nursing documentation to include individual needs. This action was to be completed by June 2020. Other than introducing new documentation, no other interim action, such as; staff training, care record audits etc had been planned or introduced to address the significant and ongoing shortfalls in patient centred care planning whilst awaiting new documentation to be rolled out. Following our inspection, the trust told us they had reintroduced their exemplar ward reviews (the trust's own quality and safety assessment tool). The use of the exemplar ward reviews had been paused due to inspection activity and the Covid 19 pandemic. We will assess if this has been an effective governance tool at our next inspection

Areas for improvement

The trust must:

Ensure effective systems are in place to assess and mitigate individual patient safety risks. This includes, but is not limited to; bed rails, falls, pressure care, pre-existing medical conditions and behaviours that challenge. Regulation 12 (1)(2)(a) and (b): Safe care and treatment.

Ensure complete and accurate records are maintained that describe the care and treatment delivered to individual patients. Regulation 17 (1)(2)(c): Good governance

Ensure effective systems are in place to share learning from incidents to prevent further incidents from occurring. Regulation 17 (1)(2)(b): Good governance

Ensure staff are competent in their roles. This includes but is not limited to the use of; equipment to meet individual needs and care planning. Regulation 12 (1)(2)(c) and (e): Safe care and treatment.

Ensure that when patients are unable to make decisions about their care and treatment, the requirements of the Mental Capacity Act 2005 are consistently followed. Regulation 11 (1)(2) and (3): Need for consent.

Ensure that people are only deprived of their liberty in a lawful manner, by following the deprivation of Liberty Safeguards. Regulation 13(5) Safeguarding service users from abuse and improper treatment.

Medical care (including older people's care)

Ensure that staff have access to the information they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients' individual needs and preferences, including needs relevant to the formulation of care plans and mental health needs where appropriate. Regulation 9 (1)(a)(b)(c) and (3)(a)(b): Person-centred care.

Ensure effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care. Regulation 17 (1)(2)(a) and (b): Good governance.

End of life care

Inadequate ● ↓

Summary of this service

Our overall rating of this service went down. We rated it as inadequate because:

- Staff did not keep detailed records of patients' preferences for care and treatment provided at the end of their life. This had not improved since the last inspection.

- The service did not ensure that all staff were competent for their roles, placing patients at risk of receiving unsafe and inconsistent care. This had not improved since the last inspection.

- Staff did not consistently support patients who lacked capacity to make their own decisions.

- The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. This had not improved since the last inspection and was identified at our inspection in 2018.

- Specialist palliative care services were not available on site seven days a week to support timely patient care. This had not improved since the last inspection.

- It was possible that palliative and end of life care patients could be missed due to the lack of systems to identify patients. This had not improved since the last inspection.

- Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced.

- The culture of the service was not centred on the needs and experience of patients.

- The service did not operate effective governance systems to improve the quality of services. Leaders had not effectively implemented new ways of working to drive improvement and they were not always available to provide day to day support to staff. This had not improved since the last inspection.

Is the service safe?

Inadequate ● ↓

Our rating of safe went down. We rated it as inadequate because:

- Although the service had enough suitable equipment to help them care for patients it was unclear if these were available in a timely manner.

- Staff did not consistently complete and update risk assessments for each patient. The service did not consistently identify patients in the last days or hours of their life.

- The service did not have enough nursing and support staff to keep patients safe.

- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- The service did not always have a consultant on call during evenings and weekends. Staff could telephone a local hospice for advice and support. However, there was no formalised agreement for this in place.

End of life care

- Staff did not keep detailed records of patients' care and treatment in respect of resuscitation. Records were not clear or up-to-date.

- Staff did not always report incidents and the service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Inadequate 🔴 ⬇

Our rating of effective went down. We rated it as inadequate because:

- Staff did not routinely monitor the effectiveness of care and treatment. They did not use the findings to make improvements and achieve good outcomes for patients. The service had not been accredited under relevant clinical accreditation schemes. The service did not audit pain and symptom control or time taken for fast track audits.

- The service did not ensure that all staff were competent for their roles.

- Key services were not available seven days a week to support timely patient care.

- Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. This had not improved since the last inspection.

Is the service caring?

- Staff did not consistently treat patients with compassion and kindness, respect their privacy and dignity, and take account of their individual needs.

- Staff did not consistently support and involve patients, families and carers to understand their condition and make decisions about their care and treatment.

Is the service well-led?

Inadequate 🔴 ⬇

Our rating of well-led went down. We rated it as inadequate because:

- Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced.

- The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy had not been ratified by the board at the time of our inspection.

- The culture of the service was not centred on the needs and experience of patients.

- The service did not operate effective governance systems to improve the quality of services.

- Leaders and teams did not use systems to manage performance effectively. They had not identified and escalated all relevant risks and issues nor had they identified actions to reduce their impact.

End of life care

Detailed findings from this inspection

Is the service safe?

At the time of our inspection, there was no dedicated end of life care ward at the trust. Patients in receipt of end of life care were cared for throughout the hospital. Prior to 05 June 2020 the trust did have an end of life care ward but this had been closed due to the realignment of the wards to accommodate Covid 19 arrangements.

Environment and equipment

Although the service had enough suitable equipment to help to care for patients it was unclear if these were available in a timely manner.

The service used specialist syringe pumps for patients who required a continuous infusion of medication to help control their symptoms. These met the current requirements of the Medicines and Healthcare Regulatory Agency (MHRA) for end of life care patients who required continuous symptom management. On review of the incidents reported this year, we noted three relating to the delay in providing patents with a syringe pump for medications to be given, resulting in potential delay in pain relieving medication being given.

Assessing and responding to patient risk

Staff did not consistently complete and update risk assessments for each patient. The service did not consistently identify patients in the last days or hours of their life.

The service did not have a system in place to identify where patients at the end of their life were throughout the hospital. This meant those approaching the last hours and days of their life may not be identified by the multidisciplinary or end of life care team.

We discussed how patients wishes were reflected on the end of life care pathway with the specialist team. We were told that this aspect of the ReSPECT form was not well completed and that this information would be captured on the end of life care plan for patients at the end of their life. However, minutes of meetings reviewed demonstrated that the use of this tool was only 30%.

We found that patients end of life care preferences had not always been recorded in accordance with local and national guidance. Two of the five ReSPECT forms we reviewed contained no record of the own patient's end of life care preferences. In the other three the patients lacked capacity, but there was minimal documentation of the conversation with the patient's family.

Nurse staffing

The service did not have enough nursing and support staff to keep patients safe.

End of life care was provided by an end of life care team. The service also had a specialist palliative care team. These teams worked throughout the Princess Royal Hospital and the Royal Shrewsbury Hospital.

The end of life care team consisted of a whole time equivalent (WTE) end of life care facilitator and three end of life care nurses who provided the equivalent of 1.8 (WTE) staff. The end of life team covered across both sites from 8.30am to 4.30pm Monday to Friday. Out of hours cover was provide through an on-call service at a local hospice.

The specialist palliative care team consisted of four clinical nurse specialists (CNS) who provided the equivalent of 3.8 WTE cover for the specialist palliative care team. The four nurses worked across both sites and provided a service Monday to Friday from 9am to 5pm.

End of life care

Nurse staffing levels did not meet the minimum standards of the National Institute of Health and Care Excellence (NICE) which states access to specialist palliative care should be made available seven days per week.

There were no specific handovers from the specialist palliative care team (SPCT) and the end of life care team to the nursing and medical staff.

At our inspection in November 2019 we found breaches in staffing levels in line with guidance from the National Institute of Health and Care Excellence. However, the trust's most recent action plan, received 23 July 2020 did not contain updates on the action the service had taken to improve nursing staff levels within the team.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not always have a consultant on call during evenings and weekends.

One palliative medicine consultant was employed by a local hospice who provided the equivalent of 0.8 whole time equivalent (WTE) cover at the trust. This did not meet the minimum standards of the Royal College of Physicians (RCP), which requires 1.4 WTE consultants based on the size of the trust and level of patient activity. At the time of our previous inspection, in November 2019, the trust had started the recruitment process to employ a new consultant to provide an extra 0.5 WTE across both sites. This post had still not been recruited despite this being advertised twice, and last advertised in February 2020 just prior to the National lockdown.

Records

Staff did not keep detailed records of patients' care and treatment in respect of resuscitation. Records were not clear or up-to-date.

Two of five patient records we reviewed showed that the patients were not for resuscitation. This means that the patient was not for cardiopulmonary resuscitation which is an emergency lifesaving procedure which is performed on people whose heart has stopped. There was no documented discussion with the patients regarding their treatment plan if they were to deteriorate and need resuscitation and/or critical care intervention in the notes we reviewed. We showed one of the records to the ward manager on ward 32, to see if it was documented elsewhere, but they agreed, there was no documentation to show discussions had been held with the patient. Therefore, we could not be assured that those patients knew they were not going to be resuscitated if needed.

Incidents

Staff did not always report incidents and the service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring . Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

At our previous inspection in November 2019 we were told that since the 2018 inspection the trust had introduced a category for end of life care incidents. This meant relevant staff could identify, track and analyse incidents relating to end of life and palliative care patients. We asked the trust for incidents relating to end of life care from 01 January 2020 to the present date, as on our review we could not see a category for end of life care. The trust sent us details of 14 incidents which had been reviewed as end of life care incidents. We reviewed the incidents submitted to national databases by the hospital and found between 1 January and 20 July 2020, that there were at least 34 incidents reported involving patients at the end of their life. Eight of these related to poor management of pain, medication or access to syringe drivers. Five incidents related to patients not being transferred to the correct ward and five related to pressure area care. The remaining 16 incidents related to poor care planning.

