Bundle Quality, Safety & Experience Committee 3 November 2020

10.00am Via Webex Conferencing

Public Session

0 Note - Pre Meeting of Independent Members to take place at 09:30

1.0 OPENING BUSINESS AND EFFECTIVE GOVERNANCE

1.1 10:00 - QS20/186 Chair's Opening Remarks

1.2 10:01 - QS20/187 Declarations of Interest

1.3 10:02 - QS20/188 Apologies for Absence

Arpan Guha (Kate Clark deputising)

1.4 10:03 - QS20/189 Minutes of Previous Meeting Held in Public on 28th August 2020 for Accuracy, Matters Arising and Review of Summary Action Log

QS20.189a Minutes 28.8.20 Public v0.03.docx

QS20.189b Summary Action Log QSE Public.docx

1.4.1 Members' Briefing Notes

3.9.20 Deprivation of Liberty Safeguards
9.9.20 Follow up backlog
1.10.20 Thrombosis
12.10.20 Data reporting

1.5 10:13 - QS20/190 Patient Story - Matt Joyes

QS20.190 Patient Story.docx

2.0 FOR DISCUSSION

2.1 Performance Reports

2.1.1 10:18 - QS20/191 Quarter 2 Plan Monitoring Report - Mark Wilkinson

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

QS20.191a Q2PMR template.docx

QS20.191b Q2PMR September 2020 FINAL.pdf

2.1.2 10:28 - QS20/192 Quality & Performance Report - Mark Wilkinson

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

QS20.192a QPR template.docx

QS20.192b QPR September 2020 FINAL at 27.10.20.pdf

2.2 10:43 - QS20/193 Essential Services and Restart Update : Gavin MacDonald

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

QS20.193 Essential Services.docx

2.3 Infection Prevention & Control Reports : Debra Hickman

2.3.1 10:58 - QS20/194 Infection Prevention (IP) Report Quarter 2 (July - September 2020/21) : Debra Hickman

Recommendation:
The Committee is asked to take assurance from the Infection Prevention report.

QS20.194a IPC Q2 report.docx

QS20.194b IPC Q2 report_Appendix 1.pptx

2.3.2 11:08 - QS20/195 Hospital Acquired Infection

Paper 195.1 COVID-19 Review
Recommendation:
The Committee is asked to receive the paper

Paper 195.2 COVID-19 Delivery Group - Proposed workstreams
Recommendation:
The Committee is asked to note the report.

QS20.195.1a HAI Review Report.docx

QS20.195.1b HAI review_appendices.docx

QS20.195.2a IPC Delivery Group.docx

QS20.195.2b IPDC Delivery Work programme_Appendix 1.xlsx

2.4.1 11:23 - Comfort Break

2.5 11:33 - QS20/196 Patient Safety Q2 Report : Matt Joyes

Recommendation:
The Quality, Safety and Experience Committee is asked to:
1\. Note the report\.
2\. Note the focus on improving learning\, reducing incidents resulting in avoidable harm and the evolving improvement of assurance in this area recognising significant work remains\.
3\. Receive this report and provide feedback on its evolving content and layout\.

QS20.196 Quarter 2 Patient Safety Report.docx

2.6 11:43 - QS20/197 Serious Incident Report August to September 2020 : Matt Joyes

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

QS20.197 SI Report.docx

2.7 11:53 - QS20/198 Patient & Carer Experience Report – Q2 2020/21 : Matt Joyes

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

QS20.198 Quarter 2 Patient Carer Experience Report.docx

2.8 12:03 - QS20/199 Clinical Audit Update : Kate Clark

Recommendation:
The Committee is asked to adopt the interim clinical audit plan 2020/21 as the approved plan.

QS20.199a Clinical Audit Plan 2020-2021.docx

QS20.199b Clinical Audit Plan 2020-21_Appendix 1.xlsx

2.9 12:13 - QS20/200 Mortality Review Q2 - Kate Clark

Recommendation:
The Committee is asked to discuss the newly developed quarterly mortality report to determine if this provides an acceptable level of assurance around learning from deaths within BCUHB acute & community inpatient services and the Mental Health & Learning Disabilities (MH/LD) Division, recognising that a process for learning from deaths in primary care requires development.

QS20.200a Mortality Review Q2.docx

QS20.200b Mortality Review Q2 slides.pptx

2.10 12:23 - QS20/201 Vascular Services Update : Kate Clark

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

QS20.201a Vascular Update November 2020 v1.0.docx

QS20.201b Vascular TF Group Action Tracker v0.9 without attachments.xlsx

2.11 12:33 - QS20/202 Holden Report Update : Matt Joyes

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

QS20.202 Holden Report.docx

2.12 12:43 - QS20/203 Mental Health & Learning Disabilities Division Exception Report: Teresa Owen

Recommendation:
The Committee is asked to:-
1\. Note the content of the report which has been re\-structured around the Division's four priorities of:
• Review of capacity and capability
• Delivery of safe and effective in partnership
• Stronger and aligned management and governance
• Engagement with staff, service users and stakeholders
2\. Provide feedback on the report structure and any recommendations for future reporting\.

QS20.203 MHLDS 23.10.2020 FINAL TAO.doc

2.13 12:58 - Lunch break

2.14 13:18 - QS20/204 Quality Governance Review (Updated Terms of Reference of the 4 Groups reporting into QSE) : Matt Joyes

Recommendation:
The Committee is asked to approve the terms of reference as presented.

QS20.204a TORs Paper.docx

QS20.204b TORs Appendix A SOHSG.docx

QS20.204c TORs Appendix B Patient Safety Quality Group.docx

QS20.204d TORs Appendix C Patient Carer Experience Group.docx

QS20.204e TORs Appendix D Clinical Effectiveness Group.docx

2.15 13:28 - QS20/205 Update report on the investigation of concerns regarding Speech and Language Therapy services in the West Area - Adrian Thomas

Recommendation:
The Committee is asked to note the internal investigation that has taken place and its findings.

Ffion Johnstone to attend

QS20.205a SLT West v1.0.docx

QS20.205b SLT Appendix 1 Recommendations.pdf

QS20.205c SLT Appendix 2 Summary Action Plan updated 20.10.20.pdf

QS20.205d SLT Appendix 3 SLT West concerns.pdf

QS20.205e SLT Appendix 4 Steering group Terms of Reference.pdf

2.16 13:43 - QS20/206 Healthcare Inspectorate Wales Reports - Matt Joyes

Recommendation:
The Committee are asked to note the following reports:
1. Healthcare Inspectorate Wales Tier 1 Quality Check (Planned), of Ward 11, Ysbyty Glan Clwyd on 26 August 2020
2. Healthcare Inspectorate Wales Tier 1 Quality Check (Planned), of Moelwyn Ward, Ysbyty Gwynedd on 28 August 2020
3. Healthcare Inspectorate Wales Tier 1 Quality Check (Planned), of Bonney Cohort Ward, Wrexham Maelor on 3 September 2020
4. HIW Inspection (Unannounced), Heddfan Psychiatric Unit, Wrexham Maelor Hospital on 7 to 9 July 2020

QS20.206 HIW reports.docx

3.0 13:53 - FOR CONSENT

3.1 QS20/207 Clinical Audit Policy and Procedure (Amended) - Melanie Maxwell

Recommendation:

The Committee is asked to approve the amendments as noted within the attached policy

QS20.207a Clinical Audit Policy_report template.docx

QS20.207b Clinical Audit Policy MD22_Appendix 1.docx

QS20.207c Clinical Audit Policy-DRAFT-BCU EqIA Procedure _Appendix 2.doc

3.2 QS20/208 Nurse Staffing Levels (Wales): Adult Acute Medical And Surgical Inpatient wards : Debra Hickman

Recommendation:
The Committee is asked to note the compliance with the prescribed requirements of the Nurse Staffing Levels (Wales) Act 2016 bi annual calculations for medical and surgical wards which meet 25B requirements and support the report.

QS20.208a Nurse Staffing Levels - October 2020 final.docx

QS20.208b Appendix 1 - CNO Letter with guidance regarding the repurposed COVID-19 wards.pdf

QS20.208c Appendix 2 - Letter from CNO - Covid19 disruption to Nurse Staffing Levels (Wales) Act 2016.pdf

QS20.208d Appendix 3 - Letter Supporting Nurses and Midwives across the UK and Nursing Associates.pdf

QS20.208e Appendix 4 - Acuity Data.docx

QS20.208f Appendix 5 - Annual Presentation of the Nurse Staffing Levels.docx

QS20.208g Appendix 5.1a Summary of nurse staffing level YWM.docx

QS20.208h Appendix 5.1b Summary of nurse staffing levels YGC.docx

QS20.208i Appendix 5.1c Summary of nurse staffing levels YG.docx

3.3 QS20/209 Quality Awards : Matt Joyes

Recommendation:
The Committee is asked to note this report.

QS20.209 Awards Paper.docx

3.4 QS20/210 Health & Safety Q2 Update : Sue Green

Recommendation:
The Committee is asked to note the position outlined in the Quarter 2 Report and support the actions being taken to delivery against the recommendations agreed by the Strategic Occupational Health and Safety Group

QS20.210a Health and Safety.docx

QS20.210b H&S Appendix 1 V&A.pdf

3.5 QS20/211 Prison Health Update - HMP Berwyn Annual Report : Chris Stockport

Recommendation:
The Committee are asked to receive the report for information, noting the ongoing particular areas for attention in the following areas:
1. High level of planned appointments not attended which was highlighted by the Independent Monitoring Board (IMB) report in their annual report which was published in September 2020 – Page 5
2. Increasing waiting list / access to routine dental services at HMP Berwyn – Page 6
3. Upcoming Her Majesty's Inspectorate of Prisons (HMIP) Scrutiny Visit planned for November 2020 – Page 9
4. HMP Berwyn Risk Register – Page 13
5. The Health & Wellbeing Service COVID delivery plan, staged approach in line with Her Majesty's Prison & Probation Service (HMPPS) model – Page 14

QS20.211a Prison Health.docx

QS20.211b HMP Berwyn Annual Report 2020.docx

3.6 QS20/212 Patient Safety & Quality Group Chair's Report from 9.10.20 : Debra Hickman

QS20.212 PSQ Chair Report.docx

3.7 QS20/213 Clinical Effectiveness Group Chair's Report from 15.10.20 - Melanie Maxwell

QS20.213 CEG Report.docx

3.8 QS20/214 Audit Committee Update

Recommendation from Audit Committee that QSE Committee be informed that:
1\. In response to the Covid\-19 pandemic\, this work will take the form of an overview of the whole system governance arrangements for Test\, Track and Protect\, and of the Local Covid\-19 Prevention and Response Plans for each part of Wales\.
2\. The field work for this review is underway\.
3\. Work to complete the Review of Unscheduled Care has been postponed and replaced with work on TTP\.

QS20.214 Audit Committee update.pdf

4.0 14:03 - FOR INFORMATION

4.1 QS20/215 Issues Discussed in Previous Private Session

QS20.215 Issues discussed in previous private session.docx

4.2 QS20/216 Internal Audit Report Decontamination

Copy of report from Audit Committee 17.9.20 for information of QSE members

QS20.216 Final Internal Audit Report Decontamination.pdf

4.3 QS20/217 Documents Circulated to Members

27.8.20 Patient Safety Q1 Report
27.8.20 Patient Experience Report
30.9.20 Q2 annual plan monitoring report
20.10.20 Quality Safety Group September notes

4.4 QS20/218 Issues of Significance to inform the Chair's Assurance Report

4.5 QS20/219 Date of Next Meeting

5th January 2021

4.6 QS20/220 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 28.8.20 via Webex

Present:

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

In Attendance:

Clare Darlington	Assistant Director Primary Care and Community Services
Kate Dunn	Head of Corporate Affairs (*for minutes*)
David Fearnley	Executive Medical Director
Jo Garzoni	Vascular Network Manager (*part meeting)*
Sue Green	Executive Director of Workforce and Organisational Development (OD)
Arpan Guha	Deputy Medical Director
Gill Harris	Executive Director of Nursing and Midwifery / Deputy Chief Executive
Matthew Joyes	Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience
Andrew Kent	Head of Planned Care Improvement (*part meeting)*
Melanie Maxwell	Senior Associate Medical Director/Improvement Cymru Clinical Lead (*part meeting)*
Teresa Owen	Executive Director of Public Health
Michael Rees	Vice Chair, Healthcare Professionals Forum (HPF) *(part meeting)*
Mike Smith	Interim Director of Nursing, Mental Health & Learning Disabilities (*part meeting)*
Adrian Thomas	Executive Director of Therapies and Health Sciences
Marian Wyn Jones	Board Adviser (*part meeting)*

Agenda Item Discussed	Action By
QS20/150 Chair's Opening Remarks **QS20/150.1** The Chair recorded her thanks that there had been a clear improvement overall in the quality of committee papers. She noted there was a long agenda with many items having been listed for information. She assured officers and authors that the members had read all the papers but that in order to manage the meeting time that she intended not to invite presentations of papers but to go straight to questions from members.	
QS20/151 Declarations of Interest **QS20/151.1** None declared.	
QS20/152 Apologies for Absence **QS20/152.1** Recorded for Dave Harries, Gareth Evans, Jill Newman, Chris Stockport and Andy Burgen.	

QS20/153 Minutes of Previous Meeting Held in Public on the 29th July 2020 for Accuracy, Matters Arising and Review of Summary Action Log **QS20/153.1** The minutes were agreed as an accurate record pending an amendment to QS20/136.2 to read "…reflected that deaths can be included in more than one trigger group on stage 1 review as these groups were not mutually exclusive" **QS20/153.2** A matter arising was raised regarding the wearing of face masks by staff on BCU premises and it was confirmed that a joint communication had gone out from the Executive Director of Nursing and Midwifery and the Executive Director of Workforce and OD to mandate this was for staff. The Chair thanked them on behalf of members for progressing this. **QS20/153.5** It was noted that a briefing on eye care services had been circulated to members. A member noted it referred to the use of charitable funds and felt that the narrative indicated an assumption that funding had already been agreed whereas the funds are currently overcommitted. Another member noted that the briefing paper alluded to the procurement of equipment to increase productivity and felt that this indicated a risk to be addressed. The Executive Director of Nursing and Midwifery undertook to share the comments with the Director of Performance and to raise at the primary care group that afternoon. **QS20/153.4** Updates were provided and recorded against the summary action log.	GH
QS20/154 Patient Stories **QS20/154.1** Members enquired whether the stories were shared back with wards and staff to both share positive aspects and to help them improve. It was confirmed this was the case and that the relevant management team was also required to demonstrate how it cascaded the learning. A member asked that future reports to Committee also summarise the learning. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience agreed that the template could be amended to incorporate learning. Members also acknowledged that basic or small interactions can have a huge difference on a patient care, and that Covid-19 will have had a detrimental impact on much wider aspects of the patient experience. **QS20/154.2 It was resolved that** the Committee receive the patient stories which help to understand the impact of COVID-19 on the care provided and that the template would be reviewed to incorporate learning.	GH/MJ
QS20/155 Quality & Performance Report **QS20/155.1** A member requested that Covid-19 rates per 100,000 of population be included rather than just by age group, and the Executive Director of Public Health indicated that this data was available from the dashboard and she would work with the performance team to include in future reports. A comment was made that dental care was not specifically reported upon within the QPR. The Assistant Director of Primary	TO