End of life care

On review of the spreadsheet sent by the trust all but one of the incidents were incidents that we had reviewed. The spreadsheet had a description of the incident, immediate action taken, details of the investigation and lessons learnt. However, the lessons learnt pertained only to the individual member of staff or patient and the wider lessons had not been identified except in one case where the policy for admission to ward 35 had been amended. Four incidents involved delays in transferring the patient and three related to no support being available to staff. All incidents were graded as low or no harm despite the results being recorded as; delay in diagnosis and treatment, ongoing pain, disruption to the service and no injury, harm or adverse outcome.

This meant the hospital was not monitoring all incidents that occurred within this service. The service was also failing to share the lessons learnt in these incidents with the wider hospital team. The end of life care safety meeting minutes from February 2020 demonstrated that an incident had been discussed at the meeting. However, this was not one on the spreadsheet by the trust. The minutes also highlighted there were issues with staff using the end of life care category when reporting incidents.

Is the service effective?

Evidence-based care and treatment

Staff did not routinely monitor the effectiveness of care and treatment. They did not use the findings to make improvements and achieved good outcomes for patients. The service had not been accredited under relevant clinical accreditation schemes. The service did not audit pain and symptom control or time taken for fast track audits.

Managers and staff did not carry out a comprehensive programme of repeated audits to check improvement over time. On reviewing the Quality Improvement Plan sent to the CQC in July 2020 the action to establish an audit plan for this service was rated as being in progress.

At our inspection in November 2019 we found that the service recorded patient information onto an electronic database, including the patients preferred place of death, however, the service did not audit this information. We noted from the results of audits that the trust sampled whether the patients preferred place of death was recorded and how many patients achieved this. However, there was no record of whether all patients achieved their preferred place of care and the time taken to move patients into their preferred place of care. The lack of cohesion between the specialist palliative care team and the end of life care team did not help the movement of patients and information between these two services.

At our inspection in November 2019 we found that the service did not audit pain or symptom control for end of life care patients, this meant the service was unable to tell if pain and symptom control was effective or if improvements could be made for end of life care patients in their care. This had not improved since our last inspection. We received one complaint where a patient had not been prescribed adequate pain relief to meet their needs. The staff did not review the effectiveness of the medication or discuss the medication this patient was on at home and provide this whilst in hospital. This patient was not offered regular analgesia nor was a syringe pump offered to manage their pain. This had not improved since our last inspection.

At our inspection in November 2019 we found that the service did not have a comprehensive audit programme, which meant that care was not improved as a result. This had not improved since our last inspection. We reviewed the minutes of the End of Life Steering Group for February 2020 and saw that the trust planned to audit mouthcare, care after death and use of syringe pumps. We did not receive any data from the trust on these audits despite asking for audits in relation to the end of life care service.

The trust confirmed that they had undertaken a "Spot Check on End of Life Care plan". This audit was undertaken in June 2020. A previous audit was carried out in January 2020 but this does not appear to have been discussed at the

End of life care

February End of Life Safety and Governance Meeting. The audit reviewed five sets of notes at this location. Due to the way in which the report is collated it was not possible to identify all of the results at this location. The results demonstrated that all patients were on the end of life care plan. Most patients had a ReSPECT form completed prior to being commenced on an End of Life Care Pathway. All patients reviewed did not have a documented conversation around their preferences for end of life care. However, there was a documented discussion with the family or relatives of the patient in all records. Three sets of records did not have a preferred place of care recorded. None of the five records had all sections of the end of life care plan completed. This was worse than the previous audit. The action to be taken following the audit was to improve compliance through training. However, at the point at which this report was written, March 2020, compliance with the eLearning package was 50%.

The latest data from the National Audit for Care at the End of Life (NACEL) was published on 9 July 2020. The audit presents results against seven themes. For six themes, performance is calculated by aggregating scores from a series of questions and converted to a score out of 10 for each theme. In comparison against the national average the Royal Shrewsbury Hospital seem to perform relatively poorly in three of the four measures they have results for. These include communication with the dying patient, communication with family and others and individualised care planning. In the remaining theme workforce/specialist palliative care performance was towards the national average.

We reviewed the minutes of the End of Life Steering Group for February 2020 and found the local audit in the use of the service's end of life care plan had increased from 15% to 30%. A further audit was planned around the time of our inspection. This meant that only three out of ten patients who were receiving end of life care had a plan to follow specifically for them at the end of their life.

Following the inspection, the trust sent us this audit. This showed that 23% of patients there was uncertainty if the patient would die during this admission and active treatment was continued. Of the notes reviewed only 29% had the palliative care team involved in their care and 18% had the end of life care team involved in their care. This was despite 97% of patients being recognised by staff that they may die and only 12% of patients having had a conversation with staff about the fact that they may die. The audit results reflected that conversations about the patients death was more likely to be had with the patients family or relatives (94%). The audit demonstrates that 32% of patients were placed on the end of life care plan. Only one patient was involved in planning their care at the end of their life. 44% of records reviewed demonstrated that neither the patient nor the family were involved in planning the care at the end of a patient's life. This means that the patient was not involved in their care at the end of their life and did not have the support of specialist nurses.

This audit demonstrates that anticipatory medications were prescribed for around 75% of patients to support their potential discomfort. However, a syringe pump, to assist consistent pain management, was only used in 32% of patients. The preferred place of care was discussed with 41% of patients and carers. In most (86%) cases this was discussed with the patients carer. In 58% of patients the preferred place of care was not achieved. The free text of this audit highlights that staff are not recognising patients at the end of their life in a timely manner, once recognised there were delays in an end of life pathway being commenced. We were not sent an action plan following this audit to improve the recognition of patients at the end of their lives or in ensuring that they received appropriate care. It is therefore unclear how the trust is planning to improve the care given to patients at the end of their life.

The trust undertook an audit of the completion of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form in January 2020. This demonstrated that:

- The patients' personal preferences for care were only documented 62% of the time.

- Over 30% of clinicians did not give recommendations for emergency care and most did not provide clinical guidance on appropriate interventions.

- In all cases the clinician identified if cardiopulmonary resuscitation (CPR) was recommended and in all but one case the patients were not recommended for CPR.

End of life care

- Over 90% of ReSPECT forms had section 6 completed but less than half had documented who was involved in the discussion.

- Where a patient was recorded not to have capacity only one patient out of 67 had the appropriate legal documentation to support this decision. .

Whilst this audit made recommendations for improvement this was not presented at the Quality Operational Committee until 16 June 2020. However, in discussion with senior executives the outcomes of this audit were known. This meant that we were not assured that actions and learning from audits were implemented in a timely manner to ensure improvements to practice could be made.

Following our inspection, the trust sent CQC an Clinical Audit action plan, 24 July 2020, which centred on training and raising awareness of the ReSPECT form and the audit. Eight actions were colour coded green but rated as recommendation never actioned. Three actions were marked as amber, action in progress and one action coloured red and rated as recommendation agreed but not yet actioned. It was difficult to see how the trust had implemented this action plan given that some completion dates were marked as the end of July 2020.

The trust told us that training in the use of the ReSPECT form was incorporated into resuscitation training. Current compliance for this training which is a two year rolling compliance figure is 79%. However, the ReSPECT form was only introduced at the end of October 2019. Therefore, this figure would include staff where this training had not included information on the ReSPECT form. The trust introduced an eLearning package which 257 staff had completed. Furthermore, the lead resuscitation officer had trained 29 people. The end of life care team were not involved the provision of this training.

The trust undertook a bereavement survey between April 2019 and March 2020. This demonstrated that relatives had had discussions with staff about the fact that their loved one may die. However, only 45% of relatives were involved in planning the care with the care staff during the last days of their loved ones life. Most relatives (80%) felt that their loved one had received appropriate care. The survey identified some areas requiring improvement, including discussion with the patient about where they wanted to die (45%), use of the end of life plan (57%) and provision of the information leaflet (23%). Relatives of the patients felt that care was appropriate, but this is not reflective of the evidence in the case notes audited by the trust.

Competent staff

The service did not ensure that all staff were competent for their roles.

Staff told us they had not received effective training to enable them to use Recommended Summary Plans for Emergency Care and Treatment (ReSPECT) forms in line with national and local guidance. ReSPECT forms are designed to provide a summary of a patient's end of life care wishes which includes resuscitation decisions. ReSPECT forms had been rolled out at the trust in 2019 but no effective and measurable training programme was in place. This meant the trust could not assure themselves or us of how many staff had been trained and were competent in the use of ReSPECT documentation.

Following our inspection, the trust shared with us the training numbers for use of syringe pumps up to the date of our inspection. A syringe pump is a small infusion device that is used to administer a continuous infusion of medication from a syringe. This demonstrated that only one ward area had a compliance of over 90%. The lowest score was 0% on ward 32R which is a respiratory ward. Most ward areas had a compliance rate of less than 50%. This meant there was a risk that patients may not receive their medication through a syringe driver in a timely manner as not enough staff had been assessed as competent in many of the wards throughout the hospital.

End of life care

Following our inspection, the trust sent CQC an action plan for the training of staff in using the syringe pumps. This highlighted that it would be incorporated into further intravenous study days, reports on training would be made available for the ward managers and train the trainer sessions would continue. The action plan stated that the trust were looking in to providing an eLearning package for staff. It was not clear who had approved this plan.

Seven-day services

Key services were not available seven days a week to support timely patient care.

When we inspected the trust in 2018, we told the trust they should ensure it provided and meets the recommendations for a minimum service level for access to specialist palliative care as recommended by the National Institute of Health and Care Excellence (NICE), which is 9am to 5pm, seven-days per week.