Care and Community Services confirmed there were concerns about a backlog following the pandemic and this was being monitored by the primary care team in liaison with General Dental Practitioners. A member referred to unscheduled care performance in terms of patient safety, noting a related conversation had taken place at the Finance and Performance (F&P) Committee. The Executive Director of Nursing and Midwifery confirmed that the unscheduled care improvement group had been re-established and advised that if escalation reached level 4, a joint area and site investigation was undertaken to identify critical factors and whether any early warning signs missed. She undertook to discuss with the Interim Director of Operations how the learning from associated root cause analysis could be shared with the Committee. It was requested that future reports include a brief narrative against graphs showing the impact of Covid-19 on activity/waiting lists. This request would be shared with the Director of Performance.	GH GH
QS20/155.2 A discussion took place on Covid-19 testing and it was acknowledged that whilst there was good access within communities and for staff, there was a need for improvements in terms of communication and messaging. The Executive Director of Public Health added that the Board was following national guidance for testing of symptomatic individuals, and that asymptomatic testing was undertaken as appropriate, for example upon the identification of clusters.	
QS20/155.3 A member set out her concerns around capacity within phlebotomy services and the Executive Director of Therapies and Health Sciences confirmed that demand was increasing and there were some challenges in relation to accommodation due to the requirement for social distancing. He reported that a recruitment programme was underway and options were being investigated in terms of utilising the Ysbyty Enfys and Deeside Hospitals for accommodation. The same member enquired as to the timeframe for returning surgical cases from Alder Hey, and it was confirmed that BCUHB access to Alder Hey was much reduced and assessed on a priority basis as their surgical capacity was low for similar reasons to that of BCUHB.	
QS20/155.4 In response to a question regarding supply of seasonal flu vaccinations, the Executive Director of Public Health confirmed that additional orders had been made and she had no concerns about supply at present. She acknowledged there was potential for a more challenging flu season and that the ongoing trials of a Covid-19 vaccine were of high importance. She added that currently it was thought that if this vaccine was developed it would need to be given separately to the seasonal flu vaccine.	
QS20/155.5 The Executive Director of Nursing and Midwifery noted she was conscious of the risk to mental health services in terms of increase in demand following Covid-19 and that it would be important for the Committee to be sighted on any expected increases in specific elements of this service eg Child Adolescent Mental Health Services (CAMHS). The Chair requested that this be noted on the cycle of business. The Executive Medical Director undertook to follow up and explain why no improvement was reported for delayed transfers of care within mental health as stated on page 14. The Board Adviser noted the marked improvement in performance against the Mental Health Measure for adult services and suggested that learning be shared	KD DF

with CAMHS where performance was markedly poorer for assessments and interventions. The Executive Medical Director confirmed that discussions of this nature had taken place to maximise opportunities for learning, notwithstanding there were different challenges across adult and CAMHS services. **QS20/155.6** The Acting Associate Director of Quality Assurance agreed to contact the Director of Performance regarding the correlation of Never Event information as the Chair noted a discrepancy in that the July report had stated that two Never Events had been opened and not closed, however the latest report stated there remained only one open event. The Chair also requested that the Committee receive clearer information on learning outcomes arising from Never Events. She advised the Committee of recent correspondence that had been circulated to the service by the Executive Director of Nursing and Midwifery highlighting issues with compliance of the surgical checklist. The Chair reported that she had raised the issue of reporting outstanding patient safety notices within the QPR as this should have been noted as an exception and highlighted to the Committee. This was being addressed by the Executive Director of Planning and Performance. The Acting Associate Director of Quality Assurance agreed that he would also consider the wider aspect of identifying learning. **QS20/155.7 It was resolved that** the Quality, Safety & Experience Committee note the report.	MJ
QS20/156 Covid-19 Pandemic Update **QS20/156.1** The Executive Director of Nursing and Midwifery delivered a presentation which focused on the Wrexham outbreak. She confirmed that an outbreak was declared on 20.7.20 and had been Executive-led since the 25.7.20 with daily outbreak control meetings taking place. These had now been stepped down to three per week with the full support of Public Health Wales and partners, however, the outbreak could not be declared over until 28 days after the last positive case. It was also confirmed that if a negative test had been returned but the patient continued to show symptoms of Covid-19 they would remain isolated until a retest was undertaken. Members were advised that themes from post infection reviews had been discussed and there were helpful elements of thematic learning. The Executive Director of Nursing and Midwifery noted that there had been some issues of poor compliance with the use of personal protective equipment which had been addressed and a number of audits undertaken. **QS20/156.2** The Executive Director of Workforce and OD provided an update on staff testing, confirming that a separate reconciliation of agency staff had been undertaken. One contributory factor identified was around staff movement between and within shifts and the decision had been taken that temporary or agency staff would not go on adjacent shifts on a Covid-19 or non Covid-19 ward. It had also been agreed to commence a rapid risk based testing programme for roving staff whose roles required them to move from ward to ward and that 689 staff met this criteria. The Committee were advised this was a precautionary measure but would help inform plans for further outbreaks or resurgence of the virus.	

QS20/156.3 The Executive Director of Public Health outlined the epidemiology and geneology work that was ongoing to understand the strains of the virus that were circulating and patterns of transmission. She indicated that the metadata relating to the Wrexham outbreak suggested it was a closed transmission within the hospital but that epidemiology reports would be used over time to identify if wider actions were required. **QS20/156.4** The Executive Director of Nursing and Midwifery added that clinical teams were also undertaking mortality reviews of patients who had died as result of the outbreak and that they were complying with the principles of a Duty of Candour with relatives. She concluded by confirming a key role for the outbreak control group would be to take actions and learning from the outbreak and share these widely. **QS20/156.5 It was resolved** that the Committee receive the update	
QS20/157 Serious Incident Report June/July 2020 **QS20/157.1** A member noted reference to mental health deaths within the community, recognising that these require reporting even where the death is not necessarily attributable the service but that with no further detail provided it was difficult to interpret this. The Acting Associate Director of Quality Assurance confirmed these would have been included within the category "unexpected deaths where the death is related to healthcare service delivery/failures". He assured members that mental health deaths within a community setting continued to be reported and scrutinized although the small numbers would make the identification of trends and clusters difficult. **QS20/157.2** The Executive Director of Workforce and OD assured the Committee that in terms of the death of a member of staff from Ysbyty Glan Clwyd (YGC), colleagues continued to work very closely with the Health and Safety Executive (HSE) and that immediate learning had been implemented. **QS20/157.3** The Chair set out her continued concern that there was insufficient follow through from incidents in terms of findings and closing the loop, notwithstanding the reporting processes that the organisation was required to follow. She gave an example of the three unexpected deaths within the mental health setting and that she so far remained unassured that the review had determined if any of those deaths were related to mental health issues. The Executive Director of Nursing and Midwifery accepted the comment but felt that an improved level of corporate oversight to incidents would be achieved as the newly appointed Interim Director of Nursing within the Division was working with the Acting Associate Director of Quality Assurance on reporting structures. The Chair welcomed this and asked that the Committee be updated at the next meeting on this approach and associated timescales. **QS20/157.4 It was resolved that** the Quality, Safety and Experience Committee note the report.	MJ

QS20/158 Make it Safe Process : Updated Rapid Review Process **QS20/158.1** A member enquired whether the team members on the panel of a 'Make it Safe' review had the capability and credibility to make the required decisions. The Acting Associate Director of Quality Assurance assured the Committee he had no concerns at the level of seniority in this regard. He also would take on board a suggestion that the proforma at Appendix 1 needed to clarify who was accountable for signing off the review. **QS20/158.2 It was resolved that** the QSE Committee note the report.	MJ
QS20/159 Quality Governance Structure Review **QS20/159.1** The Chair welcomed the paper and acknowledged the work that had gone into the review aimed at strengthening the governance and reporting to QSE Committee. A member queried the status of the Occupational Health and Safety Group as a sub group of QSE Committee and the need for trade union input to any changes to the group. The Executive Director of Workforce and OD acknowledged that a great deal of work had gone into the paper but apologised that some elements of reporting lines regarding health and safety had not been clarified and there was further work to be done in terms of terminology and membership. It was agreed that trade unions would be involved in any change to the terms of reference of this group. The Chair reminded the Committee that the purpose of the paper today was to agree the proposal for the four groups directly reporting into the Committee. The Executive Director of Nursing and Midwifery and the Acting Director of Quality Assurance agreed that the detail with regards to the structure underneath those, including mapping out their functions and membership would be part of the next phase of work. **QS20/159.2** The Vice Chair of the HPF offered the support of the Advisory Group in developing the sub-structure to the QSE Committee and noted there was a wealth of expertise amongst the professional staff. The Executive Director of Therapy Services queried where the Radiological Services Group would sit as there are statutory reporting requirements for this group. It was confirmed that this would be followed up as part of phase 2 of the discussions. The Chair asked if the clinical audit function would be incorporated into the Clinical Effectiveness Group. The Deputy Medical Director confirmed this would be the case. The Chair would wish to see primary and community care representation more visible within the membership of the subgroups as well. She asked whether a similar piece of work is going to be undertaken for the other committees to look at their reporting structures and that the overall structure would be reported to the Audit Committee and Board. The Executive Director of Nursing and Midwifery confirmed that this is planned and that the quality governance structure was the first piece of work of a wider plan. **QS20/159.3** The Chair clarified some of the recommendations for the paper as the wording was unclear for some of them. She advised for example that the Committee	GH MJ

would not be in a position to approve the terms of reference for the four subgroups at this point in time because more work was required. The Acting Director of Quality Assurance agreed and suggested that the Committee should be asked to approve the principle of some of the papers. **QS20/159.4** The Chair then reviewed each recommendation in turn, seeking members' agreement to any adjustments as follows:- 1. The Committee supported 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 (SOHSG) noting that the accountability of the SOHSG would be clarified. 2. The Committee approved the requirement that any changes to the structure must have approval of either the parent Committee for changes to its reporting groups, or the new groups for the sub-structure. This did not prevent specific task and finish groups being established for clear, discrete purposes. 3. The Committee supported the principle of a standard terms of reference to be used for all subgroups which must be agreed by the parent committee/group and acknowledged further work was required on the draft terms of references provided. 4. The Committee approved the principle of standard templates for use across the quality governance structure, with the relevant Chairs to agree the detailed content and guidance for completion. 5. The Committee approved the use of a Chair's Report template instead of an Issues of Significance Report. 6. The Committee noted the draft cycles of business for the four sub groups which will be further refined by each group. 7. The Committee supported and approved the 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).	
QS20/160 Quality Safety Group (QSG) Assurance Reports July and August 2020 **QS20/160.1** A comment was made that there was a lack of correlation between the summary of matters discussed and the key advice being highlighted to the Committee, and that some of the terminology and phrasing was not helpful in a document in the public domain. The Executive Director of Nursing and Midwifery would take this on board. **QS20/160.2** The Chair noted that the July report indicated that an update on actions relating to therapies waiting lists would be submitted to the next meeting, however, this was not reflected in the August report. The Executive Director of Nursing and Midwifery confirmed that QSG had received the action plan but not updates against the closed actions. In terms of harms the assessment had been completed but lessons	

learnt not yet described and there was therefore a more significant piece of work yet to be undertaken within the performance team.	
QS20/161 Mental Health & Learning Disabilities Division Update Report *[Mike Smith joined the meeting]* **QS20/161.1** A member welcomed the balanced and refreshed approach evident within the paper and noted the importance of working closely with workforce colleagues as recruitment to key vacancies would be important to address the concerns across the Division. She enquired as to how communications would be moved forward within the Division and with partners. The Interim Director of Nursing thanked the Committee for the opportunity to share his personal opinion via the exception report and noted that he was confident it was a reliable summary of the current situation. In terms of communication he had specifically highlighted that this aspect, together with wider consultation and engagement, needed urgent attention to remedy the situation and ensure internal and external processes were more robust. He acknowledged that this would also apply to communications with partners in health and social care. **QS20/161.2** In response to a question around confidence in patient safety across the Division the Interim Director of Nursing reported that he had undertaken many site visits and meetings with teams within the Division and he had consistently seen good quality patient care, with nothing having alarmed him that patients were at risk. He added that his intention was to be visible around the Division and to be approachable for teams and individuals. The Assistant Director Primary Care and Community Services offered her assistance in enabling contact with primary care colleagues either via the established clusters or other existing groups. **QS20/161.3** A question was asked around sustainability of improvements. The Interim Director of Nursing confirmed that his engagement with the Division was for 6 months and that whilst he would not be able to change everything within that timeframe, he could change the experience for people and the basis of mental health services provision through the Together for Mental Health Strategy for Wales. **QS20/161.4** The Chair welcomed the honest and open paper and acknowledged the amount of effort being made in the background with a number of regular meetings taking place to address the concerns for the Division. In this regard she accepted there was still a great deal of work to be done but that plans were being agreed. **QS20/161.5** The Chair reminded members that the psychological therapies review had been paused during Covid-19 but this would need to be picked back up and the organisation would need to prepare for an increased demand post-pandemic. The Vice Chair of the HPF took the opportunity to provide some positive feedback about the important roles that clinical psychologists had played with the Staff Well Being and Support Service during the Covid-19 outbreak. The Interim Director of Nursing added that there was an international workshop the following week around developing a	

world-wide response to the post Covid-19 situation within mental health. He alluded to predictions of a possible 20% increase in primary care morbidity and up to a 40% increase in psychosis cases. The Chair asked that an update on these matters be included within the next paper from the Division to the Committee. The Executive Medical Director added that maintaining and improving relationships would be key in managing the changes ahead, and that aligning an approach regionally would be helpful. **QS20/161.6 It was resolved that** the Committee note the report.	MS DF
QS20/162 Holden Report Update **QS20/162.1** The Executive Director of Nursing and Midwifery reminded the Committee that there was a significant amount of interest in this report and that work was ongoing to go back through the original recommendations to pull out lessons learned and to identify any gaps in implementation. She assured members that this work was being triangulated with that relating to the HASCAS and Ockenden recommendations. The Chair stated that this work was an important piece of assurance for the Health Board and stakeholders. **QS20/162.2 It was resolved that** the QSE Committee note the report.	
QS20/163 Improvement Group (HASCAS & Ockenden) Chair's Assurance Report **QS20/163.1** A member expressed concern at the statement that “the CHC advised that they do not support sign off at this stage”. The Executive Director of Nursing and Midwifery indicated that the Community Health Council (CHC) wished to consider the matter further with their members and that a stakeholder meeting was being arranged, with the Interim Director of Nursing (Mental Health and Learning Disabilities Division) being part of those discussions. She felt that the position reflected that there remained further work to do with stakeholders, however, there were many examples of great engagement. The Chair enquired whether it was still intended that an internal audit review be undertaken to provide an independent opinion of implementation of the recommendations, and it was confirmed that this was the case but not in the immediate future. **QS20/163.2 It was resolved that** the Committee note the progress against the recommendations to date. *[Mike Smith left the meeting]*	
QS20/164 Quality Governance Self-Assessment Action Plan **QS20/164.1** The Chair noted that understandably many of the actions did not meet the stated timescales and she felt that this project needed to report into the Audit	

Committee as part of the quality governance review. In response to a question regarding the deadline for the clinical audit plan, the Senior Associate Medical Director/Improvement Cymru Clinical Lead confirmed that confirmation from Welsh Government was still awaited relating to the mandated audits but the intention was to share the plan with the Committee in October. She also confirmed that although some of the work around pathways had a deadline of March 2021, some aspects of the work could proceed sooner. **QS20/164.2 It was resolved that** the QSE Committee: 1. Approve the 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	MM
QS20/165 Mortality Review Update **QS20/165.1** A presentation was delivered by the Deputy Medical Director and the Senior Associate Medical Director/Improvement Cymru Clinical Lead. It was acknowledged there was a need to refine the reporting of mortality to the QSE Committee and that the emphasis should be on learning. A process chart from the time of confirmation of death was shared and it was highlighted that a key aspect of the review stage remained the mortality/morbidity meetings. With regards to the learning stage it was stated that the role of the QSG would need refining in terms of analysing and identifying contributory streams to mortality. Members' attention was drawn to the development of a Medical Examiner Service for Wales which had already been partly implemented in England and would provide an independent scrutiny of all deaths not involving the coroner. The Medical Examiners would be experienced doctors with additional training in death certification and documentation review and they would work independently to ensure that an accurate cause of death was recorded and any concerns identified for investigation. A process would need to be in place to enable the organisation to respond quickly to the Medical Examiner. A question was asked around capacity and the Senior Associate Medical Director/Improvement Cymru Clinical Lead indicated she was not able to fully assure the Committee on this currently as it was dependent on efficiency although calculations suggested that 1.6wte would be needed. **QS20/165.2** The Deputy Medical Director referred to discussions around mortality within primary care and that Cwm Taf Health Board had set up a panel of healthcare professionals not just medics. The Assistant Director Primary and Community Services indicated that Dr Liz Bowen had an interest in this area of work. **QS20/165.3** The Chair thanked officers for the helpful update which enabled members to better understand the process and how it was planned to be standardised. She reiterated previous concerns that whilst there was plentiful raw data around mortality, the Committee needed it to be presented in a meaningful and clear way including learning arising from the reviews.	