We re-inspected the service in November 2019 and found the hours of the service had not increased. This meant the trust was not providing a minimum service level for access to specialist palliative care as recommended by NICE. The trust still only provided nursing staff to offer a specialist palliative care service Monday to Friday from 9am to 5pm. Again, we told the trust it should provide its specialist palliative care services seven days a week in line with NICE guidance.

Following a review of the service in July 2020, we found the service operated between 8.30 and 5pm Monday to Friday with on call support from a local hospice. This lack of seven-day provision was included on the services risk register. The minutes of the end of life care steering group, February 2020, reported that there was no update. However, data was being gathered to support a business case. This had not improved since our previous inspection.

On reviewing the Quality Improvement plan sent to the CQC in July 2020 the action to establish a service level agreement with the hospice was still in progress

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. This had not improved since the last inspection.

We found that mental capacity assessments were not always completed in accordance with the Mental Capacity Act (MCA) when patients were unable to make decisions about their end of life care needs. We reviewed five ReSPECT forms. Two of these forms related to patients who staff documented did not have capacity to make decisions about their care and treatment. However, the records for these two patients contained no evidence to show mental capacity assessments had been completed. This meant that the requirements of the MCA had not been followed to evidence these patients did not have the capacity to make these decisions and that these decisions were made in their best interests.

We discussed how the medical staff assess a patients' mental capacity when completing the ReSPECT form with the specialist nurse. We were told that there was a separate form to complete. We reviewed eight patients, two of which were deemed to lack capacity to make decisions. However, a formal mental capacity assessment had not been undertaken for either of these patients. The specialist nurse told us that even when a patient had capacity to make a decision about their care it was good practice to discuss the proposed care with the family in order to ascertain what the patient was like at home or if they had any concerns about the decision of the patient.

Is the service caring?

Compassionate care

Staff did not consistently treat patients with compassion and kindness, respect their privacy and dignity, and take account of their individual needs.

End of life care

In a recent Healthwatch end of life report January 2020 there were six negative comments about staffing, one neutral comment and four positive comments. Those that were positive included that the staff were kind, showed compassion and dignity to their relatives. Those that were negative highlighted a lack of privacy and dignity to their relatives.

Understanding and involvement of patients and those close to them

Staff did not consistently support and involve patients, families and carers to understand their condition and make decisions about their care and treatment.

In the recent Healthwatch end of life report January 2020 there were five negative comments about communication and three positive comments. Those that were negative highlighted a lack of communication about what to expect during the last days and hours of their relatives lives.

We received a complaint about the care at the Royal Shrewsbury Hospital which highlighted the fact that the patient had not felt listened to and that staff were slow to recognise that they were at the end of their life. The carer also felt that the communication between the hospital and themselves was very poor.

Is the service well-led?

Leadership

Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced.

End of life care and specialist palliative care services sat within the division of scheduled care. Scheduled care was led by a medical director, an assistant chief operating officer and a head of nursing.

At board level, the chief nurse and the chair were the executive leads for the end of life care and specialist palliative care services throughout the trust. However, the chief nurse had only just assumed this responsibility and was not aware that the end of life care strategy was in draft format. The end of life care team was directly managed by the matron for oncology and haematology. On reviewing the most up to date Quality Improvement Plan (QIP) for the trust, the action update in respect of leadership stated that a non-executive director was required to lead this service. Yet this action is marked as completed on the QIP.

The executive lead for end of life care did not attend the steering group meetings prior to June 2020 and end of life care was not discussed at the trust's board meetings.

Leaders did not effectively introduce new ways of working. For example, the roll out and implementation of the ReSPECT form was not robust which led to staff not having an adequate understanding of this process. Staff told us that despite there being an implementation plan and policy, no resource was allocated for education. Doctors we spoke with told us they received some training through their grand rounds where they reflected on clinical cases. Junior doctors also told us that they had received training at induction. However, they were unaware that they had to complete a separate mental capacity assessment form. Nurses told us they had received minimal training and did not feel confident in the use of the ReSPECT forms. We were told of the use of the Chatterbox newsletter to promote its introduction. However, nursing staff stated that the respect form had just appeared in the patients notes one day.

Vision and strategy

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy had not been ratified by the board at the time of our inspection.

End of life care

We were told at our previous inspection that there was an end of life care strategy. We asked the trust for their end of life care strategy and action plan, however, the strategy was still in draft form and there was no action plan. Staff told us the strategy had been developed approximately 18 months prior to our inspection. This had been taken to the Clinical Governance Executive Group in November 2019 to be endorsed. Minutes of the meeting concurred that an end of life care strategy should be implemented in early 2020 and discussed at the next board meeting. However, at the time of our inspection, the strategy had not been discussed at any board meeting, it had not been endorsed, approved by the board or implemented.

There were two teams of specialist staff who were responsible to provide specialist knowledge and experience to general staff. The end of life care team supported people who had days or hours of life left. The specialist palliative care that helped staff in the management of patients who had weeks or months of their life left. It was not clear how information form either team was passed between the teams to improve the patient and carer's experience of a dying patient.

Culture

The culture of the service was not centred on the needs and experience of patients.

We found that there was a deference to medical staff held by nursing staff. We spoke with a specialist lead about how patient wishes were captured in respect of resuscitation. We were told that patients cannot demand treatment and that it was the doctor's decision if a patient should be resuscitated. When discussing the poor completion of ceilings of care area on the ReSPECT form we were told that it was everyone's responsibility to complete this. When asked if there was an action plan to address this failing, we were told that during the COVID pandemic that awareness had been highlighted but that the specialist nursing time is limited. This raised concerns around the culture of service. This highlighted the acceptance of poor care and the poor understanding of the ReSPECT form's purpose.

We saw in the patient records we reviewed and the audits from the trust demonstrated that there was a lack of communication between staff and patient who was dying. Whilst we appreciate that this may not always be possible in the last days and hours of a patients life there was an apparent reluctance to do this. However, most families or carers had been spoken to about the fact that the patient was dying and what their wishes were during this time. When we spoke to the lead nurse we were told that they believed that even when a patient had capacity to make decisions staff should talk to the family to see if they have any concerns or what the patient is usually like. This meant that whilst the family were involved in discussions there was little acknowledgement that the patient may have different wishes to those of their family. There was a culture of not involving the patient in decisions made about their care.

Governance

The service did not operate effective governance systems to improve the quality of services.

Minutes of the Clinical Governance Executive Group in November 2019 highlighted that there was a lack of medical staff compliance to complete the end of life care pathway. Patients had been either late to start on the end of life care pathway or they had not commenced this at all. The minutes state that "End of life care is not consistent across all areas and it is important that everyone delivers. The action pertaining to these comments was to check what training had been delivered and report back. However, in subsequent minutes there was no further update. This was corroborated in the Healthwatch End of Life Report, January 2020, which stated that people had a poor experience until the care staff at the hospital recognised that the patient was at the end of their life when the experience improved.

We reviewed the minutes of the End of Life Steering Group for December 2019 and February 2020 and found that whilst there was some improvement between December 2019 and February 2020 on the training of medical staff to address the medical staff completion of the end of life care pathway and the ReSPECT forms there was little traction on other issues discussed at these meetings.

End of life care

The service continued to not take timely and effective action in response to quality and safety audits where concerns or poor compliance was identified. For example, effective action had not been taken in response to an audit of ReSPECT documentation completed in January 2020. At the time of our inspection, six months had lapsed, and the senior leadership team had been aware of the results of the ReSPECT audit but had taken no action to make improvements in its application.

Action plans sent by the trust following our inspection were not clear as to whether action had been taken or embedded. The Clinical Audit Action plan updated 21 July 2020 had items listed as being complete but had a rating of 4 which meant recommendation never actioned. This document also had actions such as roll out of training which had commenced but had not been fully embedded having only started in June or July. The Quality Improvement Plan, updated in July 2020, stated that there was a requirement for a non-executive end of life care lead but the chair told us it was him at our inspection in June 2020.

The trust told us that they had had nine complaints since January 2020 in respect of the end of life care service of which six related to the Royal Shrewsbury Hospital. The themes from these complaints included poor communication with the family, delays in medication and poor communication around resuscitation

Managing risks, issues and performance

Leaders and teams did not use systems to manage performance effectively. They had not identified and escalated all relevant risks and issues nor had they identified actions to reduce their impact.

The current risk register for end of life care had three risks on it. These were in relation to training around the mental capacity act and deprivation of liberty safeguards, the provision of specialist consultant input and the risk that the end of life care and palliative care team were not sufficient to meet the needs of patients. When we asked for the detail of these risks we were provided with only two risks the sufficiency of the service to meet demand had been on the risk register since April 2019 and had not been updated since November 2019. The shortage of specialist consultant staff had last been updated in November 2019 and interviews were due to take place in January. However, at the time of our inspection there was no new appointee in place. The risk in relation to training around the mental capacity act and deprivation of liberty safeguards was not on this "detailed" information. There were no risks related to auditing or training on specific end of life care issues.

The trust failed to act on the risks following audits. We noted that a number of audit results were available but that these were not acted upon in a timely manner within this service. Examples of this includes the audit of completion of the ReSPECT form and the audit on the completion of the end of life care pathway. This meant that whilst the trust was in receipt of information on the risks held by the service this was not used to improve services in timely manner.

Areas for improvement

The trust must:

- The service must ensure staff are competent in their roles. This includes but is not limited to the use of the completion of ReSPECT forms and the use of syringe pumps. Regulation 12 (1)(2)(c) and (e): Safe care and treatment.

- The service must ensure that staff have access to the information they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients' individual needs and preferences, including those highlighted on the ReSPECT forms. Regulation 9 (1)(a)(b)(c) and (3)(a)(b): Person-centred care.

- The service must ensure effective systems are in place to share learning from incidents to prevent further incidents from occurring. Regulation 17 (1)(2)(b): Good governance

End of life care

- The service must ensure that when patients are unable to make decisions about their care and treatment, the requirements of the Mental Capacity Act 2005 are consistently followed. Regulation 11 (1)(2) and (3): Need for consent.

- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.

- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing

- The trust must ensure it has full oversight of end of life care services and fully embeds the end of life care team into the governance processes. Regulation 17(2)(a): Good Governance.

- The service must have an electronic system which accurately identifies and tracks end of life and palliative care patients. Regulation 12 (2)(a): Safe Care and Treatment.

Our inspection team

The team included a head of inspection, two inspection managers and four inspectors.

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

The Princess Royal Hospital

Grainger Drive
Appley Castle
Telford
Shropshire
TF1 6TF
Tel: 01952641222
www.sath.nhs.uk

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Ratings

Overall rating for this hospital	Inadequate ●
Are services safe?	**Inadequate** ●
Are services effective?	**Inadequate** ●
Are services responsive?	**Inadequate** ●
Are services well-led?	**Inadequate** ●

Summary of findings

Overall summary of services at The Princess Royal Hospital

Inadequate ● → ←

Our rating of services stayed the same. We rated them as inadequate because:

During this inspection we used our focused inspection methodology. We did not cover all key lines of enquiry. We have rated the service as inadequate and have taken enforcement action as a result of this inspection to promote patient safety. Our enforcement action included the use of our urgent enforcement powers where we placed conditions on the trust's registration in relation to the assessment and management of risk, care planning, and incident management. We also served two warning notices to the trust requiring them to make improvements in the following areas; end of life care staffing, end of life staff competencies, end of life governance systems and the way the staff support patients in line with their personal preferences and individual needs.

- Staff did not keep detailed records of patients' preferences for care and treatment provided at the end of their life. This had not improved since the last inspection.

- The service did not ensure that all staff were competent for their roles, placing patients at risk of receiving unsafe and inconsistent care. This had not improved since the last inspection.

- Staff did not consistently support patients who lacked capacity to make their own decisions.

- The end of life care service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. This had not improved since the last inspection and was identified at our inspection in 2018.

- Specialist palliative care services were not available on site seven days a week to support timely patient care. This had not improved since the last inspection.

- It was possible that palliative and end of life care patients could be missed due to the lack of systems to identify patients. This had not improved since the last inspection.

- Leaders did not demonstrate that they had the skills and abilities to run the services. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.

- The culture of the services was not centred on the needs and experience of patients.

- The services did not operate effective governance systems to improve the quality of services. Leaders had not effectively implemented new ways of working to drive improvement and they were not always available to provide day to day support to staff. This had not improved since the last inspection.

- Staff did not always complete risk assessments for each patient in a prompt manner. Action was not always taken to remove or minimise risks to patient's health and wellbeing. Safety incidents were not always managed well to protect patients from avoidable harm. This had not improved since the last inspection.

Medical care (including older people's care)

Inadequate 🔴 ➔ ⬅

Summary of this service

Our overall rating of this service stayed the same. We rated it as inadequate because:

- Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed. This had not improved since the last inspection.

- Staff did not keep detailed records of patients' care and treatment. Records were not always clear or up-to-date. This had not improved since the last inspection. However, records were stored securely and easily available to all staff providing care.

- The service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

- The service did not always provide care and treatment based on national guidance and evidence-based practice.

- The service did not ensure that all staff were competent for their roles. This had not improved since the last inspection.

- Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. At times, patients continued to be unlawfully restricted. This had not improved since the last inspection.

- The service did not take into account the individual needs and preferences of patients. This had not improved since the last inspection.

- Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.

- The culture of the service was not centred on the needs and experience of patients.

- The service did not operate effective governance systems to improve the quality of services. This had not improved since the last inspection.

Is the service safe?

Inadequate 🔴 ➔ ⬅

Our rating of safe stayed the same. We rated it as inadequate because:

- Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed. This impacted upon the safe care patients received. This had not improved since the last inspection.

- Staff did not keep detailed records of patients' care and treatment. Records were not always clear or up-to-date. This meant that care staff could not easily identify care to be given to individual patients. This had not improved since the last inspection. However, records were stored securely and easily available to all staff providing care.

Medical care (including older people's care)

- Staff did not always report incidents and the service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Inadequate 🔴 →←

Our rating of effective stayed the same. We rated it as inadequate because:

- The service did not always provide care and treatment based on national guidance and evidence-based practice.
- The service did not to ensure that all staff were competent for their roles. This had not improved since the last inspection.
- Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. At times, patients continued to be unlawfully restricted. This had not improved since the last inspection.

Is the service responsive?

Inadequate 🔴 ↓

Our rating of responsive went down. We rated it as inadequate because:

- The service did not take into account the individual needs and preferences of patients. This had not improved since the last inspection.

Is the service well-led?

Inadequate 🔴 →←

Our rating of well-led stayed the same. We rated it as inadequate because:

- Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.
- The culture of the service was not centred on the needs and experience of patients.
- The service did not operate effective governance systems to improve the quality of services. This had not improved since the last inspection.

Detailed findings from this inspection

Is the service safe?

Assessing and responding to patient risk

Medical care (including older people's care)

Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed. This impacted upon the safe care patients received. This had not improved since the last inspection.

The service continued not to complete holistic and effective falls assessments and falls mitigation plans in line with national guidance which placed patients at serious risk of harm. Six of the 12 falls assessments we reviewed were not fully completed, meaning six patients were not appropriately protected from the risk of harm from falling. One of the patients whose falls assessment and mitigation plan was not fully completed had experienced an inpatient fall on ward 10 and experienced harm as a result of this fall.

Staff did not have access to the information they needed to protect patients from the risk of falling. We found that when a risk of falling had been identified, the plans to reduce the risk of harm were not formally recorded in patient records or nursing handover documentation, so some staff were unable to tell us how they kept this cohort of patients safe. For example, a nurse on ward 10 told us a patient who had fallen on the ward required one to one continuous supervision from a member of staff. We asked the staff member who was in the bay where this patient was located how they kept that patient safe and they told us they were not aware that the patient required one to one supervision.

Staff did not manage the risks associated with bed rails which placed people at risk of serious harm. We found that bed rails were used when contraindicated in five of the 12 bed rail assessments we reviewed. In one of these examples, a patient who was acutely confused which is a significant contraindication in the use of bed rails, fell from their bed when bed rails were in situ. This resulted in injury to the patient.

The service continued not to ensure patients were protected from the risk of developing pressure ulcers. Four of the 12 pressure care assessments we reviewed showed patients had evidence of high to very high risk of skin damage. Nursing records also evidenced that these four patients had skin damage ranging from category one to three pressure ulcers. Despite this, none of the four patient's records contained a patient specific skin care plan that detailed how staff should monitor and treat their skin. This meant patients were at risk of suffering a preventable deterioration in their skin.

The service continued not to effectively assess and plan for the risks associated with behaviours that challenged. These behaviours included agitation and aggression. This placed patients and staff at risk of serious harm. Five of the 12 full patient records we reviewed showed that patients with behaviours that challenged had no care plans in place to guide staff on how to safely respond to these behaviours.

The service did not effectively assess and plan for the risks associated with pre-existing conditions that patients were admitted with, placing patients at risk of harm or a deterioration in their pre-existing medical condition(s). For example, two of the patient's whose care we reviewed were admitted to hospital with respiratory conditions that required specialist equipment and treatment. Neither of the care plans for these two patients contained risk assessments or care plans relating to their respiratory conditions. As a result, staff were unable to tell us and care records failed to show if the equipment one of these patients was admitted with to enable them to breathe effectively was used during their inpatient stay. The other patient's condition meant they were at serious risk of harm if their surgical airway (tracheostomy) became blocked. The emergency equipment required in the event of an airway blockage was not available on the ward and staff did not know this was required. After we raised this with staff they did obtain an emergency tracheostomy care kit for the ward. However, the staff member responsible for this patient's care at that time told us they had not been trained to use the kit.

Nursing staff displayed a lack of accountability with regards to their role in assessing and managing patient risk. For example, when we asked a staff member why a patient's care plan did not contain risk assessment and management for their respiratory equipment needs. They told us this should have been completed by the nurse in the acute medical unit. They did not acknowledge their role in assessing and managing this risk as the patient was now their patient on their ward.

Records

Medical care (including older people's care)

Staff did not keep detailed records of patients' care and treatment. Records were not always clear or up-to-date. This meant that care staff could not easily identify care to be given to individual patients. This had not improved since the last inspection. However, records were stored securely and easily available to all staff providing care.

Assessments contained in the nursing documentation were not always completed to ascertain patients' individual needs. Five of the 12 assessment documentation we reviewed contained significant gaps in these assessments. The gaps included important areas of care, such as; vision, hearing, bowel and urological patterns and history and social history. All of which is essential to provide safe, effective and responsive care. This meant patients were at risk of receiving care and treatment that did not reflect their needs.

The service continued not to ensure that the information needed to guide staff in how to provide safe and consistent care was available as the relevant generic care plan options contained within the nursing documentation were not highlighted to show the care each patient required. None of the 12 patient generic care plans we reviewed highlighted the care and treatment each of the 12 patients required to meet their needs. This meant patients were at risk of receiving unsafe and inconsistent care that was not in line with their individual needs.