[Marian Wyn Jones and Melanie Maxwell left the meeting]	
QS20/166 Healthcare Inspectorate Wales (HIW) Annual Report 2019/20 **QS20/166.1** It was noted that the planned presentation from HIW had been stood down as their representative was unable to attend. The Chair noted that the slides referred to an observation by HIW that actions were not always being taken by the Health Board as a result of HIW inspections, and she queried whether there was harm caused as a result. The Executive Director of Nursing and Midwifery was unable to provide full assurance that this wasn't the case but she confirmed that where significant issues were raised at HIW inspections these were followed through robustly at QSG. The Interim Associate Director of Quality Assurance undertook to establish if similar issues continued to be raised by HIW and weren't being addressed, and to discuss with Emma Scott in HIW. He noted that HIW had recently recommenced a virtual visiting programme. **QS20/166.2** The Chair felt that it was important to have clarity on outstanding HIW actions before the report was submitted to the September Health Board. The Executive Director of Workforce and OD noted that the interdependencies between findings and actions was always challenging. The Executive Director of Nursing and Midwifery felt there was an opportunity for QSE Committee to feed the Board business in order to have a far more quality driven Board, whilst accepting there were difficulties in collating and aligning external reports to maximise learning opportunities. **QS20/166.3** A member commented that the annual report was well-balanced and positive overall, but suggested that the organisation needed to pre-empt wider interest in infection prevention compliance issues as noted within the presentation slides for both primary and secondary care. **QS20/166.4 It was resolved that** the Committee receive for assurance the report and the presentation from the Healthcare Inspectorate Wales (HIW) Senior Inspector for the Health Board.	MJ MJ GH
QS20/167 BCUHB Annual Quality Statement 2019/20 **QS20/167.1** A member felt that the narrative within the CHC's statement about it "having grave reservations about the unique I-CAN service model" was unfortunate. The Executive Director of Nursing and Midwifery indicated that the CHC's concern related to their view that there was too much focus and reliance on I-CAN. Another member noted a typographical error on page 29 in that "compromised" should read "comprised". She also suggested the HIW section could be more appropriately placed within the document, and that reference should be made around Allied Health Professionals to encompass a wider range of students. The Chair felt the document was very secondary care focused and suggested that the Assistant Director of Primary and Community Services liaise with the Interim Associate Director of Quality Assurance	CD MJ

around strengthening the primary care aspect including reference to the Primary Care Academy as a way of demonstrating how the Health Board was responding to the recruitment challenges for primary care. **QS20/167.2 It was resolved that** the Committee: 1. Note the Annual Quality Statement Editorial Group, Terms of Reference 2. Note the Welsh Health Circular titled "Annual Quality Statement 2019 / 2020 Guidance" Welsh Government 3. Approve the Annual Quality Statement 2019/20 final draft pending comments made above	
QS20/168 Primary Care Update **QS20/168.1** The Executive Director of Nursing and Midwifery welcomed the paper and felt it provided a helpful opportunity to consider a range of issues through a Health Board lens on a pathway basis. She would like to see a more integrated approach for some areas e.g. eye care and mental health. The Chair referred to the development of Quality Improvement Projects through the Quality Assurance Improvement Framework and enquired whether there were any plans to review priorities within these in light of Covid-19 – for example the management of diabetic patients. The Assistant Director of Primary and Community Services would follow this up through the national group. The HPF Vice Chair enquired what the position was within primary care in terms of getting the workforce safely back to work and ensuring premises were Covid-19 secure. The Assistant Director of Primary and Community Services explained that the establishment of red hubs had enabled primary care to provide essential services and they were now reinstating enhanced services and working to ensure infection prevention guidance was followed. She felt that the ability to be more explicit around premises being Covid-19 secure would reassure patients to feel safe to returning to access primary care services. **QS20/168.2 It was resolved that** the Committee 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	CD
QS20/169 Care Homes Update **QS20/169.1** The Assistant Director of Primary and Community Services clarified that she was not the author of the paper as stated on the front template, but she would be happy to take away any questions to the lead officer Grace Lewis-Parry.	

QS20/169.2 A member noted that the paper indicated the assessment of need for patients was done separately by social care and by health, and she felt it would it be better as a more inclusive partnership approach. She felt that a positive outcome of Covid-19 was how much closer health and social care had had to work, and the Assistant Director Primary and Community Services suggested that this would be further strengthened by the regional care home action plan. A member referred to the financial implications within the paper and the Assistant Director of Primary and Community Services confirmed that additional retrospective funding of the order of £5m had now been confirmed by WG to support care homes during Covid-19. In response to a question regarding the Discharge to Recover then Assess model, it was confirmed this aimed to ensure patients were discharged home or to a familiar community setting first before further assessment was made. **QS20/169.3** It was resolved that the Committee 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.	
QS20/170 Essential services and re-start update *[Andrew Kent joined the meeting]* **QS20/170.1** In response to a question regarding the table of services that were re-starting, the Head of Planned Care Improvement confirmed the date shown was the date it had been agreed to restart the service, not necessarily when it had restarted. This was monitored on a weekly basis with a definitive standard operating procedure and restart toolkit being considered by the area or site management team, and cross referencing with other services being undertaken. It was reported that there was a move away from WG 36 week targets to a risk stratification approach and that the key challenge was that the waiting lists were now held by the clinicians. The Head of Planned Care Improvement also outlined the requirement for winter surge plans to be aligned far more closely. In terms of financial implications, it was reported that a paper had been considered by the F&P Committee on the 27th August which articulated the potential capital and revenue costs. The Executive Director of Nursing and Midwifery stated that the priority would be to mitigate the risk to patients ahead of confirming funding. **QS20/170.2** The Chair queried what communication was being provided to referrers as services are restarted across the Health Board, noting that this covered all primary care not just general medical practice. The Assistant Director of Primary and Community Services offered to assist the planned care team in terms of sharing information with primary care generically or through links with the Local Medical Committee. A member suggested that it was vital to ensure accuracy and clarity of any information for the	

public around the restarting of services as she had noted inconsistency relating to when a patient would be tested for Covid-19 prior to admission. **QS20/170.3** The Chair noted that the paper highlighted a risk around the Patient Administration System and asked whether the Digital and Information Governance Committee needed to be sighted on this and if consideration had been given to escalating to the corporate risk register. The Head of Planned Care Improvement confirmed that he had requested appropriate escalation including potentially to the corporate risk register. The Executive Director of Nursing and Midwifery added that the work on virtual access to clinicians (eg; the Attend Anywhere and Consultant Connect programmes) had underpinned the organisation's digital approach to the delivery of planned care. **QS20/170.4** The question was asked whether the men within HMP Berwyn had been receiving any form of diagnostics service. The Head of Planned Care Improvement noted that the prison was regarded as an essential service but he would check this specific query and provide a response outside of the meeting. He did assure the Committee that he hadn't been made aware of any issues in this regard. **QS20/170.5 It was resolved that** the Committee note the content of the paper and the progress being made. *[Andrew Kent left the meeting]*	AK
QS20/171 Vascular Services Update *[Jo Garzoni joined the meeting]* **QS20/171.1** A member enquired as to the timescale for the external review by the Royal College of Surgeons (RCS). The Vascular Network Manager reported this had not been confirmed as of yet but the RCS had indicated it was not likely to commence for several months. The terms of reference for the review had been developed and shared with the Committee Chair. In response to a question regarding CHC involvement the Vascular Network Manager confirmed that the CHC and carer/patient representatives had been involved in drafting the invitation to the RCS to undertake the review. A question was raised regarding palliative care and the Vascular Network Manager assured the Committee that patients were receiving appropriate palliative care currently. In terms of staff morale it was acknowledged that vascular services was a challenging area to work within currently, although the Chair was pleased to report that on a recent visit she was impressed with the dedication of the team and their candour. The service demonstrated that they were aware of the areas for improvement and the challenges that they had faced and were committed to doing so. **QS20/171.2** The Chair stated that the response provided to the Committee questions previously submitted highlighted the wider governance issues evident within the service on implementation and noted that there were examples where key issues had been reported to the Vascular Implementation Group and/or Executive Management Group	

but not to the Board as would be expected. She felt that there was a wider learning in this respect which could apply to other service change implementation projects. The Executive Medical Director indicated that the vascular task and finish group had not focused on the governance aspects within its current remit. The Executive Director of Nursing and Midwifery agreed that the need to improve governance processes could be applied to any area of service change, and that wider benefits realisation must be pursued. **QS20/171.3 It was resolved that** the Committee note the progress made by the Vascular Task and Finish Group	
QS20/172 Internal Audit Report Deprivation of Liberty Safeguards **QS20/172.1** A member sought a timeline for when the outstanding training aspects would be delivered. Another member enquired as to what data was held around trends, figures and the impact of case law re young people aged 16 and 17. The Executive Director of Nursing and Midwifery would ask the Assistant Director of Safeguarding to respond on these points outside of the meeting but she anticipated that in terms of the case law query there would not be sufficient data to enable the monitoring of trends. **QS20/172.2** A member noted that changes in responsibilities regarding the Liberty Protection Safeguards from April 2022 will mean an increase in assessment requests. The Executive Director of Nursing and Midwifery agreed that the Committee would need to remain sighted on this matter. The Chair clarified that the recommendations of the internal audit report itself would be tracked through the Audit Committee. **QS20/172.3 It was resolved that** the Committee 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.	GH
QS20/173 Occupational Health and Safety Annual Report 1st April 2019 to 31st March 2020 and Quarter 1 Report **QS20/173.1** The Chair noted that this report had been scheduled for information, however, the recommendation was seeking approval and that some of the annual reports were submitted for approval whereas others were for information/to note. It was not possible to confirm at the meeting whether there was a statutory requirement for the report to be approved. **QS20/173.2** A comment was made that there appeared to be a high number of sharps incidents, and this had also come up as low compliance in terms of the gap analysis.	

It was also noted that the issue of incidents being related to ethnicity was being picked up with the equalities team. The Executive Director of Workforce and OD wishes to record her thanks for the amount of work that the occupational health and safety teams had undertaken during the pandemic, and how responsive they had been. The Chair and Committee members also supported this. **QS20/173.3 It was resolved that t**he Committee: 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	
QS20/174 Independent Review of Fire Precautions at Ysbyty Gwynedd Stage 1 Report Prior to Agreement of Action Plan (May 2020) **QS20/174.1** The Chair confirmed she had accepted this report as a late inclusion to the agenda on the basis of it being a high risk area. She noted that recommendation 4 within the paper asked the Committee to support the inclusion of Ysbyty Gwynedd fire precaution risks being included on the Health Board corporate risk register, and she did not feel the Committee were in a position to do so as were not in possession of the appropriate detail. The Executive Director of Workforce and OD agreed with this and indicated that the Executive Team had recognised the specific risk did need to be on the risk register but the paper was being presented to QSE primarily to sight the Committee on the work ongoing. **QS20/174.2 It was resolved that** the Quality Safety and Experience Committee 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 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. 5. 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.	
QS20/175 Pharmacy and Medicines Management Annual Report **QS20/175.1 It was resolved that** the Committee receive the report for information	
QS20/176 Annual Organ and Tissue Donation Report 2019-20 **QS20/176.1**The Executive Director of Therapies and Health Sciences wished to highlight to members the statement that organ donation was a gift that transformed and saved lives. He wished to record his thanks to all donors and their families who had made a precious gift in the last year. He added that it was pleasing to note that 6 donors had come forward by the 17th July which was extremely positive in the current circumstances. **QS20/176.2 It was resolved that** the Committee note the report content and the future aims and objectives of the Organ and Tissue Donation Committee.	
QS20/177 Care Quality Commission (CQC) report and ratings for Shrewsbury and Telford NHS Trust **QS20/177.1 It was resolved that** the QSE Committee note the report.	
QS20/178 Documents Circulated to Members 18.8.20 Notes of July QSG 19.8.20 Briefing on eyecare services	
QS20/179 Issues of Significance to inform the Chair's Assurance Report To be agreed with Chair	
QS20/180 Date of Next Meeting 27th October 2020 @ 9.30am	
QS20/181 Exclusion of Press and Public **QS20/181.1 It was resolved that** representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be	

prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.	

BCUHB QUALITY, SAFETY& EXPERIENCE COMMITTEE - Summary Action Log Public Version				
Officer/s	**Minute Reference and summary of action agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
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 (Katie Sargent) 28.8.20 Briefing note to be available for next meeting. 27.10.20 Briefing paper on agenda for 3.11.20	August November closed
~~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 require investment in terms of licensing and	 August

			training. It was suggested a set of principles be agreed to help consistency and this will be taken forward. 10.10.20 Meeting held and briefing paper prepared for Chair's consideration 12.10.20 Briefing note circulated.	October Closed
~~L Singleton~~ M Smith I Wilkie	**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 28.8.20 Action re-opened as paper did not meet the specific action. 27.10.20 Refreshed paper on agenda 3.11.20	August November Closed
17th March 2020				
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. 28.8.20 Reported that Executive Team had discussed recently and relocation of the ward was planned. Confirmed that workforce and TU colleagues were well sighted. Members were happy to close the action.	July August closed
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. 21.10.10 Due to capacity and prioritisation this action hasn't been completed, however, preparatory work has commenced to establish a task and finish group.	August January
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. 28.8.20 Members were happy to close the action.	August Closed
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 28.8.20 Members were happy to close the action.	August 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 28.8.20 Reported that the meeting had taken place with a range of actions to be followed up. The situation with face to face training remained challenging. The Committee members were content to close the specific action.	closed

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. 27.10.20 Nurse staffing report on agenda for 3.11.20	October Closed
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. 11.9.20 Final draft was submitted for approval under Chair's Action.	August September Closed
29th July 2020				
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. 28.8.20 Members were content to close the action.	 Closed
L Reid	**QS20/135.1** provide Chair's statement for AQS	August	28.8.20 Noted that a joint Chair and CEO introduction was included within the AQS and therefore a QSE Chair statement may be duplication.	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. 28.8.20 Members were happy to close the action.	Closed

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. 28.8.20 Members were happy to close the action.	Closed
28th August 2020				
G Harris	**QS20/153.5** Share the comments on the eye care services briefing with the Director of Performance and to raise at the primary care group that afternoon.	August	27.10.20 Position statement to be provided at the meeting	
G Harris M Joyes	**QS20/154.1** Amend patient stories template to ensure future reports to QSE captured and demonstrated learning	November	17.9.20 New patient story template is being developed for the next QSE meeting, and Patient Story Procedure being amended.	Closed
T Owen	**QS20/155.1** Work with the performance team to include Covid rates per 100,000 of population in future Quality and Performance Reports.	November	27.10.20 Rate per 100,000 now added to Covid-19 Summary page within QPR	Closed
G Harris	**QS20/155.1** Discuss with the Interim Director of Operations how the learning from associated root cause analysis of USC performance could be shared with the Committee.	November	17.9.20 New process being finalised to provide governance around the reviews (this has been developed with services and governance leads). This will involve the collation of themes from the reviews into an aggregated rolling action plan. Themes and learning will be incorporated into the Patient Safety and SI Reports.	closed
G Harris	**QS20/155.1** Discuss with Director of Performance the need for a brief narrative in future Quality Performance Reports against graphs showing the impact of Covid-19 on activity/waiting lists.	November	27.10.20 Graphs showing impact of Covid-19 on Activity/Referrals included within QPR.	Closed
K Dunn	**QS20/155.5** Update CoB to reflect Committee would wish to be sighted on any	Immediate	Noted against MHLDS item on CoB	Closed

	increased demand on mental health services as a result of Covid – eg CAMHS			
D Fearnley (T Owen)	**QS20/155.5** follow up and explain why no improvement was reported for delayed transfers of care within mental health as stated on page 14 of the QPR	September	27.10.20 Position statement to be provided at the meeting	
M Joyes	**QS20/155.6** Consider the wider aspect of identifying learning from patient safety notices	November	11.9.20 A complete review and re-design of the Safety Alert process is planned and will take place during Q3. Compliance will continue to be reported through the Quarterly Patient Safety Report to QSE.	Closed
M Joyes	**QS20/157.3** Update the Committee at the next meeting on the approach and associated timescales for improvements to corporate oversight of incidents.	November	11.9.20 To be included in the Quarterly Patient Safety Report at the November 2020 meeting.	Closed
M Joyes	**QS20/158.1** Amend the Make it Safe process proforma at Appendix 1 to provide clarify as to who was accountable for signing off the review.	September	11.9.20 Completed	Closed
G Harris M Joyes	**QS20/159.2** Ensure the HPF were engaged with phase 2 of the quality governance review, and progress the development of the relevant supporting documentation (ToRs etc)	November	11.9.20 Contact made with Chair of HPF by the Head of Quality Assurance and will be taken forward as the work progresses.	Closed
M Smith ~~D Fearnley~~ (now T Owen)	**QS20/161.5** Ensure that the next MHLDS Division paper to the Committee included feedback from planned international workshop on developing a world-wide response to the post Covid-19 situation within mental health. Together with reflection on predictions of a possible 20% increase in primary care morbidity and up to a 40% increase in psychosis cases.	November	27.10.20 The conference was a WHO collaborating centre project in mental health. An output of the meeting was an international discussion paper on the impact of Covid 19 in mental health services around the world and using this as a time for change toward more community based and owned MH service delivery. The Division received the paper in October and circulated it within the senior leadership team. One of the lead authors is being	Closed

			invited to attend meet with senior leadership team members of the Division to discuss the implications of the paper as the collaborating network are working with a number of Welsh Health Boards regarding the potential of a pan wales approach to this collaboration. An invitation has been extended to the Committee Chair. The data regarding actual expected numbers /growth is mostly narrative in the world literature, and is still referred to as a broad 20% increase in expected numbers of presentations/demand to impact on mental health services - see link to UK GOV report below. At this early stage, post Covid, many countries are now asking for, and commissioning, more quantitative data on what the expected impact will be in secondary mental health care and its timing. Very little quantitative data has yet emerged to robustly and reliably inform service planning, the horizon remains scanned. UK report on community impact of Covid 19 https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-surveillance-report/2-important-findings-so-far WHO impact report on statutory MH services in 130 countries https://www.who.int/news/item/05-10-2020-covid-19-disrupting-mental-health-services-in-most-countries-who-survey	
M Maxwell	**QS20/164.1** Share clinical audit plan at next meeting	November	On agenda 3.11.20	Closed

M Joyes	**QS20/166.1 E**stablish if similar issues continued to be raised by HIW and weren't being addressed, and to discuss these with Emma Scott in HIW.	September	11.9.20 Issue confirmed with Emma Scott at HIW and briefing submitted to Gill Harris, Lucy Reid and Debra Hickman.	Closed
G Harris M Joyes	**QS20/166.2** Ensure clarity on outstanding HIW actions ahead of submission of HIW annual report to Board	September	11.9.20 Issue confirmed with Emma Scott at HIW and briefing submitted to Gill Harris, Lucy Reid and Debra Hickman.	Closed
C Darlington	**QS20/167.1** Liaise with the Interim Associate Director of Quality Assurance around strengthening the primary care aspect within the AQS including reference to the Primary Care Academy as a way of demonstrating how the Health Board was responding to the recruitment challenges for primary care.	September	11.9.20 Additional content from primary care was included in the final AQS.	Closed
C Darlington	**QS20/168.1** Enquire at the national group whether there were any plans to review priorities in light of covid as part of the development of Quality Improvement Projects through the Quality Assurance Improvement Framework– for example the management of diabetic patients.	November	14.10.209 A new QI project related to planning for urgent care and learning from COVID across clusters has been added to the projects in the QAIF, with strong links to work already begin undertaken at a cluster level.	Closed
A Kent	**QS20/170.4** Establish and feedback whether the men within HMP Berwyn had been receiving any form of diagnostics service.	September	6.9.20 Email sent to Cheryl Carlisle confirming the range of diagnostic services that were being offered to men at the prison.	Closed
G Harris	**QS20/172.1** Feedback on queries raised on DoLS paper regarding training timeframe and case law data for 16 and 17 year olds	September	3.9.20 Briefing note circulated	Closed

Patient Story

Collecting patient stories is an important component in understanding how patients view the care they have received and how we can improve on the many different aspects of service delivery in our hospitals and community services.

Patient stories are a key part of quality improvement and assist staff in improving the experience for patients and can assist staff through education and reflection.

The patient story framework and template is currently being reviewed and developed to focus on learning and improvement alongside the introduction of audio and video stories.

The Story:

Prior to my surgery, I was instructed to be at the front door of the hospital at 8am, where a member of staff would meet me. My husband was not be allowed to accompany me, and I understood the reasons behind this.

At 8am, no one was there to collect me, and eventually I had to make my way up to the ward. On arrival, a nurse showed me to a side ward where I was left. I had virtually no contact with staff other than 2 pop ins to make sure I was ok, that was it.

The time of my procedure arrived and a Nurse and Porter arrived to take me down to theatre. I asked the nurse if I could have a pre-med as I had been thinking about the procedure all day and felt anxious. She informed me that I would have to ask for that downstairs in theatre. When I arrived in theatre, I asked one of the team members for some sedation, but was told it was too late, and that I should have asked the staff upstairs. I felt even more anxious now.

The team were getting the theatre ready, they were gathering the equipment, and I was watching then. A woman was sitting next to me; she was there to calm me. I explained to her that I had asked for something to relax me but she said, “its ok, you’ll be fine.” I reiterated that I had asked for sedation, but by now, I knew that I had run out of time, as I had been lying there for some time whilst they were getting everything ready. I asked whether there would be a screen, as I did not want to see the procedure.

The team erected the screen and the Doctor was ready. He said, “We are going to start the procedure and I will give you injections to numb the site we are working on and if you need anything else you can ask.” When he started, I felt the cut straight away, I said to the woman “I can feel that,” and the woman said, “[Doctor] the patient can feel that”. I assume that the [Doctor] administered another injection but I could not see anything. I thought they might have been putting the injection in the wrong place, as it was not working, I could not stop myself shaking. I had no idea what they were doing. I do not know if they found the hernia. I did not ask for an explanation, I just wished it over as quickly as possible. I asked at one

point how long was left as I had had enough; “three quarters of the way through” was the reply.

As the procedure was ending, I was numb; I just wanted to get out of there. I was still shaking as someone was stitching me up. The Doctor was telling me he did not need to see me again and there would be no follow up, I would be ok in a couple of weeks. He described my after care, and said the sooner I was mobile the better, but not to overdo things. As he was talking, I could feel the stitches going in; I was half listening, but not really. I was trying to take on board what he was saying but I was conscious of the person stitching me up, and I wanted it over.

They then wheeled me in to recovery. As I was wheeled into recovery, I passed two women who commented, “Your patient is shaking there, is she alright?” People noticed I was shaking and they came down towards me and put a blanket on me. I was there for about 5 minutes, and then taken back to my bed on the ward.

The Porter then left, and one of the nurses looking after the ward came in. Before she could speak, I said: “can I phone my husband, I want to go home.” My bag was not there, I think because I had left it on my chair they had put it somewhere safe. She responded: “you’ll have to eat something and so long as you have a wee you can go”. I quickly drank a bottle of water and ate a sandwich, which I had in my bag, and she said I could call my husband to pick me up. Whilst I was waiting for him to come the nurse came back into my room, they could not find my medication so I would have to get the medication tomorrow from my GP or chemist.

My husband was waiting for me in the car park, he thought I was in shock, as I was rude to him and said: “I want to go home, get me home.” I was very rude to him. That night at home, I was very upset and relived the operation so much so I called my doctor for some diazepam to calm myself down.

After a couple of days, I reflected that I did not want anyone to go through this experience. I mentioned my experience to one of my friends, who shared that her father in law had his hernia done in the same way as me and he was in considerable pain. I wish they had told me because I would never have had it done that way. During my consultation prior to surgery, the options were discussed and because of my medical condition, it was perceived that local anaesthetic would be the best. I believe that this type of operation is usually done this way. However, had I known I would never have gone for a local anaesthetic, as the lack of pain relief made it traumatic, I have a high pain tolerance and will never have local anaesthetic again, based on my last experience. If I need another operation, I am going to put myself at risk because of the experience I have had.

My recovery 4 weeks post op is slow. There is a restriction in my leg movement and I am monitoring this at this time. The full recovery process will take between 6-8 weeks.

I have received a follow up call from a Doctor following my contact with the PALS team, she said they had found the hernia and it was deeper than they thought, I had not had the gauze, but she mentioned a ligament. I did not pursue that any further.

What is being done to improve:

The story has been shared with the service and Helen Kotkowicz, Ward Manager of Tudno Ward at Ysbyty Gwynedd has advised that:

- Awareness has been raised regarding with staff regarding the importance of communication and listening to patients concerns;
- Staff have been reminded to re-assure and keep patients updated throughout the day to help alleviate concerns and fears;
- Staff will take time to make sure patients fully understand the post operation advice letter given on discharge;
- All the above actions have been added to the daily safety brief for two weeks so the learning is cascaded across all staff;
- The story will also be shared with the lead for theatres to for them to consider any actions within their service.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 3rd November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quarter Two Plan Monitoring Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Mark Wilkinson, Executive Director of Planning & Performance
Awdur yr Adroddiad Report Author:	Mr Ed Williams, Head 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 note the 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**	✓

Sefyllfa / Situation:

This report provides a self-assessment by the executive leads of the progress being made in delivering the key actions contained in the 2020/21 Operational Plan for Quarter 2.

Cefndir / Background:

The operational plan has a number of key actions required to be delivered during Quarter 2 of 2020/21. The Executive lead reviews on a monthly basis progress against their areas for action and Red/Amber/Green (RAG) rates progress. Where an action is complete this is RAG rated purple. Amber and red ratings are used for actions where there are risks to manage to secure delivery or where delivery was not achieved. For red rated actions a short narrative is provided.

Asesiad / Assessment & Analysis

Strategy Implications
Delivery of the operational plan actions is key to implementation of the Board's strategy

Options considered
N/A

Financial Implications
Delivery of the operational plan within the budget set by the Health Board is part of ensuring resources are well-managed and care effectively provided within the allocated resources.

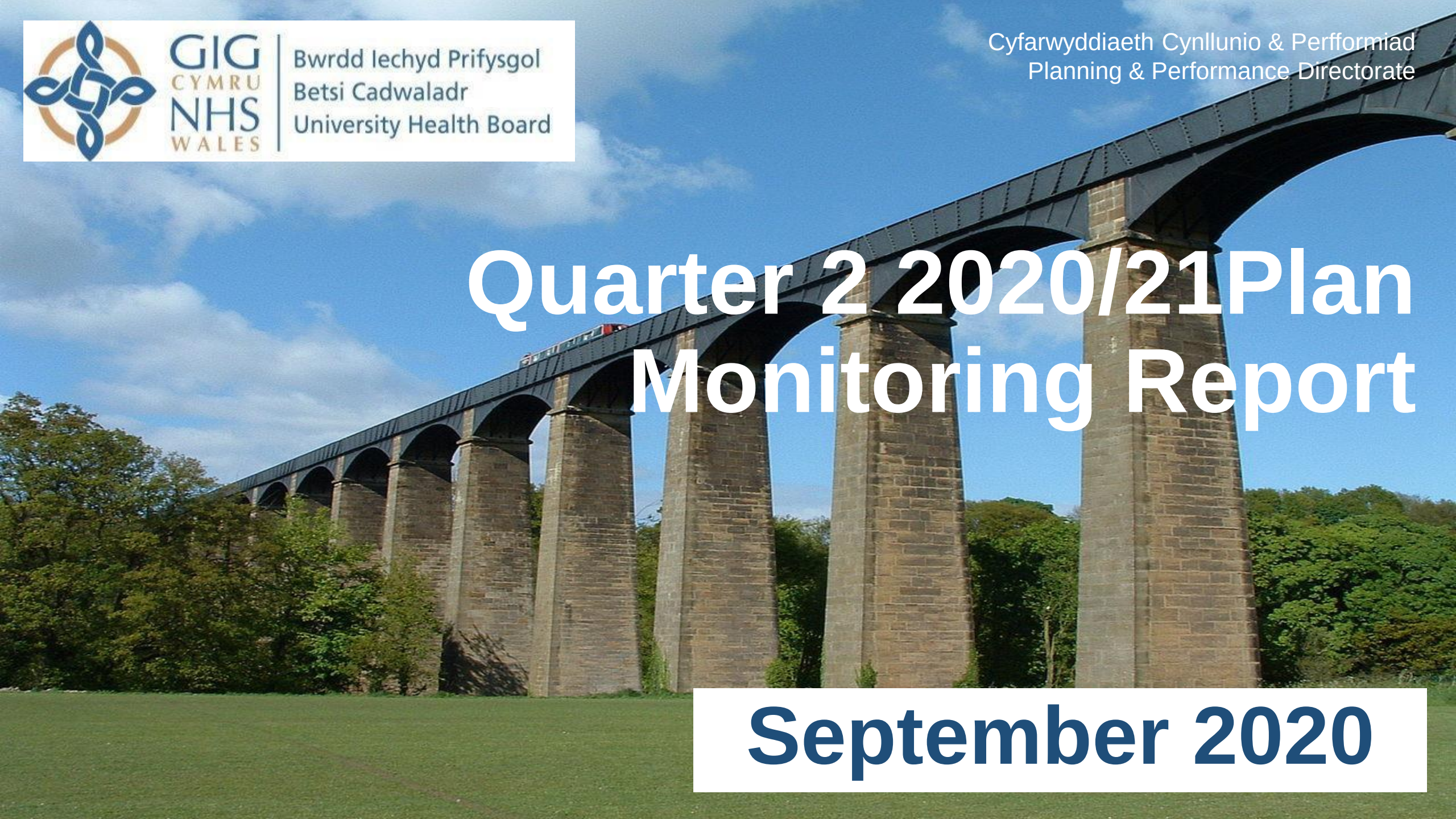
Risk Analysis
The RAG-rating reflects the risk to delivery of key actions

Legal and Compliance
N/A

Impact Assessment
The operational plan has been Equality Impact Assessed.