Patient repositioning charts were not always completed fully to outline patients individual repositioning needs. Four of the 12 patients who were identified as at high or very high risk of skin damage had incomplete repositioning charts in place. This meant we could not be assured that patients were being supported to change their position at a frequency that was in line with their individual needs and best practice guidance.

Daily top to toe skin assessments were recorded for all patients who received assistance with personal care assistance from staff. However, these assessments were not completed accurately so did not effectively record the condition of individual patient's skin. Where wounds were present, this documentation also lacked detail as to the size and depth of the wound. This meant that a nurse could not assess if patient's skin was improving or deteriorating.

We found that where catheters were used, catheter care plans or passports were not in place to record when the catheter should be reviewed or changed. We reviewed the records of two patients on ward 10 who had urinary catheters insitu. We found that accurate records detailing the reason for catheterisation and catheter review dates were not always completed for both patients. For example, the records of one of these patients showed they had a catheter insitu for nine days, however, on eight of these nine days the documentation that should have showed the reason for catheterisation and review date was blank. This meant the information needed to guide staff on how to provide safe catheter care was not always available, placing patients at risk of unsafe care.

We found that records did not contain an accurate account of the care patients had received. For example, on ward 10 the falls documentation had been signed by staff to show that lying to standing blood pressure readings had been taken. However, staff were unable to evidence that these blood pressure readings had been taken as these readings were not recorded in the patients' records.

The staff continued not to always follow the trust and their professional bodies best practice guidance for record keeping. It was not always clear which staff had assessed and treated patients as records did not always contain a clear record of the staff members name and role who had completed the written entry. Dates and times of written entries were also not consistently recorded to demonstrate an accurate timeline of patients' care.

Incidents

Staff did not always report incidents and the service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

Medical care (including older people's care)

This inspection was triggered by a never event that had occurred on a medical ward at the Royal Shrewsbury Hospital site. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Following the never event, the trust told us that a patient safety alert had been sent to staff to highlight the never event and share learning to prevent a similar incident from reoccurring. We asked 13 members of staff on wards nine and 10 if they were aware of the recent never event.

Only one of the 13 members of staff were aware of the incident and the learning from it. This meant that the systems in place to manage safety incidents were not always effective.

We found that staff did not identify the safety concerns we identified as incidents. Therefore, these incidents were not reported. For example, the lack of appropriate risk assessment and management plans and the poor record keeping were not reported as incidents. This meant learning from these incidents could not take place to improve safety and care.

Is the service effective?

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

We found that the trust's falls and pressure ulcer policy was not based on the most up to date national guidance.The trust's, 'Slips, Trips and Falls Policy' which was last updated and approved in February 2020 continued to reference the National Institute for Health and Care Excellence (NICE) falls guidance for older people from 2004. This guidance has been replaced and the latest NICE guidance recommends that falls prediction tools are no longer used to identify if older people are at risk of falling. These prediction tools should have been replaced with multifactorial assessments for all patients who are 65 and over. We found that this new guidance was not being followed to ensure all patients aged 65 and over had a multifactorial falls assessment and intervention plan.

The trust's, 'Pressure Ulcer Prevention and Management Policy' which was last updated in February 2019 following the February 2019 NICE update. However, we found that this policy did not fully reflect best practice. For example, the need to consider all pressure ulcers as potential serious incidents dependent upon individual circumstances. The policy referred to only reporting grade three and four pressure ulcers as serious incidents. The policy does not reflect that a grade two pressure ulcer could meet the serious incident reporting criteria under certain circumstances. This meant NHS England serious incident guidance was not accurately incorporated into the policy.

Competent staff

The service did not to ensure that all staff were competent for their roles. This had not improved since the last inspection.

On ward nine a nurse responsible for the care of a patient with a tracheostomy told us they had not been trained to use the emergency tracheostomy care kit. This placed that patient at significant risk of harm in the event of a medical emergency involving their tracheostomy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. At times, patients continued to be unlawfully restricted. This had not improved since the last inspection.

Medical care (including older people's care)

Staff continued to not always follow the requirements of the Mental Capacity act 2005 (MCA) to ensure decisions about care and treatment were made in patient's best interests when they were unable to make these decisions for themselves. On ward 10 we saw two patients were receiving

sedative medicines to control and restrict their behaviours. No mental capacity assessment or best interest decisions were completed to ensure this treatment was in their best interests.

The service continued to not consistently ensure that patients were only deprived of their liberty in line with the Deprivation of Liberty Safeguards (DoLS). We found that a patient on ward nine and a patient on ward 10 were both being unlawfully deprived of their liberty. Both patients were acutely confused and unable to make decisions about their care and treatment and both were prevented from moving freely around their wards. Neither patient had a DoLS application in place or in progress.

On ward 10, two of the patient records we reviewed contained DoLS applications which showed staff had completed appropriate applications. However, one of these patients had previously been admitted to the ward in May 2020. Records from that admission showed there was a four-day delay in applying for their DoLS which meant they were unlawfully restricted for a four-day period. We also saw that the mental capacity assessment required for the DoLS was completed the day after the DoLS application was made. This meant that the requirements of the MCA and DoLS were not consistently followed correctly and in a timely manner.

Staff continued to inform us they had not completed training in MCA and DoLS. For example, only one of the six staff members we spoke with on ward nine told us they had completed this training. Staff on this ward told us they would seek advice from their ward manager if they suspected a patient required a DoLS application. However, at the time of our inspection, the ward manager on ward nine had not been in work for a four-week period. This meant that at the time of our inspection, the support system staff described to us on ward nine around DoLS was not effective.

Is the service responsive?

Meeting people's individual needs

The service did not take into account the individual needs and preferences of patients. This had not improved since the last inspection.

Patients continued to be at risk of receiving care and treatment that was not person centred as assessments to ascertain patients' care preferences and individual needs were not completed. None of the 12 care assessment and care plans we reviewed contained any record of patients care preferences or individual care needs. For example, the care records for five patients who displayed behaviours that challenged, such as agitation and aggression, contained no information about their likes or interests that could be utilised to help staff manage these behaviours in an effective manner.

The service continued to not support patient's with acute confusion to be orientated to time and place. For example, on ward 10 we saw that two patients with acute confusion were located in a

bay where the orientation board was not updated. The month on the board stated it was May which meant staff had not updated the board for at least 10 days.

The preferences of patients at risk of falling were not always considered. The falls prevention practitioner told us they were aware that these patients were often nursed in bed. On ward 10, we saw a patient that was at risk of falling attempting to stand up from their chair. The member of staff did not attempt to find out why the patient wanted to stand up but instead insisted the patient sat back down. This demonstrated a lack of understanding of the patient's needs and a lack of application of a person-centred approach.

Medical care (including older people's care)

Is the service well-led?

Leadership

Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.

Many of the concerns we identified at this inspection were ongoing concerns that had been identified at previous inspections and had not been effectively addressed. For example, we reported concerns with the lack of effective falls risk assessment and mitigation plans at our 2018 and 2019 inspections. However, leaders had not effectively driven the safety and quality improvements that were required to address this.

Leaders were not always visible or available. Staff on ward nine told us their ward's purpose had significantly changed during the Covid 19 pandemic as it had moved from a predominantly respiratory ward to a short stay admissions ward. They also told us their ward manager had been absent from work for a four-week period and that no interim leadership was put in place to ensure this team were consistently and appropriately supported. This meant the day to day leadership support that staff required was not always available. For example, some ward nine staff told us they would seek advice from their ward manager when they needed advice and support reading DoLS applications. However, this advice could not be sought when the ward manager was absent.

Culture

The culture of the service was not centred on the needs and experience of patients.

We saw that the lack of appropriate risk assessment and care planning had been normalised on the wards we inspected. Staff at all levels did not recognise that this failure to adequately assess and plan patient care led to practice that was unsafe and uncaring.

We found that there was a normalisation of poor care and a complacency around professional curiosity and challenge. For example, nursing staff and allied healthcare professionals did not challenge medical staff when decisions were made about care or did not contain evidence of patient's individual preferences. Furthermore, we found that staff did not challenge one another when they witnessed witnessed poor care or documentation of that care. For example, where body maps,used to highlight areas of pressure damage, were marked with a simple x on the area affected and there was no documentation as to what this meant staff did not challenge their colleagues to complete the document appropriately so that care given could be assessed for impact.

Governance

The service did not operate effective governance systems to improve the quality of services. This had not improved since the last inspection.

There was an absence of effective audit of care documentation to ensure the quality of the information contained in care records was person centred and appropriate. For example, action had not been taken to ensure nursing assessments were completed correctly or to ensure care plans were in place to ensure staff had access to the information they needed to keep people safe. Following our inspection, the trust told us they had reintroduced their exemplar ward reviews (the trust's own quality and safety assessment tool). The use of the exemplar ward reviews had been paused due to inspection activity and the Covid 19 pandemic. We will assess if this has been an effective governance tool at our next inspection'

We saw that there was a lack of learning from previous incidents. We spoke to a specialist nurse about the trust's improvement plan following a prosecution of the trust by the Health and Safety Executive in 2017, in regard to patient

Medical care (including older people's care)

falls. Prior to inspecting the trust, we reviewed a number of recent incidents relating to falls at the trust and found the same issues reported as had been highlighted in the prosecution summary judgement. For example, a lack of staffing, poor risk assessments, poor documentation of care and poor falls management. At this inspection we found the same issues on the medical wards were still evident in the care that was given to patients at risk of falling. This compounded our concerns that the trust failed to learn from significant incidents.