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

Cyfarwyddiaeth Cynllunio & Perfformiad
Planning & Performance Directorate



Quarter 2 2020/21Plan Monitoring Report

September 2020

Overview and Purpose of this Report

- The Quarter 2 Plan of the Health Board has been agreed by the Board
- The Plan recognises that the disruptive nature of the pandemic has shortened planning horizons, resulting in plans being time limited to quarterly plans for 2020-21
- The Quarter 2 plan relates to the need to maintain essential non Covid-19 services to minimise risk of harm for life-saving or life-impacting treatments.
- This report is a self-assessment by the Executive Director responsible for each of the work streams to have delivered the actions set out in the plan by the 30th September 2020, with supporting narrative where delivery has not been achieved. This report provides an update from each Executive Director for the end of September 2020 actual position. The entire report is the reviewed and approved by the Executive Team.
- Work is underway in developing the plan for Q3 and Q4 which will also reflect the shift in phasing of response to the pandemic from mobilisation towards parallel running of the pandemic and re-activation of some business as usual activities where it is safe to do so. This will reflect transition to sustainable service delivery phase of the plan. In the plan for Q3 and Q4 plan actions incomplete at the end of Q2 2019/20 will be included with revised timescales to deliver, where these actions are still relevant for delivery.

RAG	Every month end	By end of Quarter	Actions depending on RAG rating given
Red	Off track, serious risk of, or will not be achieved	Not achieved	Where RAG given is Red: - Please provide some short bullet points explaining why and what is being done to get back on track
Amber	Some risks being managed	N/A	Where RAG is Amber: No additional Information required
Green	On track, no real concerns	Achieved	Where RAG is Green: No additional Information required
Purple	Achieved	N/A	Where RAG is Purple: No additional Information required

Table of contents

Chapter 1: Improving Quality Outcomes

QP 01 Improving Quality Outcomes						
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Scrutinising Board Committee**	**End of September 2020**
AN1.1	Publish revised year 3 of Quality Improvement Strategy	Executive Director Nursing & Midwifery	30.09.2020	AP 040	QSE	**R**

AN1.1: Publish revised year 3 of Quality Improvement Strategy

The impact of the Covid-19 Pandemic has delayed work on the review of the Quality Improvement Strategy and the delivery timescale has now been extended. The review will be taken to the board in January 2021 with a view to launching the strategy from 1st April 2021.

QP 02 Test, Trace, and Protect						
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Scrutinising Board Committee**	**End of September 2020**
AN2.1	Establish a timely testing programme for antibodies and antigens	Executive Director Of Public Health	30.09.2020	N/A	SPPH	**P**
AN2.2	Lead the development of a 12/24, 7/7 comprehensive tracing programme	Executive Director Of Public Health	30.09.2020	N/A	SPPH	**P**
AN2.3	Establish 'Protect' programme	Executive Director Of Public Health	30.09.2020	N/A	SPPH	**P**
AN2.4	Develop Test, Trace, and Protect	Executive Director Of Public Health	30.09.2020	N/A	SPPH	**P**

QP 03: Promoting Health & Well-being						
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**End of September 2020**
AN3.1	Review of Healthy Weight Services for children	Executive Director of Primary & Community Care	31.07.2020	AP 002	SPPH	R

AN3.1: Review of Healthy Weight Services for Children

Business case and options appraisal complete. Funding for preferred option has been confirmed as recurrent via BAHW monies. Recruitment to posts commenced in Sept/Oct 2020.

QP 04: Achieve compliance with the Primary Care Operating Framework						
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**End of September 2020**
AN4.1	Use the World Health Organisation framework for essential healthcare services as a schema to ensure we are delivering the breadth of essential services in primary care during COVID-19	Executive Director Primary & Community Care	31.07.2020	N/A	SPPH	P
AN4.2	Align with the national Strategic Programme to undertake a review of Betsi Cadwaladr commissioned Enhanced Services during Q2.	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	A
AN4.3	Development of Locality 2020/21 Plans	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	A
AN4.4	Identify actions for primary care for Q3 and Q4, with a focus on Winter planning	Executive Director Primary & Community Care	11.09.2020	N/A	SPPH	P

QP 05: Capture and embed proven technologies in primary care						
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**End of September 2020**
AN5.1	Capture good practice /legacy actions from use of technology and different working practices during first phase of COVID-19, and share these across primary care	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
AN5.2	Build on the initial implementation of virtual attendances in General Medical Services.	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
AN5.3	Build on the initial implementation of the e-Consult web-based self-triage platform in General Medical Services.	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
AN5.4	Ensure patients know how to access primary care services and are confident about new ways of working (virtual or if appropriate, face-to-face).	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
AN5.5	Increase use of primary care technology within care home settings as requested by care homes	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P

QP 06: Efficient and effective immunisation activities						
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**End of September 2020**
AN6.1	Develop locality level flu immunisation delivery plans for 2021 ***Linked to Action 3.5 & 6.3***	Executive Director Primary & Community Care	31.08.2020	N/A	SPPH	**P**
AN6.2	In partnership with Public Health and Welsh Government colleagues, prepare rolling plans for the delivery in Primary Care of Covid-19 vaccination programme that can be enacted as soon as a vaccine is available.	Executive Director Primary & Community Care	14.09.2020	N/A	SPPH	**P**
AN6.3	Review uptake of childhood immunisations and implement catch up programmes as required ***Linked to Action 3.5 & 6.1***	Executive Director Primary & Community Care	30.09.2020	N/A	F&P	**P**

QP 07: Develop the Primary Care & Community Academy

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN7.1	Further develop the Advanced Paramedic Practitioner Pacesetter Project	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
AN7.2	Develop our version of Scottish *Project Joy* scheme for the recruitment of general practitioners & senior primary care clinicians	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	R
AN7.3	Develop business case for Education and Training Local Enhanced Services	Executive Director Primary & Community Care	30.09.2020	N/A	F&P	P
AN7.4	Progress support programme for General Practitioner practices in partnership with Royal College of General Practitioners	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
AN7.5	Further develop the Academy website and social media marketing and promotional material to capitalise upon positive recruitment interest that the initiative has brought.	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P

QP 08: Implement General Medical Services Recovery Plan						
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**End of September 2020**
AN8.1	Agree changes to local covid-19 assessment centres with each Locality that allow step up/ down as appropriate according to prevailing incidence.	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
AN8.2	Commission revised care homes Directed Enhanced Service contract.	Executive Director Primary & Community Care	31.07.2020	N/A	F&P	P
AN8.3	Support General Practitioner practices with its *readiness for recovery* including provision of dedicated protected education time session and a recovery plan *toolkit* alongside Welsh Government Operational Guide	Executive Director Primary & Community Care	31.07.2020	N/A	SPPH	P
AN8.4	Prescribing plan to reduce foot-fall and workload associated with repeat prescribing	Executive Director Primary & Community Care	31.08.2020	N/A	SPPH	A

QP 09: Implement Dental Services Recovery Plan

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN9.1	Implement Welsh Government Dental Recovery Plan	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
AN9.2	Continuation & strengthening of Urgent Designated Dental Centres provision for those requiring aerosol generating procedures	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
AN9.3	Implement the national 'buddy' system to inform contract reform	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	R

QP 10: Implement Community Pharmacy Recovery Plan

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN10.1	Implement Welsh Government Community Pharmacy Recovery Plan	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
AN10.2	Improve rapid access to palliative care drug	Executive Director Primary & Community Care	31.07.2020	N/A	SPPH	A

QP 011: Implement Community Optometry Recovery Plan

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN11.1	Implement Welsh Government Optometry Recovery Plan	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
AN11.2	Support the delivery of reinstated secondary care pathways e.g. Glaucoma, Wet Age-Related Macular Degeneration, Optometric Diagnostic and Treatment Centres	Executive Director Primary & Community Care	30.09.2020	N/A	F&P	R
AN11.3	Address backlog of activity arising due to Covid.	Executive Director Primary & Community Care	30.09.2020	N/A	F&P	P
AN11.4	Reinstate full access to urgent care pathway	Executive Director Primary & Community Care	30.09.2020	N/A	F&P	P

QP 12: Develop primary care out of hours services and NHS 111

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN12.1	Implement agreed management structure for Out of Hours	Executive Director Primary & Community Care	31.07.2020	N/A	SPPH	A
AN12.2	Prepare for implementation of new clinical system and implementation of 111	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P

AN9.3 - The Contract Reform programme is currently on hold during the escalation phases of COVID response.
Practices are completing ACORNS as required by current stage guidance. Where required practices are buddied with Contract Reform practices to provide support and guidance.
ACORN submission is being monitored and reported nationally, and support and guidance will be provided by the Health Board to practices who are not submitting to ensure that any issues are resolved.

AN11.2 - (line 82) This change is on basis that Diabetic Retinopathy pathway was to progress to CAG (Clinical Lead progression): to allow agreement for 1200, R1 patients to pass to Primary Care for data gathering and subsequent Ophthalmology virtual review.

QP 13: Deliver safe Community Hospital services						
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**End of September 2020**
AN13.1	Consolidation of Home First / Step Down pathways	Executive Director Primary & Community Care	31.07.2020	N/A	QSE	P
AN13.2	Consolidation of covid related protocols in Community Hospitals	Executive Director Primary & Community Care	31.07.2020	N/A	QSE	P
AN13.3	Maximising stroke rehabilitation services ***Linked to Action 28.5***	Executive Director Primary & Community Care	30.09.2020	N/A	QSE	R

QP 14: Support Care Homes and reintroduce CHC						
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**End of September 2020**
AN14.1	Capture good practice and legacy actions internally and share across partners.	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
AN14.2	Ensure BCU wide approach to care home support and escalation to ensure sustainability and business continuity (Care Home Directed Enhanced Service, Escalation Levels)	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
AN14.3	Care home testing	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
AN14.4	Community Health Care Framework	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	R
AN14.5	Complete the governance and reporting arrangements for the Care Home Group	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P

QP 16: Transform Community Services

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN16.1	Community Transformation Programme	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	A
AN16.2	Community Response Team working inclusive of third sector	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	A
AN16.3	Feasibility study for inclusion of Community Geriatrician within Community Response Team model of care	Executive Director Primary & Community Care	30.09.2020	N/A	F&P	A

QP 17: Develop Community Resilience

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN17.1	*Complete baseline evidence collation for Right sizing* Community Services	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	A
AN17.2	Progress implementation of Phase 2 of the Digital Communities initiative	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P

AN13.3 - Review of the ESD component of the Stroke Business Care with a view to implement pan BCU - linked to Q3/4 action for Executives to revisit the Stroke Business Case.

AN14.4 - Cannot be implemented as the CHC Framework publication is delayed by WG

AN16.1 - East transformation board approved reboot. Business case complete to secure ongoing funding through to March 2022

AN16.2 - CRT working closely with third sector however further work still to do to have a comprehensive approach.

AN16.3 - west action. Part of the Q3/4 plan. West piloting this on behalf of the other two areas and will review at end of Q4.

AN17.1 - Regionally led - Grant Thornton contracted to progress, DPIA just signed off. Delays starting as a result of internal process barriers.

QP 18: Mental Health / Learning Disabilities (Part 1 of 2)

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN18.5	Commence implementation of the Primary Care Programme at pace.	Executive Medical Director	01.09.2020	N/A	SPPH	A

QP 18: Mental Health / Learning Disabilities (Part 2)

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN18.6	Implementation of recommendations from the Psychological Therapies Review	Executive Director of Public Health	01.09.2020	N/A	SPPH	R
AN18.7	Re-establish the Rehabilitation Programme of work	Executive Director of Public Health	01.09.2020	N/A	SPPH	P
AN18.8	Begin roll out of Attend Anywhere virtual consultation platform across the division	Executive Director of Public Health	01.09.2020	N/A	F&P	P
AN18.9	Implementing division wider QI training plan	Executive Director of Public Health	01.09.2020	N/A	SPPH	A

AN18.5 Commence implementation of the Primary Care Programme at pace:
Undertaking stakeholder engagement activities with the area teams , but no confirmed implementation date yet

AN18.6 Implementation of recommendations from the Psychological Therapies Review:
Progression of the Psychological Therapies has been paused for the moment pending the series of engagement sessions that have taken place with the Psychologists . The Division plan to implement in the latter quarter's of the year. Psychological therapies will be an enabling work stream which will be embedded throughout the pathway work

AN18.9 Implementing division wider QI training plan:
Discussions are ongoing with Elliot Blanchard to re commence the training plan . Meeting scheduled for the 30/09/20

QP 19: Maximise Capacity within Each Site

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN19.1	Review current process for booking and allocation to ensure it is fit for purpose and consistently applied across North Wales.	Executive Director Nursing & Midwifery	30.09.2020	N/A	F&P	A
AN19.2	Delivery of OPD programme	Executive Director Nursing & Midwifery	30.07.2020	N/A	F&P	A
AN19.3	Utilisation of workforce dashboard to identify staffing resource	Executive Director of Workforce and OD	30.07.2020	N/A	F&P	P

QP 20: Develop a single risk stratification approach across the pathway of care						
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**End of September 2020**
AN20.1	**Stage 1** Outpatient transformation project focused upon delivering virtual appointments wherever possible and only face to face where necessary	Executive Director Nursing & Midwifery	30.09.2020	N/A	F&P	A
AN20.2	Stage 4 Specialty specific risk stratification using P1-P4 categorisation as per essential services framework	Executive Director Nursing & Midwifery	30.07.2020	N/A	F&P	P
AN20.3	Create specialty multi-disciplinary teams to review cases and ensure clinical handover if surgical team listing patient is not able to operate	Executive Director Nursing & Midwifery	30.07.2020	N/A	QSE	A
AN20.4	Review current performance measures to ensure they reflect necessary quality metrics including reviewing and strengthening current reporting structure to ensure patient allocation can be monitored	Executive Director Nursing & Midwifery	31.08.2020	N/A	QSE	P

QP 21: Identification of highest priority services with risk based capacity shortfalls						
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**End of September 2020**
AN21.1	Identify specialties where local resource does not meet needs for P1-P2 demand and implement pan BCU approach including identify specialties with significant variance in waiting times to implement pan BCU approach	Executive Director Nursing & Midwifery	31.07.2020	N/A	F&P	P

QP 22: Identification of areas for service review						
Ref	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**End of September 2020**
AN22.1	Review and refresh priority business cases e.g. Ophthalmology, Orthopaedics, Urology & Stroke	Executive Director Nursing & Midwifery	31.08.2020	N/A	SPPH	R
AN22.2	Review of specialties identified where a pan BCU risk stratification approach may not on its own provide the necessary impact.					P

QP 23: Identify the required metrics to monitor performance						
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**End of September 2020**
AN23.1	a. Quality Outcome Measures of clinical pathways identified	Executive Medical Director	30.09.2020	N/A	QSE	R
	b. Pan BCU service metrics developed					R
	c. Effectiveness of implementation plans monitored & reviewed					R

QP 24: Improve quality outcomes and patient experience						
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**End of September 2020**
AN24.1	Identify clinical pathways requiring review or development	Executive Medical Director	30.07.2020	N/A	QSE	P
AN24.2	Coordinate with Clinical Advisory Group a programme and timetable for pathway development and review	Executive Medical Director	30.07.2020	N/A	QSE	P
AN24.3	Develop pathways in line with the digitally enabled clinical services strategy	Executive Medical Director	30.07.2021	N/A	QSE	A
AN24.3b	Establish the Eye Care Digital Programme Board to lead the implementation of the Digital Eye Care programme funded by Welsh Government	Executive Medical Director	30.07.2020	N/A	QSE	R
AN24.4	Ensure quality outcome measures are referenced and measurable	Executive Medical Director	30.07.2020	N/A	QSE	A
AN24.5	Ensure Patient Reported Outcome Measures and Patient Reported Experience Measures are included and measured in pathway development	Executive Medical Director	31.08.2020	N/A	QSE	R

AN22.1 Review and refresh priority business cases e.g. Ophthalmology, Orthopaedics, Urology & Stroke
The proposed diagnostic and treatment centres will impact will impact on these priority cases and it isn't possible at this stage to be clear about the extent as the DTC model is at an early stage. There are specific commitments in the Q3 and Q4 plan around orthopaedics, ophthalmology and stroke. On stroke services, we have decided to focus on the rehabilitation aspects of the previous case. Progress has been made on aspects of the urology case with the progression of a proposal to introduce Robotic Assisted Surgery.

AN23.1 Clinical Pathways
There are a very large number of pathways, some of which are also being modified as the clinical situation regarding Covid-19 changes. These are being worked through, however due to the uncertainties of working with Covid-19 it would be difficult to say that all pathways [> 40 and counting] will be Green and by when.

AN24.3 Develop pathways inline with the digitally enabled clinical services strategy:
No consistent representation from digital/informatics on CAG. Now included in amended TOR starting 02.10.20

AN24.4 Ensure quality outcome measures are referenced and measureable:
Amended TOR include representation from performance. Clinical pathway template includes DPIA and clinical outcomes

AN24.5 Ensure patient reported outcome measures and patient reported experience measures are included and measured in pathway development:
Not previously consistently included in pathways template. Very few specialties have validated PROMS/PREMs - Work required to define PROMs and PREMs aligned to national guidance. RECOMMENDATION: Completion date refresh to Dec 2020

QP 25: Provide care closer to home

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN25.1	Provide virtual appointments wherever possible	Executive Director Nursing & Midwifery	30.09.2020	N/A	F&P	P
AN25.2	Support outpatient transformation to identify community facilities where face to face consultations could be offered and deliver appointments and treatments as local as possible where there is equity of access	Executive Director Nursing & Midwifery	30.09.2020	N/A	F&P	A
AN25.3	Primary Care Optometric Diagnostic and Treatment Centres undertaking training with Consultants as part of skill development to provide shared care for Glaucoma patients	Executive Director Nursing & Midwifery				A

QP 26: Reduce health inequalities

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN26.1	Ensure that patients are prioritised using an agreed risk stratification tool and offered the soonest appointment based on their clinical needs	Executive Director Nursing & Midwifery	30.07.2020	N/A	QSE	P

QP 27: Planned Care

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN27.1	Develop preferred service model for acute urology services	Executive Director Nursing & Midwifery	30.09.2020	AP 021	F&P	A
AN27.6	Transform eye care pathway to deliver more care closer to home delivered in partnership with local optometrists	Executive Director Nursing & Midwifery		AP 023	F&P	R
AN27.7	Systematic review and plans developed to address service sustainability for all planned care specialties (RTT).	Executive Director Nursing & Midwifery		AP 025	F&P	A
AN27.8	Implement year one plans for Endoscopy	Executive Director of Therapies & Health Sciences	30.07.2020	AP 025	F&P	R
AN27.9	Systematic review and plans developed to address diagnostic service sustainability	Executive Director of Therapies & Health Sciences	30.09.2020	AP 025	F&P	R

AN27.6 - Transform eye care pathway to deliver more care closer to home delivered in partnership with local optometrists:
Key clinical appointment has been made this month which will help lead the development of this service. The director of performance who lead on eye services has left on a secondment. Alyson Constantine Acute Site Director at Ysbyty Gwynedd has agreed to assume this responsibility.

AN27.7 - Systematic review and plans developed to address service sustainability for all planned care specialties (RTT):
Work continues to develop Q3/4, activity plans, however due to the Covid-19 pandemic, significant disruption has occurred with planned care. A review of how services could be sustained through a diagnostic and treatment centre approach has been discussed at Finance and performance committee last month.

AN27.8 - Implement year one plans for Endoscopy:
An endoscopy recovery plan is underway, which incorporates years 1-2. Currently once for north wales approach has been adopted and currently the organisation is out to tender for further capacity and an insourcing model.

AN27.9 - Systematic review and plans developed to address diagnostic service sustainability:
Diagnostic services were disrupted due to Covid-19, risk stratification has been applied to all diagnostics and Essential diagnostic are now maintained. Further work is being undertaken to address the backlog including business cases for further CT and MRI capacity.

QP 28: Unscheduled Care

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN28.1	**Demand:** Workforce shift to improve care closer to home (key priority for 2020/2021)	Executive Director Nursing & Midwifery	30.09.2020	AP 031	F&P	R
AN28.2	**Flow:** Emergency Medical Model (key priority for 2020/2021)	Executive Director Nursing & Midwifery	30.09.2020	AP 034	F&P	A
AN28.3	**Flow:** Management of Outliers (key priority for 2020/2021)	Executive Director Nursing & Midwifery	30.09.2020	AP 034	F&P	P
AN28.4	**Discharge:** Integrated health and social care (key priority for 2020/2021)	Executive Director Nursing & Midwifery	30.09.2020	AP 038	F&P	P
AN28.5	Stroke Services ***Linked to Action 13.03***	Executive Director Nursing & Midwifery	30.09.2020	AP 039	F&P	R

AN28.1 - Demand: Workforce shift to improve care closer to home (key priority for 2020/2021)
There have been some delays in progressing this at the pace intended due to COVID unfortunately, this is currently being reviewed in light of recent changes and learning as a result.

AN28.5 – Stroke Services (Linked to Action AN13.3)
Progress will be made in September to utilise video consultations where appropriate to increase capacity and support for stroke rehabilitation services.

QP029: Workforce & Organisational Development						
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**End of September 2020**
AN29.1	Review the previous Workforce Improvement Group structure and establish a revised structure at Strategic, Tactical and Operational Levels	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	SPPH	R
AN29.2	Ensure effective social partnership working as a key enabler for organisational development and transformation. Review the operation and management of social partnership relationships and processes and establish a programme for improvement across both medical and non-medical structures	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	SPPH	R
AN29.3	Provide 'one stop shop' workforce enabling services to support surge requirements; new developments and reconfiguration or workforce re-design linked to key priorities of the Health	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	F&P	P

QP 30: Workforce Planning and Optimisation						
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**End of September 2020**
AN30.1	Ensure a robust integrated workforce model is in place with Local Authority partners for specific projects, to support the development of a health and Social Care model across the wider health community	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	SPPH	P
AN30.2	Ensure workforce optimisation plans are in place to support the delivery of safe care and mitigate the impact of COVID-19, the Test, Trace, Protect programme on staff and they support the Health Boards adjusted surge capacity plans for Q2.	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	F&P	P
AN30.3	Ensure all key workforce indicators are in place and monitored robustly to support all surge and essential services delivery	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	F&P	R
AN30.4	Ensure agile and new ways of working deployed in order to maintain safety for staff and patients because of COVID-19 are optimised and embedded.	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	QSE	R
AN30.5	Deliver Workforce Optimisation / Efficiency Plan - reducing waste and avoidable variable /premium rate pay expenditure. Demonstrating value for money and responsible use of public funds	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	F&P	R

QP 31: Occupational Health Safety and Equality						
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**End of September 2020**
AN31.1	Implement Year 2 of the Health & Safety Improvement Plan is implemented to staff are proactively protected, supported and safe, including black, Asian, and minority ethnic, older people, co-morbidities and pregnant workers and that all environmental and social impacts are monitored and complied with	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	QSE	R
AN30.2	Effective infrastructure in place to ensure wellbeing and psychological support is accessible to all staff	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	QSE	P
AN30.3	Ensure ongoing effective management of training, equipment and supplies in line with emergency guidance	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	QSE	R
AN30.4	Implement the Strategic Equality Plan revised year 1 actions to help ensure that equality is properly considered within the organisation and influences decision making at all levels across the organisation	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	SPPH	P

AN29.1- Review the previous Workforce Improvement Group structure and establish a revised structure at Strategic, Tactical and Operational Levels:
Operational Groups in place and tactical terms of reference drafted. Strategic Group and alignment now being informed by governance review underway. Taken forward for completion in Quarter 3

AN29.2 - Ensure effective social partnership working as a key enabler for organisational development and transformation. Review the operation and management of social partnership relationships and processes and establish a programme for improvement across both medical and non-medical structures:
Medical and Non Medical structures mapped. Responsibilities for effective management of relationships at all levels linked to structure and governance review above and changes in executive leadership for medical staff. Taken forward in Quarter 3

AN30.3 - Ensure all key workforce indicators are in place and monitored robustly to support all surge and essential services delivery:
Triggers for prioritised safe deployment of staff developed and to be agreed as part of surge planning. Workforce Planning performance indicators delayed due to work on outbreaks in August and again Sept and surge planning. Taken forward for Quarter 3.

AN30.4 - Ensure agile and new ways of working deployed in order to maintain safety for staff and patients because of COVID-19 are optimised and embedded:
Model developed and socialised. Capacity to support programme lead now being secured. Taken forward in Quarter 3

AN30.5 - Deliver Workforce Optimisation / Efficiency Plan - reducing waste and avoidable variable /premium rate pay expenditure. Demonstrating value for money and responsible use of public funds:
Initial revised plan was submitted but Covid related issues have consumed the capacity to move this action forward, most notably the Wrexham and Glan Clwyd Outbreaks that have been a major draw on Workforce resource over the period
taken forward into Quarter 3.

AN31.1 - Implement Year 2 of the Health & Safety Improvement Plan is implemented to staff are proactively protected, supported and safe, including black, Asian, and minority ethnic, older people, co-morbidities and pregnant workers and that all environmental and social impacts are monitored and complied with:
Robust risk assessment framework for COVID -19 in place and operational. Case for change for highest risks progress to Business Case review group. Security specification delayed but underway. Taken forward into Quarter 3.

AN30.3 - Ensure ongoing effective management of training, equipment and supplies in line with emergency guidance:
Comprehensive improvement plan in place to ensure competent training and effective record keeping for PPE/Training in place. Links to work with HSE. Taken forward into Quarter 3.

QP 32: Digital Health / IM&T

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN32.2	Seek approval for funding for Welsh Emergency Department System	Executive Medical Director	30.09.2020	N/A	F&P	R
AN32.3	Development of the digital health record	Executive Medical Director	30.09.2020	N/A	DIGC	P
AN32.5	Implementation of Digital dictation project	Executive Medical Director	31.08.2020	N/A	DIGC	P
AN32.7	Scale up Implementation of Office 365	Executive Medical Director	31.12.2020	N/A	DIGC	A
AN32.8	Implement COVID-19 hardware response	Executive Medical Director	31.01.2021	N/A	DIGC	A
AN32.11	Delivery of digital infrastructure rolling programme	Executive Medical Director		AP 058	DIGC	A
AN32.12	Provision of infrastructure and access to support care closer to home	Executive Medical Director	Further review with Area teams/ dependent on Office 365	AP 059	DIGC	A

AN32.2 - Seek approval for funding for Welsh Emergency Department System:
Pending review by the business case review team and scheduled for Finance & Performance Committee in October 2020.

AN32.7 - Scale up Implementation of Office 365:
Resource being appointed and project governance established

AN32.8 – Implement COVID-19 hardware response:
Procurement of 1,300 devices underway

AN32.11 - Delivery of digital infrastructure rolling programme:
Usual rollout constrained by Covid-19 demand

AN21.12 – Provision of infrastructure and access to support care closer to home:
Funding for 600 devices and short term resource funding agreed

QP 33: Estates & Capital						
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**End of September 2020**
AN33.1	Well-being hubs	Executive Director of Planning and Performance	30.09.2020	AP 064	SPPH	R
AN33.8	Complete reviews to initiate the following programmes:	Executive Director of Planning and Performance	30.09.2020	N/A	SPPH	R
	- Health economy programme business case					
	- Relocation of services from Abergele					R
	- Rationalisation of Bryn y Neuadd					R

AN33.1: Well Being Hubs
This action remains relevant however has not been prioritised for Quarter 3 & 4 plan.

AN33.8: Complete Reviews to initiate Health Economy Programme Business Case, Relocation of Services from Abergele, Rationalisation of Bryn-y-Neuadd
This action remains relevant and will be part of the work-plan for the newly established Capital Investment Group. However it has not been prioritised for the Q3 & 4 plan

Further Information

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

- tolerances for red, amber and green

Further information on our performance can be found online at:

- Our website www.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 & Experience Committee 3rd November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quality & Performance Report (QPR)
Cyfarwyddwr Cyfrifol: Responsible Director:	Mr Mark Wilkinson, Executive Director of Planning & Performance
Awdur yr Adroddiad Report Author:	Mr Ed Williams, Head of Performance Assurance
Craffu blaenorol: Prior Scrutiny:	The data and information in this report has been scrutinised by the Director of Performance and the Executive Director of Planning & 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.

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, due to the continued Covid-19 pandemic, whilst Welsh Government will not be performance managing Health Boards based on the performance measures included in this report, they have recommenced the monitoring and publishing of the data.

This report includes available indicators from the National Delivery Framework, together with a section on Covid-19.

Cefndir / Background:

Our report outlines the key performance and quality issues that are of priority for the Health Board. The summary of the report is now included within the Executive Summary pages of the QPR and demonstrates the work related to Covid-19 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 & 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-19 services. The impact of Covid-19 on non-Covid-19 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.

Impact Assessment

The Report has not been Equality Impact Assessed

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

Quality and Performance Report







Quality, Safety & Experience Committee

September 2020

About this Report

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 herein is not compared as 'like-for-like' to previous year's performance. It is also important to note that national reporting and performance management arrangements remain suspended at this time.

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 complementary 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.
The direction of travel of performance is indicated through trend arrows.

↑ Performance has improved since last reported

↓ Performance as got worse since last reported

→ Performance remains the same as last reported

For September 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.

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

Key Messages

- Significant areas of North Wales in Lockdown due to rise in cases of Covid-19
- Number of Covid-19 cases rising and bed occupancy is increasing
- Essential services largely maintained, however activity remains significantly reduced

Executive Summary

The committee are asked to note the following:

Covid-19 Update
At the time of writing, to date over a quarter of a million tests have been carried out, of which 9,380 were positive for Covid-19. The turnaround from Test to Result is now averaging at 99% completed within 24 Hours.

In light of the second wave of the pandemic, testing capacity has been increased with the opening of an additional testing centre on Anglesey.

The Health Board is putting into action its surge capacity plans to ensure that services can manage the increasing demand on acute services as admissions of patients tested positive for Covid-19 begin to rise.

Quadruple Aim 1:Prevention
Despite the impact of the Covid-19 pandemic on most planned care services, it is encouraging to see that our immunisation of children programmes have continued to deliver throughout quarter 1, 2020/21 at 95.8% of eligible children receiving 6 in 1 Hexevalant and 93.9% of eligible children receiving 2 doses of MMR vaccinations by the age of 5.

Our seasonal flu campaign began in late September and progress will be reported in the next report for Quality, Safety and Experience Committee.

Quadruple Aim 2: Infection Prevention
In comparison to the same period of 2019/20. there has been a fall in the number of most infection types across Wales and the Health Board. However, there has been a rise in the rate of C.difficile infections across Wales.

This month's report includes a set of heatmaps that demonstrate that the majority of infections are community onset, i.e. the patients already have the infection by the time they encounter our services. The infection Prevention and Control teams continue to work on reducing the number of infections alongside their work on Covid-19.