The service did not have timely and effective actions in place in their improvement plan to appropriately address all previous inspection findings and concerns. For example, our 2018 and 2019 inspections identified a lack of person-centred care planning. The trust's 2020 action plan recorded an associated action to address this which stated, 'patients must have their individual needs assessed and planned for'. The action plan recorded that this was to be addressed by, 'implementing new nursing documentation to include individual needs'. This action was to be completed by June 2020. Other than introducing new documentation, no other interim action, such as; staff training, care record audits etc had been planned or introduced to address the significant and ongoing shortfalls in patient centred care planning whilst awaiting new documentation to be rolled out.

Areas for improvement

The trust must:

Ensure effective systems are in place to assess and mitigate individual patient safety risks. This includes, but is not limited to; bed rails, falls, pressure care, pre-existing medical conditions and behaviours that challenge. Regulation 12 (1)(2)(a) and (b): Safe care and treatment.

Ensure complete and accurate records are maintained that describe the care and treatment delivered to individual patients. Regulation 17 (1)(2)(c): Good governance

Ensure effective systems are in place to share learning from incidents to prevent further incidents from occurring. Regulation 17 (1)(2)(b): Good governance

Ensure staff are competent in their roles. This includes but is not limited to the use of; equipment to meet individual needs and care planning. Regulation 12 (1)(2)(c) and (e): Safe care and treatment.

Ensure that when patients are unable to make decisions about their care and treatment, the requirements of the Mental Capacity Act 2005 are consistently followed. Regulation 11 (1)(2) and (3): Need for consent.

Ensure that people are only deprived of their liberty in a lawful manner, by following the deprivation of Liberty Safeguards. Regulation 13(5) Safeguarding service users from abuse and improper treatment.

Ensure that staff have access to the information they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients' individual needs and preferences, including needs relevant to the formulation of care plans and mental health needs where appropriate. Regulation 9 (1)(a)(b)(c) and (3)(a)(b): Person-centred care.

Ensure effective systems are in place to consistently assess, monitor and improve patient safety and the quality of care. Regulation 17 (1)(2)(a) and (b): Good governance.

The trust should:

Review the systems in place to ensure staff are consistently supported in the absence of a ward manager.

End of life care

Inadequate 🔴 ⬇

Summary of this service

Our overall rating of this service went down. We rated it as inadequate because:

- Staff did not keep detailed records of patients' preferences for care and treatment provided at the end of their life. This had not improved since the last inspection.

- The service did not ensure that all staff were competent for their roles, placing patients at risk of receiving unsafe and inconsistent care. This had not improved since the last inspection.

- Staff did not consistently support patients who lacked capacity to make their own decisions.

- The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. This had not improved since the last inspection and was identified at our inspection in 2018.

- Specialist palliative care services were not available on site seven days a week to support timely patient care. This had not improved since the last inspection.

- It was possible that palliative and end of life care patients could be missed due to the lack of systems to identify patients. This had not improved since the last inspection.

- Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced.

- The culture of the service was not centred on the needs and experience of patients.

- The service did not operate effective governance systems to improve the quality of services. Leaders had not effectively implemented new ways of working to drive improvement and they were not always available to provide day to day support to staff. This had not improved since the last inspection.

Is the service safe?

Inadequate 🔴 ⬇

Our rating of safe stayed the same. We rated it as inadequate because:

- Although the service had enough suitable equipment to help them care for patients it was unclear if these were available in a timely manner.

- Staff did not consistently complete and updated risk assessments for each patient. The service did not consistently identify patients in the last days or hours of their life.

- The service did not have enough nursing and support staff to keep patients safe.

- The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- The service did not always have a consultant on call during evenings and weekends. Staff could telephone a local hospice for advice and support. However, there was no formalised agreement for this in place.

End of life care

- Staff did not always report incidents and the service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

Is the service effective?

Inadequate 🔴 ⬇

Our rating of effective stayed the same. We rated it as inadequate because:

- Staff did not routinely monitor the effectiveness of care and treatment. They did not use the findings to make improvements and achieve good outcomes for patients. The service had not been accredited under relevant clinical accreditation schemes. The service did not audit pain and symptom control or time taken for fast track audits.

- The service did not to ensure that all staff were competent for their roles. This had not improved since the last inspection.

- Key services were not available seven days a week to support timely patient care.

- Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. This had not improved since the last inspection.

Our rating of caring CHOOSE A PHRASE. We rated it as CHOOSE A RATING because:

Our rating of responsive CHOOSE A PHRASE. We rated it as CHOOSE A RATING because:

Is the service well-led?

Inadequate 🔴 ⬇

Our rating of well-led went down. We rated it as inadequate because:

- Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.

- The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy had not been ratified by the board at the time of our inspection.

- The culture of the service was not centred on the needs and experience of patients.

- The service did not operate effective governance systems to improve the quality of services. This had not improved since the last inspection.

- Leaders and teams did not use systems to manage performance effectively. They had not identified and escalated all relevant risks and issues nor had they identified actions to reduce their impact.

End of life care

Detailed findings from this inspection

Is the service safe?

At the time of our inspection, there was no dedicated end of life care ward at the trust. Patients in receipt of end of life care were cared for throughout the hospital.Prior to 05 June 2020 the trust did have an end of life care ward but this had been closed due to the realignment of the wards to accommodate Covid 19 arrangements.

Environment and equipment

Although the service had enough suitable equipment to helpto care for patients it was unclear if these were available in a timely manner.

The service used specialist syringe pumps for patients who required a continuous infusion of medication to help control their symptoms. These met the current requirements of the Medicines and Healthcare Regulatory Agency (MHRA) for end of life care patients who required continuous symptom management. On review of the incidents reported this year we noted three relating to the delay in providing patents with a syringe pump for medications to be given resulting in a potential delay in pain relieving medication being given.

Assessing and responding to patient risk

Staff did not consistently complete and updated risk assessments for each patient. The service did not consistently identify patients in the last days or hours of their life.

We discussed how patients wishes were reflected on the end of life care pathway with the specialist team. We were told that this aspect of the ReSPECT form was not well completed and that this information would be captured on the end of life care plan for patients at the end of their life. However, minutes of meetings reviewed demonstrated that the use of this tool was only 30%.

We found that patients end of life care preferences had not always been recorded in accordance with local and national guidance. Five of the nine ReSPECT forms we reviewed contained no record of the patient's end of life care preferences.

The service continued to not have an effective system in place to track patients who were in receipt of palliative care or end of their life care. This meant these patients were at risk of not receiving care appropriate to their needs.

We received one complaint about care provided to an end of life care patient from this hospital. This complaint included the fact that staff did not listen to the patient and provide for their individual needs at the end of their life.

Nurse staffing

The service did not have enough nursing and support staff to keep patients safe.

End of life care was provided by an end of life care team. The service also had a specialist palliative care team. These teams worked throughout the Princess Royal Hospital and the Royal Shrewsbury Hospital.

The end of life care team consisted of a whole time equivalent (WTE) end of life care facilitator and three end of life care nurses who provided the equivalent of 1.8 (WTE) staff. The end of life covered across sites from 8.30am to 16.30am Monday to Friday. Out of hours cover was provide through an on-call service at a local hospice.

The specialist palliative care team consisted of four clinical nurse specialists (CNS) who provided the equivalent of 3.8 WTE cover for the specialist palliative care team. The four nurses worked across sites and provided a service Monday to Friday from 9am to 5pm.

End of life care

Nurse staffing levels did not meet the minimum standards of the National Institute of Health and Care Excellence (NICE) which states access to specialist palliative care should be made available seven days per week.

There were no specific handovers from the specialist palliative care team (SPCT) and the end of life care team to the nursing and medical staff.

At our inspection in November 2019 we found breaches in staffing levels not in line with guidance from the National Institute of Health and Care Excellence. However, the trust's most recent action plan, received 23 July 2020 did not contain updates on the action the service had taken to improve nursing staff levels within the team.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not always have a consultant on call during evenings and weekends.

One palliative medicine consultant was employed by a local hospice who provided the equivalent of 0.8 whole time equivalent (WTE) cover at the trust. This did not meet the minimum standards of the Royal College of Physicians (RCP), which requires 1.4 WTE consultants based on the size of the trust and level of patient activity. At the time of our previous inspection, In November 2019, the trust had started the recruitment process to employ a new consultant to provide an extra 0.5 WTE across both sites. This post had still not been recruited into at our June inspection.

Incidents

Staff did not always report incidents and the service did not always manage patient safety incidents well. Safety incidents and lessons learnt were not always shared with staff to prevent further incidents from occurring. Managers did not always ensure that actions from patient safety alerts were implemented and monitored.

At our previous inspection in November 2019 we were told that since the 2018 inspection the trust had introduced a category for end of life care incidents. This meant relevant staff could identify, track and analyse incidents relating to end of life and palliative care patients. We asked the trust for incidents relating to end of life care from 01 January 2020 to the present date, as on our review we could not see a category for end of life care. The trust sent us details of 14 incidents which had been reviewed as end of life care incidents. We reviewed the incidents submitted to national databases by the hospital and found that no incidents were specifically reported under an end of life care category. However, we found between 1 January and 20 July 2020, we found that there were at least 34 incidents reported involving patients at the end of their life. Eight of these related to poor management of pain, medication or access to syringe drivers. Five incidents related to patients not being transferred to the correct ward and five related to pressure area care. The remaining 16 incidents related to poor care planning.

On review of the spreadsheet sent by the trust all but one of the incidents were incidents that we had reviewed. The spreadsheet had a description of the incident, immediate action taken, details of the investigation and lessons learnt. However, the lessons learnt pertained only to the individual member of staff or patient and the wider lessons had not been identified except in one case where the policy for admission to ward 35 had been amended. Four incidents involved delays in transferring the patient and three related to no support being available to staff. All incidents were graded as low or no harm despite the results being recorded as; delay in diagnosis and treatment, ongoing pain, disruption to the service and no injury, harm or adverse outcome.