Quadruple Aim 2: Mental Health
Both Adult and Children's Mental Health services have begun to recover as services have been re-established after the initial outbreak of the Covid-19 Pandemic. In particular CAMHS assessments within 28 days of referral are now on target of 80% and the rate of children starting therapy within 28 days of assessment is improving. However, at 52% it is clear more work needs to be done.

For Adult Mental Health there was a slight dip in performance compared to last month, however the number of patients starting therapy within 28 days of assessment remains above the 80% target at almost 90%.

The number of patients experiencing delayed transfer of care (DToC) within our mental health services has increased however, the length of time each patient is delayed for is being decreased. There are a number of issues that cause DToCs, which are being resolved and it is expected that the number and length of DToC's will reduce over the coming months.

Performance against the 26 Week target or children awaiting neurodevelopment assessment remains poor at 19.5%, however, Plans recently approved will enable us to increase capacity to see 120 children per month.

Quadruple Aim 3: Quality & Safety
There were no new never events reported in September 2020. Incident closure rates remain strong at 80% reflecting the learning from incidents and focus upon timely responses.

Quadruple Aim 4: Mortality and Timely Interventions
After reaching a high of 1.17% in the last reporting period, the Crude Mortality rate has begun to fall at 0.92%.

We are ensuring that Health Board processes are aligned with the introduction of the Medical Examiners Service (ME) which is being piloted at Ysbyty Glan Clwyd from Sept 2020.

Whilst there is still improvement to be made, at 52% the rate of provision of Sepsis Six bundles to eligible patients within our emergency departments is improving.

Covid-19

Key Messages

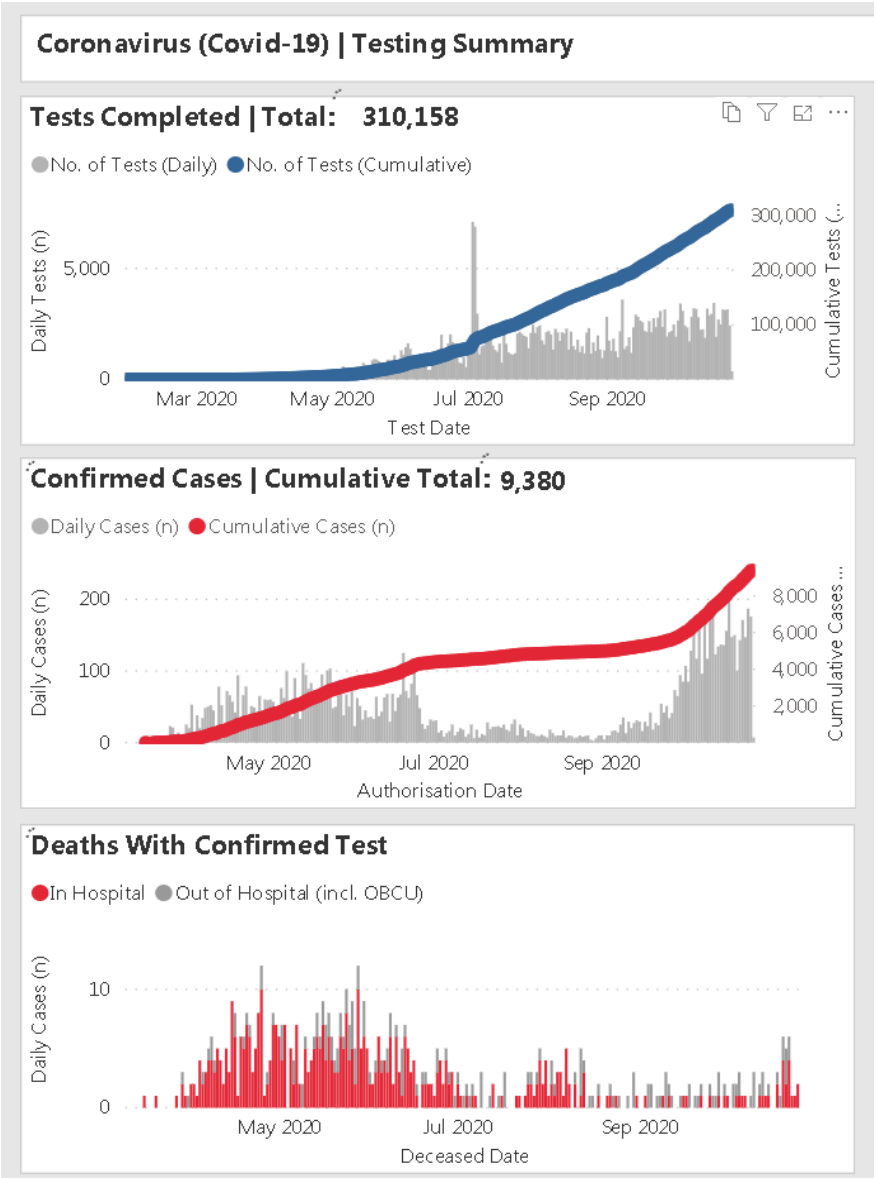
- Second wave of Covid-19 is affecting North Wales
- Local Lockdowns in place to help prevent spread of Covid-19
- Surge plan implemented to increase hospital capacity

Measures

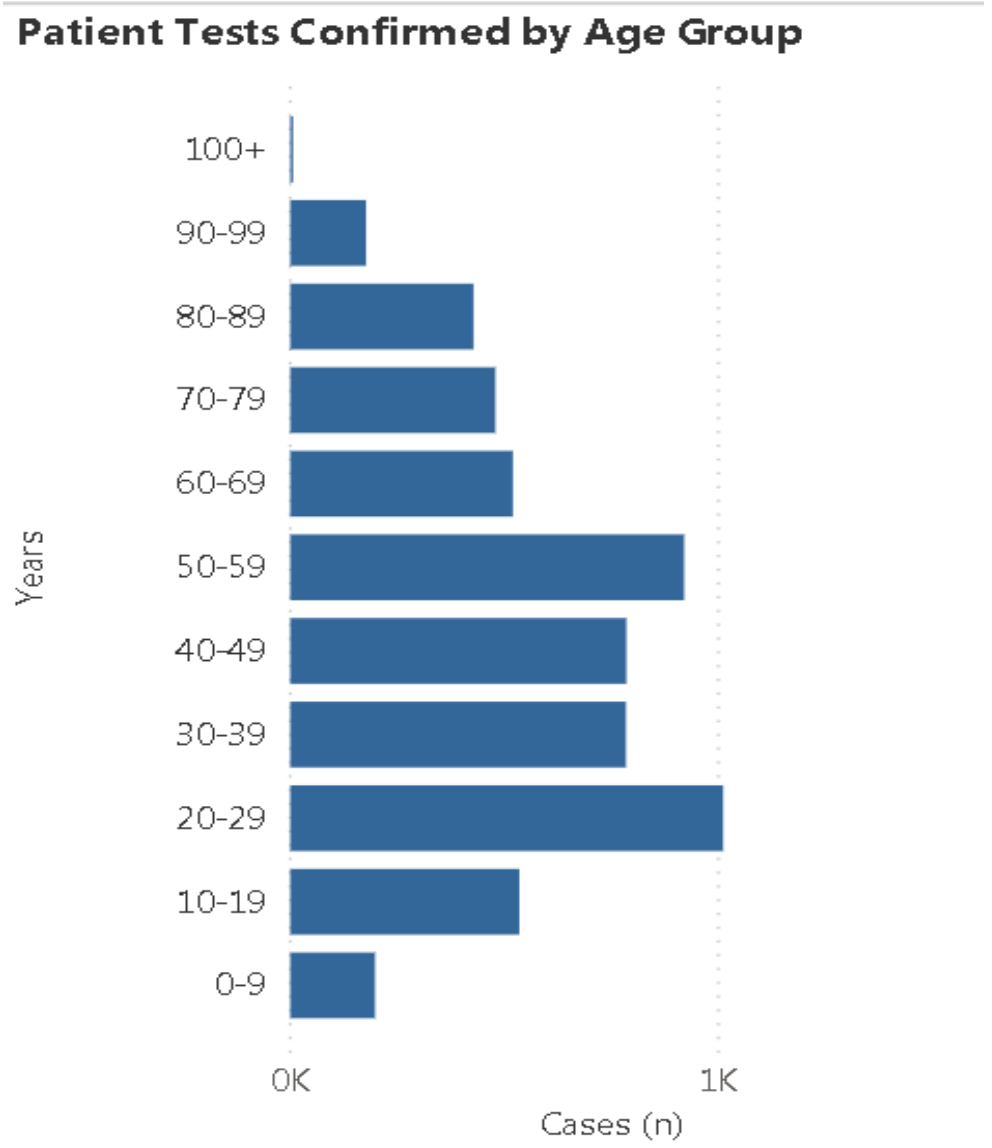
Measure	at 27th October 2020
Total number of tests for Covid-19	**310,158**
% Tests turned around within 24 Hours (Last 7 days)	**99%**
Number of results: Positive	**9,380**
Number of results: Negative	**300,778**
% Prevelence of Positive Tests (cumulative since 30th January 2020)	**3.0%**
Rate of positive cases per 100,000*	**1,268.4**
Number of Deaths - Confirmed Covid-19*	**460**

Source: BCU IRIS Coronavirus Dashboard, accessed 27th October 2020
** PHW Coronavirus Dashboard Accessed 27th October 2020*

Covid-19 Test Information

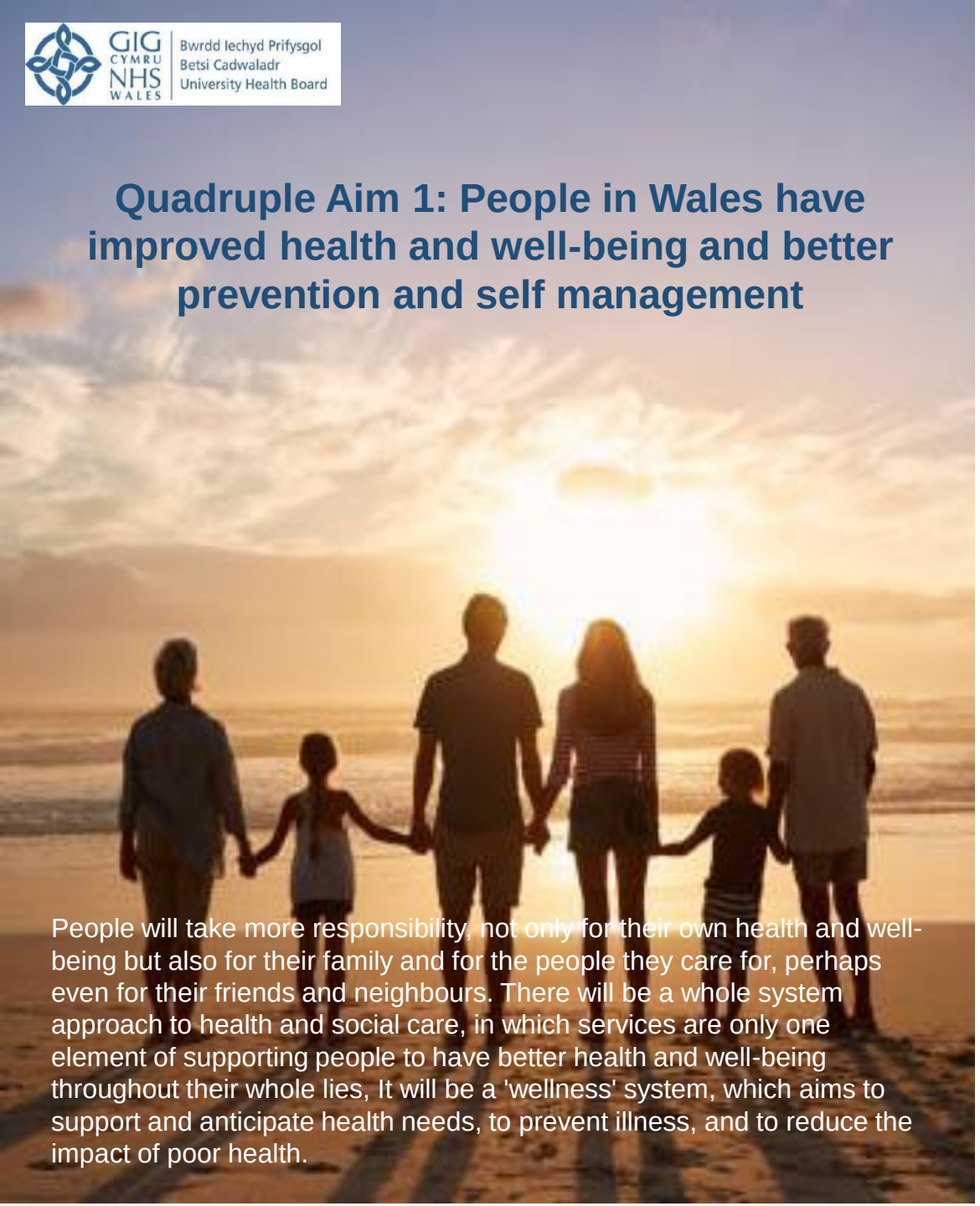


Source: BCU IRIS Covid-19 Dashboard. Accessed 27th October 2020



Cumulative number from 30th January 2020
Source: BCU IRIS Covid-19 Dashboard. Accessed 27th October 2020

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



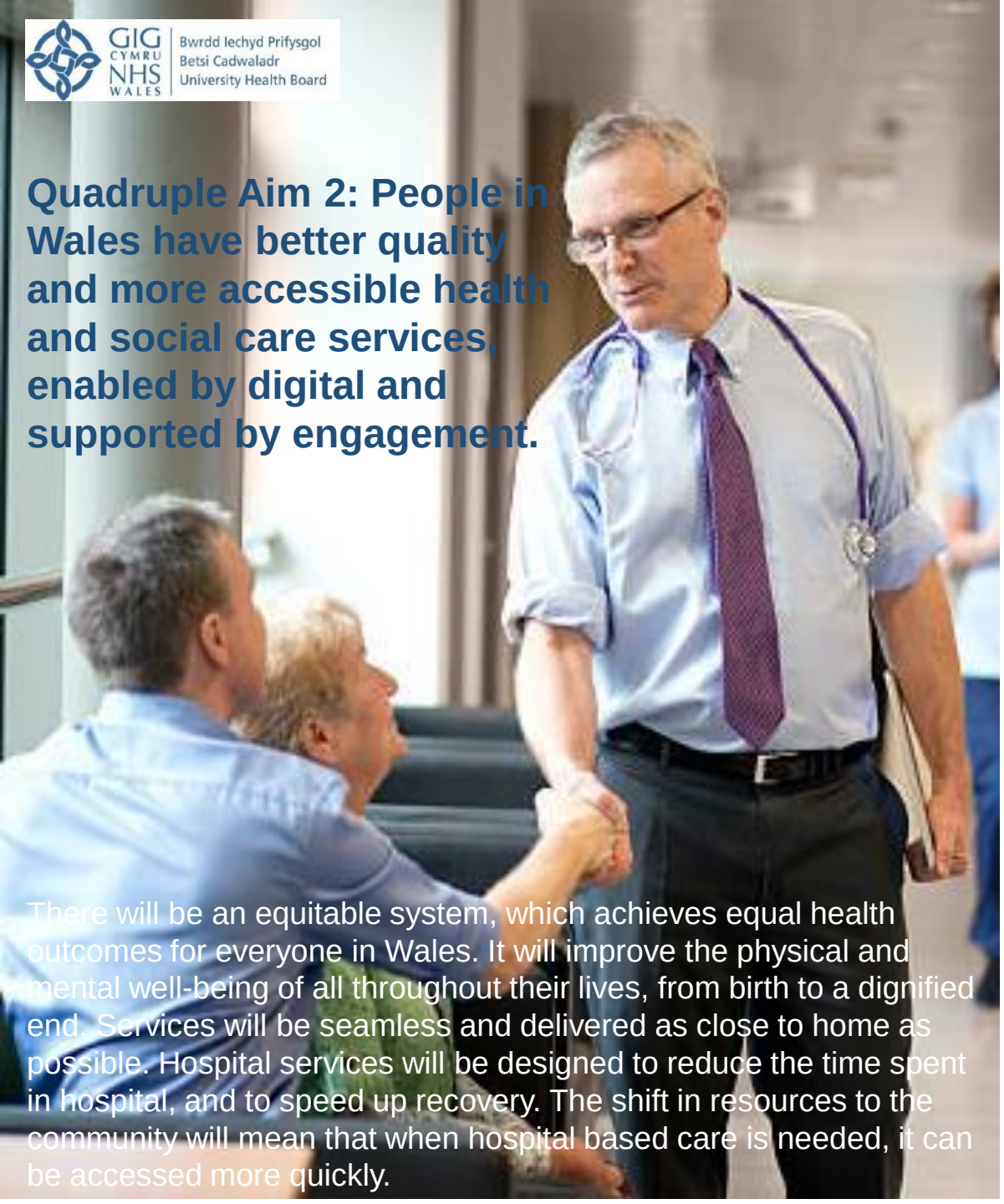
People will take more responsibility, not only for their own health and well-being but also for their family and for the people they care for, perhaps even for their friends and neighbours. There will be a whole system approach to health and social care, in which services are only one element of supporting 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 September 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
Q1 20/21	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	**>= 95%**	95.80%	↑
Q1 20/21	Percentage of children who received 2 doses of the MMR vaccine by age 5	**>= 95%**	93.90%	↓
Aug 20	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%**	90.91%	↓
Aug 20	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%**	89.80%	↑



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.

Key Messages

- Primary Care digital access and virtual consultations established
- Increase in number of Mental Health Delayed Transfers of Care
- Mental Health Assessment and Intervention times improved

Top Measures (based on movement up or down)

Period	Measure	Target	Actual	Trend
Aug 20	Percentage of children and young people waiting less than 26 weeks for neurodevelopment assessment	>= 80%	19.57%	↓
Aug 20	Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy	>= 80%	23.78%	↓
Sep 20	Total Number of mental health delayed transfers of care patints	Reduction	52	↓
Sep 20	Total Number of mental health delayed transfer of care bed days	Reduction	2,501	↓

Quadruple Aim 2: Infection Control Measures

Period	Measure	Target	Actual
Sep 20	Cumulative rate of laboratory confirmed E-Coli cases per 100,000 population	<= 67	63.69
Sep 20	Cumulative number of laboratory confirmed E-Coli cases	N/A	223
Sep 20	Cumulative rate of laboratory confirmed S.Aureus cases per 100,000 population	<= 20	21.71
Sep 20	Cumulative number of laboratory confirmed S.Aureus cases	N/A	38
Sep 20	Cumulative number of laboratory confirmed C.Difficile cases	N/A	120

Period	Measure	Target	Actual
Sep 20	Cumulative rate of laboratory confirmed MRSA cases per 100,000 population	N/A	0.86
Sep 20	Cumulative numberof laboratory confirmed MRSA cases	0	3
Sep 20	Cumulative number of laboratory confirmed MSSA cases	<= 40	73
Sep 20	Cumulative number of laboratory confirmed Klebsiela cases	<= 38	58
Sep 20	Cumulative number of laboratory confirmed Aeruginsoa cases	<= 10	23

Quadruple Aim 2: Narrative – Infection Prevention

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 Clostridium Difficile Infections (CDI).

The Health Board is over trajectory for all organisms except for E.coli. This is due to numbers in Central. West over trajectory for CDI. East only over trajectory for Pseudomonas. Community Onset (CO) remain significantly higher than Hospital Onset (HO).

- **Clostridium Difficile** Infections have increased with more HO than previously (Sept' 20/15). CDI infections are the biggest concern with a significant rise in Wales but more in BCU. Currently audits being completed in to an increase in CDI potentially due to treatment for Covid-19. Central, and West are both above trajectory. The HPV programme and antimicrobial stewardship (ARK) for Central and area must be prioritised with more HO to CO.
- **Methicillin Resistant Staphylococcus Aureus (MRSA)** 3 cases YTD. 1 CO unavoidable East, IVDU, 1 CO avoidable MRSA Blood Stream Infection (BSI) West as Contaminated Blood Culture and 1 ? Avoidable CO, catheterised in ED 10 days earlier and in a Care Home. In comparison to last year to date (September 2020) BCU has 50% fewer infections. All Wales are down 30%.
- **Methicillin Sensitive Staphylococcus Aureus (MSSA)** 26% fewer infections from last year, and all Wales down 9%. Most are Community Onset (CO) 12 compared to 1 Hospital Onset (HO).
- **E.coli** - The majority are CO, 30/5 and overall BCU have seen 24% fewer infections year to date. The majority remain unavoidable and for others devices remain a potential cause. The increase in Trans-urethral Repositioning (TURPs) and Trial Without Catheter (TWOCs) is an important consideration.
- **Klebsiella** infections are down 21% to last year compared to all Wales 13%. IPC and Epidemiology colleagues are reviewing all these. Majority unavoidable, and CO (6/3) and devices appear to play a part too.
- **Pseudomonas** BSIs have also increased in numbers, 21% compared to all Wales down 15%. 4 cases were confirmed in September 2 CO and 2 HO). These infections numbers although small are mostly avoidable and related to very unwell patients, with Carcinoma, Pneumonias, Wounds and Catheters/Urology complications.

September 2020 activity Hospital Onset and Community Onset

Infection Numbers - BCUHB

Informatics

Contact Us

Organism Type

All

- Select all
- C. diff
- E. Coli
- Klebsiella
- MRSA
- MSSA
- Pseudomonas aeruginosa

Specimen Location Hospital

All

Ward

All

Location Type

All

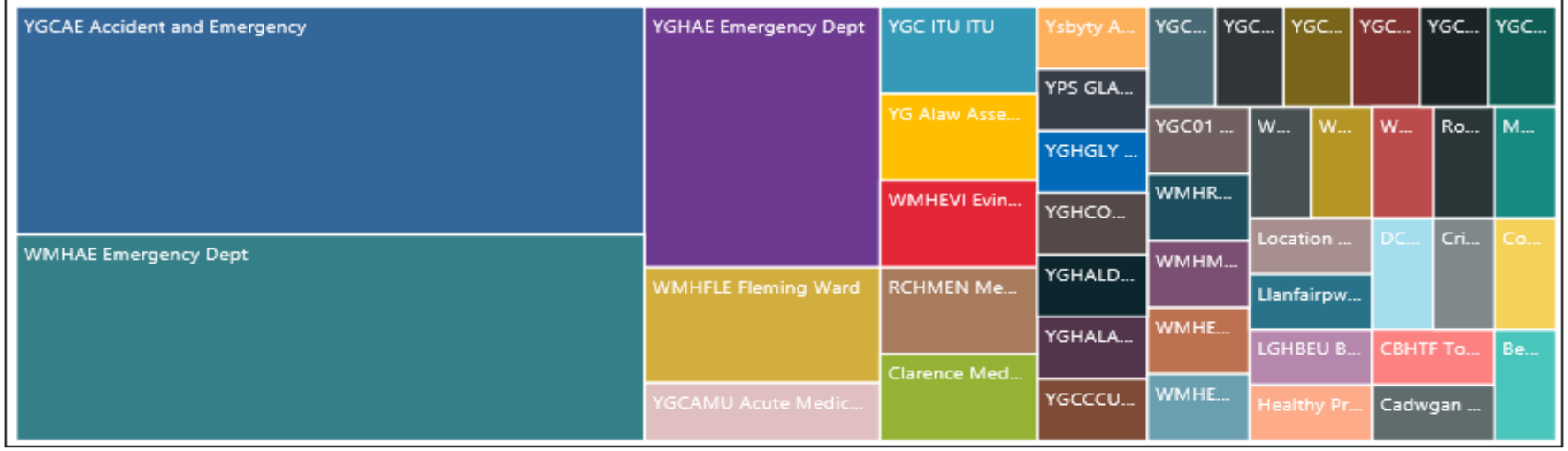
01/09/2020 30/09/2020

l from ICNet daily (Mon-Thurs) at 10:00. Any specimens that were imported into ICNet after this time will not appear until the report is updated.

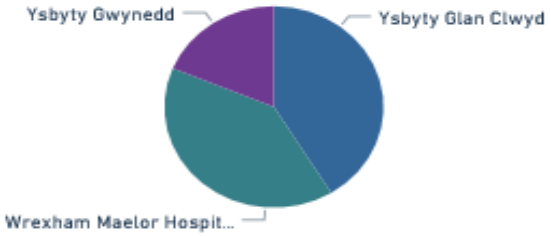
Number of Infections for Selected Criteria

98

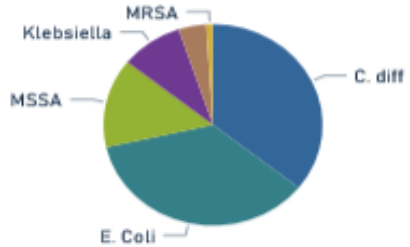
Number of Infections per Ward - Hover mouse over coloured boxes to see full Ward names and numbers of patients



Numbers and Percentages of Infections at Acute Sites



Numbers and Percentages of Infections by Organism Type



Ward	C. diff	E. Coli	Klebsiella	MRSA	MSSA	Pseudomonas aeruginosa	Total
YGCAE Accident and Emergency	1	13	2	1	3	1	21
WMHAE Emergency Dept		12	4		2	1	19
YGHAE Emergency Dept	1	4			4		9
WMHFLE Fleming Ward	2	1	1				4
Clarence Medical Centre	2						2
RCHMEN Menlli Ward	2						2
WMHEVI Evington Ward		1			1		2
YG Alaw Assessment Unit	2						2
YGC ITU ITU	1					1	2
Total	**35**	**35**	**9**	**1**	**14**	**4**	**98**

Primary, Community & Admission point specimens

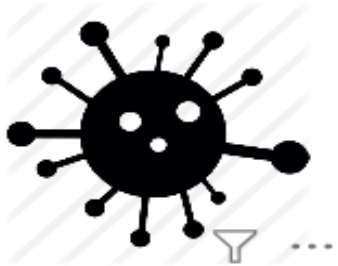
Infection Numbers - BCUHB

Informatics

Contact Us

Organism Type	Specimen Location Hospital	Ward	Location Type	01/09/2020	30/09/2020
All	All	All	Multiple selections		

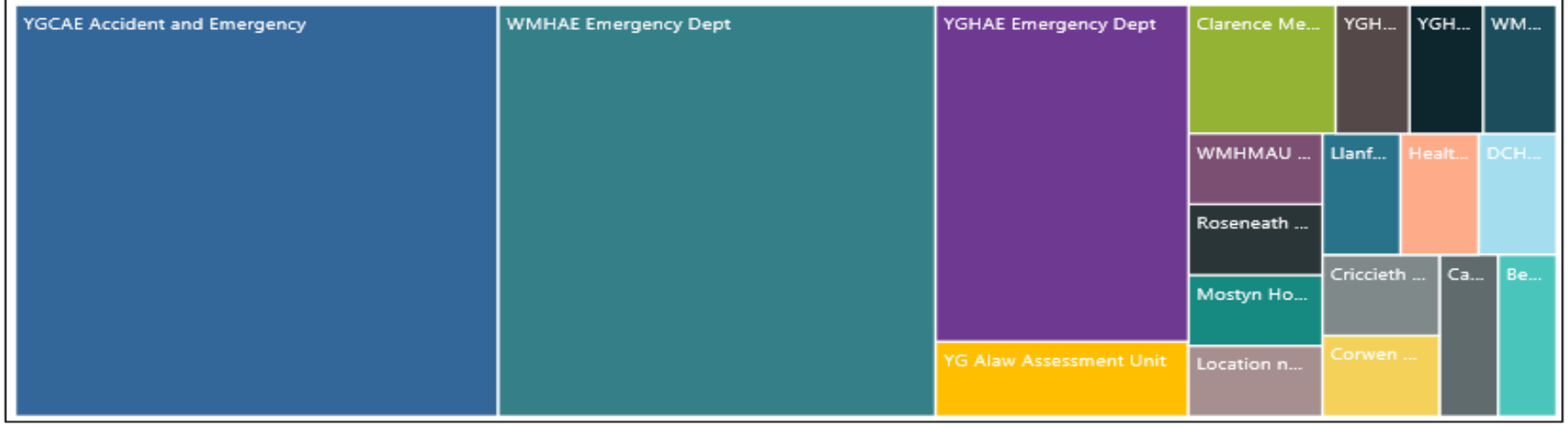
This information is updated from ICNet daily (Mon-Thurs) at 10:00. Any specimens that were imported into ICNet after this time will not appear until the report is updated.



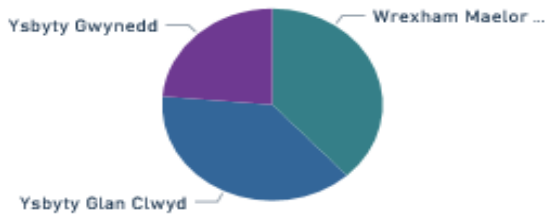
Number of Infections for Selected Criteria

67

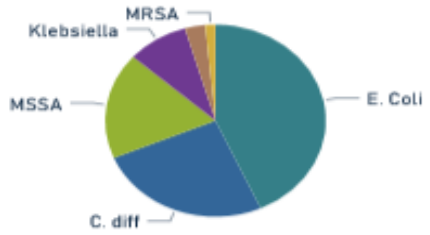
Number of Infections per Ward - Hover mouse over coloured boxes to see full Ward names and numbers of patients



Numbers and Percentages of Infections at Acute Sites



Numbers and Percentages of Infections by Organism Type

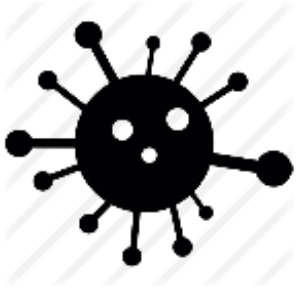


Ward	C. diff	E. Coli	Klebsiella	MRSA	MSSA	Pseudomonas aeruginosa	Total
YGCAE Accident and Emergency	1	13	2	1	3	1	21
WMHAE Emergency Dept		12	4		2	1	19
YGHAE Emergency Dept	1	4			4		9
Clarence Medical Centre	2						2
YG Alaw Assessment Unit	2						2
Beech Avenue Clinic (Wrexham)	1						1
Cadwgan Surgery	1						1
Corwen Health Centre (Corwen)	1						1
Criccieth Health Centre	1						1
Total	**17**	**29**	**6**	**1**	**12**	**2**	**67**

Comparison Numbers for C.Diff infections YTD Inpatient areas

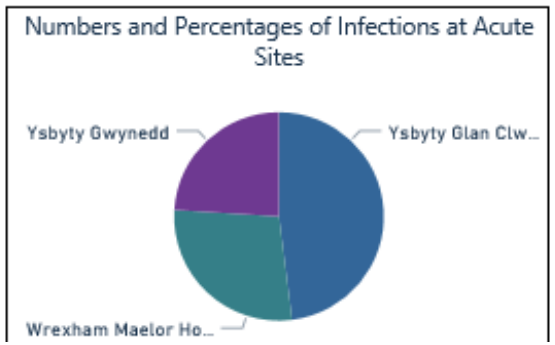
Organism