This meant the hospital was not monitoring all incidents that occurred within this service. The service was also failing to share the lessons learnt in these incidents with the wider hospital team. The end of life care safety meeting minutes from February 2020 demonstrated that an incident had been discussed at the meeting. However, this was not one on the spreadsheet by the trust. The minutes also highlighted there were issues with staff using the end of life care category when reporting incidents.

End of life care

Is the service effective?

Evidence-based care and treatment

Staff did not routinely monitor the effectiveness of care and treatment. They did not use the findings to make improvements and achieved good outcomes for patients. The service had not been accredited under relevant clinical accreditation schemes. The service did not audit pain and symptom control or time taken for fast track audits.

Managers and staff did not carry out a comprehensive programme of audits to check improvement over time. On reviewing the Quality Improvement plan sent to the CQC in July 2020 the action to establish an audit plan for this service was still in progress.

At our inspection in November 2019 we found that the service recorded patient information onto an electronic data base, including the patients preferred place of death, however, the service did not audit this information. We noted from the results of audits that the trust sampled whether the patients preferred place of death was recorded and how many patients achieved this. However, there was no record of whether all patients achieved their preferred place of care and the time taken to move patients into their preferred place of care. The lack of cohesion between the specialist palliative care team and the end of life care team did not help the movement of patients and information between these two services.

At our inspection in November 2019 we found that the service did not audit pain or symptom control for end of life care patients, this meant the service was unable to tell if pain and symptom control was effective or if improvements could be made for end of life care patients in their care. This had not improved since our last inspection. We received one complaint where a patient had not been prescribed adequate pain relief to meet their needs. The staff did not review the effectiveness of the medication or discuss the medication this patient was on at home and provide this whilst in hospital. This patient was not offered regular analgesia nor was a syringe pump offered to manage their pain. This had not improved since our last inspection.

At our inspection in November 2019 we found that the service did not have a comprehensive audit programme undertaken by the service, which meant that care was not improved as a result. This had not improved since our last inspection. We reviewed the minutes of the End of Life Steering Group for February 2020 and saw that the trust planned to audit mouthcare, care after death and use of syringe pumps. We did not receive any data from the trust on these audits.

The trust confirmed that they had undertaken a "Spot Check on End of Life Care plan". This audit was undertaken in June 2020. A previous audit was carried out in January 2020 but this does not appear to have been discussed at the February End of Life Safety and Governance Meeting. The audit reviewed seven sets of notes at this location. Due to the way in which the report is collated it was not possible to identify all of the results for this location. The results demonstrated that all patients were on the end of life care plan. Most patients had a ReSPECT form completed prior to being commenced on an End of Life Care Pathway. Four patients out of seven records reviewed did not have a documented conversation with the patient around their preferences for end of life care. However, there was a documented discussion with the family or relatives of the patient in all records. Three sets of records did not have a preferred place of care recorded. Only two of the seven records had all sections of the end of life care plan completed. This was worse than the previous audit. The action to be taken following the audit was to improve compliance through training. However, at the point at which this report was written, March 2020, compliance with the eLearning package was 50%.

The latest data from the National Audit for Care at the End of Life (NACEL) was published on 9 July 2020. The audit presents results against seven themes. For six themes, performance is calculated by aggregating scores from a series of

End of life care

questions and converted to a score out of 10 for each theme. In comparison against the national average the Princess Royal Hospital seem to perform relatively poorly in three of the four measures they have results for. These include communication with the dying patient, communication with family and others and individualised care planning. In the remaining theme Workforce/specialist palliative care performance is towards the national average.

We reviewed the minutes of the End of Life Steering Group for February 2020 and found the local audit in the use of the service's end of life care plan had increased from 15% to 30%. A further audit was planned around the time of our inspection. This meant that only three out of ten patients who were receiving end of life care had a plan to follow specifically for them at the end of their life. Following the inspection, the trust sent us this audit. This showed that 37% of patients there was uncertainty if the patient would die during this admission and active treatment was continued. Of the notes reviewed only 21% had the palliative care team involved in their care and 9% had the end of life care team involved in their care. This was despite 97% of patients being recognised by staff that they may die and only 6% of patients having had a conversation with staff about the fact that they may die. The audit results reflected that conversations about the patients death was more likely to be had with the patients family or relatives (81%). The audit demonstrates that 30% of patients were placed on the end of life care plan. Only one patient was involved in planning their care at the end of their life. 48% of records reviewed demonstrated that neither the patient nor the family were involved in planning the care at the end of a patient's life. This means that the patient was not involved in their care at the end of their life and did not have the support of specialist nurses.

This audit demonstrates that anticipatory medications were prescribed for around 60% of patients to support their potential discomfort. However, a syringe pump, to assist consistent pain management, was only used in 19% of patients. The preferred place of care was discussed with 30% of patients and carers. In most (90%) cases this was discussed with the patient's carer. In 60% of patients the preferred place of care was not achieved. The free text of this audit highlights that staff are not recognising patients at the end of their life in a timely manner, once recognised there were delays in an end of life pathway being commenced. We were not sent an action plan following this audit to improve the recognition of patients at the end of their lives or in ensuring that they received appropriate care. It is therefore unclear how the trust is planning to improve the care given to patients at the end of their life.

The trust undertook an audit of the completion of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form in January 2020. This demonstrated that:

- The patients' personal preferences for care were only documented 62% of the time.

- Over 30% of clinicians did not give recommendations for emergency care and most did not provide clinical guidance on appropriate interventions.

- In all cases the clinician identified if cardiopulmonary resuscitation (CPR) was recommended and in all but one case the patients were not recommended for CPR.

- Over 90% of ReSPECT forms had section 6 completed but less than half had documented who was involved in the discussion.

- Where a patient was recorded not to have capacity only one patient out of 67 had the appropriate legal documentation to support this decision.

Whilst this audit made recommendations for improvement this was not presented at the Quality Operational Committee until 16 June 2020. However, in discussion with senior executives the outcomes of this audit were known. This meant that we were not assured that actions and learning from audits were implemented in a timely manner to ensure improvements to practice could be made.

End of life care

Following our inspection, the trust sent CQC a Clinical Audit action plan, 24 July 2020, which centred on training and raising awareness of the ReSPECT form and the audit. Eight actions were colour coded green but rated as recommendation never actioned. Three actions were marked as amber, action in progress and one action coloured red and rated as recommendation agreed but not yet actioned. It was difficult to see how the trust had implemented this action plan given that some completion dates were marked as the end of July 2020.

The trust told us that training in the use of the ReSPECT form was incorporated into resuscitation training. Current compliance for this training which is a two year rolling compliance figure is 79%. However, the ReSPECT form was only introduced at the end of October 2019. Therefore, this figure would include staff where this training had not included information on the ReSPECT form. The trust introduced an eLearning package which 257 staff had completed. Furthermore, the lead resuscitation officer had trained 29 people. The end of life care team were not involved the provision of this training.

The trust undertook a bereavement survey between April 2019 and March 2020. This demonstrated that relatives had had discussions with staff about the fact that their loved one may die. However, only 45% of relatives were involved in planning the care with the care staff during the last days of their loved ones life. Most relatives (80%) felt that their loved one had received appropriate care. The survey identified some areas requiring improvement, including discussion with the patient about where they wanted to die (45%), use of the end of life plan (57%) and provision of the information leaflet (23%). It is clear that the relatives of the patient felt that care was appropriate, but this is not reflective of the evidence in the case notes audited by the trust.

Competent staff

The service did not to ensure that all staff were competent for their roles. This had not improved since the last inspection.

Staff told us they had not received effective training to enable them to use Recommended Summary Plans for Emergency Care and Treatment (ReSPECT) forms in line with national and local guidance. ReSPECT forms are designed to provide a summary of a patient's end of life care wishes which includes resuscitation decisions. ReSPECT forms had been rolled out at the trust in 2019 but no effective and measurable training programme was in place. This meant the trust could not assure themselves or us of how many staff had been trained and were competent in the use of ReSPECT documentation.

On ward seven, the ward manager could not tell us how many staff on the ward had received training to enable them to administer medication to patients at the end of their life through a syringe pump. A syringe pump is a small infusion device that is used to administer a continuous infusion of medication from a syringe. Following our inspection, the trust shared with us the training numbers for syringe pumps up to the date of our inspection. This demonstrated 40% of eligible staff on ward seven had completed this training. However, in some areas, such as ward four, the training compliance rate was 10%. This meant there was a risk that patients may not receive their medication through a syringe driver in a timely manner as not enough staff had been assessed as competent in many of the wards throughout the hospital. Following our inspection, the trust sent CQC an action plan for the training of staff in using the syringe pumps. This highlighted that it would be incorporated into further intravenous study days, reports on training would be made available for the ward managers and train the trainer sessions would continue. The action plan stated that the trust were looking in to providing an eLearning package for staff. It was not clear who had approved this plan.

Seven-day services

Key services were not available seven days a week to support timely patient care.

When we inspected the trust in 2018, we told the trust they should ensure it provided and meets the recommendations for a minimum service level for access to specialist palliative care as recommended by the National Institute of Health and Care Excellence (NICE), which is 9am to 5pm, seven-days per week.

End of life care

We re-inspected the service in November 2019 and found the hours of the service had not increased. This meant the trust was not providing a minimum service level for access to specialist palliative care as recommended by NICE. The trust still only provided nursing staff to offer a specialist palliative care service Monday to Friday from 9am to 5pm. Again, we told the trust it should provide its specialist palliative care services seven days a week in line with NICE guidance.

Following a review of the service in July 2020, we found the service operated between 8.30 and 5pm Monday to Friday with on call support from a local hospice. This lack of seven-day provision was included on the services risk register. The minutes of the end of life care steering group, February 2020, reported that there was no update. However, data was being gathered to support a business case. This had not improved since our previous inspection.

On reviewing the Quality Improvement plan sent to the CQC in July 2020 the action to establish a service level agreement with the hospice was still in progress

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not consistently support patients who lacked capacity to make their own decisions or were experiencing mental ill health in line with legislation and national guidance. This had not improved since the last inspection.

We found that mental capacity assessments were not always completed in accordance with the Mental Capacity Act (MCA) when patients were unable to make decisions about their end of life care needs. We reviewed seven ReSPECT forms. Four of these forms related to patients who staff told us did not have capacity to make decisions about their care and treatment. However, the records for these four patients contained no evidence to show mental capacity assessments had been completed. This meant that the requirements of the MCA had not been followed to evidence these patients did not have the capacity to make these decisions and that these decisions were made in their best interests.

We discussed how the medical staff assess a patients' mental capacity when completing the ReSPECT form with the specialist nurse. We were told that there was a separate form to complete. We reviewed nine patients, three of whom were deemed to lack capacity to make decisions, however, no formal mental capacity assessment had been completed. A further patient had not indication that their mental capacity had been considered at all. The specialist nurse told us that even when a patient had capacity to make a decision about their care it was good practice to discuss the proposed care with the family in order to ascertain what the patient was like at home or if they had any concerns about the decision of the patient.

Is the service well-led?

Leaders did not demonstrate that they had the skills and abilities to run the service. They did not demonstrate that they understood and managed the priorities and issues the service faced.

Leadership

End of life care and specialist palliative care services sat within the division of scheduled care. Scheduled care was led by a medical director, an assistant chief operating officer and a head of nursing.

At board level, the chief nurse and the chair were the executive leads for the end of life care and specialist palliative care services throughout the trust. However, the chief nurse had only just assumed this responsibility and was not aware that the end of life care strategy was in draft format. The end of life care team was directly managed by the matron for oncology and haematology. On reviewing the most up to date Quality Improvement Plan (QIP) for the trust sent in July 2020 the action update in respect of leadership stated that a non-executive director was required to lead this service. Yet this action is marked as completed on the QIP.

End of life care

The executive lead for end of life care did not attend the steering group meetings prior to June 2020 and end of life care was not discussed at the trust's board meetings

Leaders did not effectively introduce new ways of working. For example, the roll out and implementation of the ReSPECT form was not robust which led to staff not having an adequate understanding of this process. Staff told us that despite there being an implementation plan and policy, no resource was allocated for education. Doctors we spoke with told us they received some training through their grand rounds where they reflected on clinical cases. Nurses told us they had received minimal training and did not feel confident in the use of the ReSPECT forms.

Vision and strategy

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy had not been ratified by the board at the time of our inspection.

We were told at our previous inspection that there was an end of life care strategy. We asked the trust for their end of life care strategy and action plan. The strategy was still in draft form and there was no action plan. Staff told us the strategy had been developed approximately 18 months prior to our inspection. This had been taken to the Clinical Governance Executive Group in November 2019 to be endorsed. Minutes of the meeting concurred that an end of life care strategy should be implemented in early 2020 and discussed at the next board meeting. However, at the time of our inspection, the strategy had not been discussed at any board meeting, it had not been endorsed, signed off by the board or implemented.

There were two teams of specialist staff who were responsible to provide specialist knowledge and experience to general staff. The end of life care team supported people who had days or hours of life left. The specialist palliative care that helped staff in the management of patients who had weeks or months of their life left. It was not clear how information form either team was passed between the teams to improve the patient and carer's experience of a dying patient.

Culture

The culture of the service was not centred on the needs and experience of patients.

We found that there was a deference to medical staff held by nursing staff. When we questioned a specialist lead about how patient wishes were captured in respect of resuscitation, we were told that patients cannot demand treatment and that it was the doctor's decision if a patient should be resuscitated. When discussing the poor completion of ceilings of care area on the ReSPECT form we were told that it was everyone's responsibility to complete this. When asked if there was an action plan to address this failing, we were told that during the COVID pandemic that awareness had been highlighted but that the specialist nursing time is limited. This raised concerns around the culture of service. This highlighted the acceptance of poor care and the poor understanding of the ReSPECT form's purpose.

We saw in the patient records we reviewed and the audits from the trust demonstrated that there was a lack of communication between staff and the patient who was dying. Whilst we appreciate that this may not always be possible in the last days and hours of a patients life there was an apparent reluctance to do this. However, most families or carers had been spoken to about the fact that the patient was dying and what their wishes were during this time. When we spoke to the lead nurse we were told that they believed that even when a patient had capacity to make decisions staff should talk to the family to see if they have any concerns or what the patient is usually like. This meant that whilst the family were involved in discussions there was little acknowledgement that the patient may have different wishes to those of their family. There was a culture of not involving the patient in decisions made about their care.

Governance

End of life care

The service did not operate effective governance systems to improve the quality of services. This had not improved since the last inspection.

Minutes of the Clinical Governance Executive Group in November 2019 highlighted that there was a lack of medical staff compliance with completion of the end of life care pathway. Patients had been either late to start on the end of life care pathway or they had not commenced this at all. The minutes state that "End of life care is not consistent across all areas and it is important that everyone delivers. The action pertaining to these comments was to check what training had been delivered and report back. However, in subsequent minutes there was no further update. This was corroborated in the Healthwatch End of Life Report, January 2020, which stated that people had a poor experience until the care staff at the hospital recognised that the patient was at the end of their life when the experience improved.

We reviewed the minutes of the End of Life Steering Group for December 2019 and February 2020 and found that whilst there was some improvement between December 2019 and February 2020 on the training of medical staff to address the medical staff completion of the end of life care pathway and the ReSPECT forms there was little traction on other issues discussed at these meetings.

The service continued not to take timely and effective action in response to quality and safety audits where concerns or poor compliance was identified. For example, effective action had not been taken in response to an audit of ReSPECT documentation completed in January 2020. At the time of our inspection, four months had lapsed, and the senior leadership team had been aware of the results of the ReSPECT audit but had taken no action to make improvements in its application.

Action plans sent by the trust following our inspection were not clear as to whether action had been taken or embedded. The Clinical Audit Action plan updated 21 July 2020 had items listed as being complete but had a rating of 4 which meant recommendation never actioned. This document also had actions such as roll out of training which had commenced but had not been fully embedded having only started in June or July. The Quality Improvement Plan, updated in July 2020, stated that there was a requirement for a non-executive end of life care lead but the chair told us it was him at our inspection in June 2020.

The trust told us that they had had nine complaints since January 2020 in respect of the end of life care service of which three related to the Princess Royal Hospital. The themes from these complaints included poor communication with the family, delays in medication and poor communication around resuscitation.

Managing risks, issues and performance

Leaders and teams did not use systems to manage performance effectively. They had not identified and escalated all relevant risks and issues nor had they identified actions to reduce their impact.

The current risk register for end of life care had three risks on it. These were in relation to training around the mental capacity act and deprivation of liberty safeguards, the provision of specialist consultant input and the risk that the end of life care and palliative care team were not sufficient to meet the needs of patients. When we asked for the detail of these risks we were provided with only two risks the sufficiency of the service to meet demand had been on the risk register since April 2019 and had not been updated since November 2019. The shortage of specialist consultant staff had last been updated in November 2019 and interviews were due to take place in January. However, at the time of our inspection there was no new appointee in place. The risk in relation to training around the mental capacity act and deprivation of liberty safeguards was not on this "detailed" information. There were no risks related to auditing or training on specific end of life care issues.

The trust failed to act on the risks following audits. We noted that a number of audit results were available but that these were not acted upon in a timely manner within this service. Examples of this includes the audit of completion of the ReSPECT form and the audit on the completion of the end of life care pathway. This meant that whilst the trust was in receipt of information on the risks held by the service this was not used to improve services in timely manner.

End of life care

Areas for improvement

The trust must:

- The service must ensure staff are competent in their roles. This includes but is not limited to the use of the completion of ReSPECT forms and the use of syringe pumps. Regulation 12 (1)(2)(c) and (e): Safe care and treatment.

- The service must ensure that staff have access to the information they need to provide person centred care. This includes the maintenance of complete and accurate records that describe patients' individual needs and preferences, including those highlighted on the ReSPECT forms. Regulation 9 (1)(a)(b)(c) and (3)(a)(b): Person-centred care.

- The service must ensure effective systems are in place to share learning from incidents to prevent further incidents from occurring. Regulation 17 (1)(2)(b): Good governance

- The service must ensure that when patients are unable to make decisions about their care and treatment, the requirements of the Mental Capacity Act 2005 are consistently followed. Regulation 11 (1)(2) and (3): Need for consent.

- The service must ensure nurse staffing levels meet the minimum standards of the National Institute of Health and Care Excellence. Regulation 18 (1): Staffing.

- The service must ensure medical staffing levels meet the minimum standards of the Royal College of Physicians. Regulation 18 (1): Staffing

- The trust must ensure it had full oversight of end of life care services and fully embeds the end of life care team into the governance processes. Regulation 17(2)(a): Good Governance.

- The service must have an electronic system which accurately identifies and tracks end of life and palliative care patients. Regulation 12 (2)(a): Safe Care and Treatment.

Our inspection team

The inspection team consisted of a head of inspection, two inspection managers and four inspectors.

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment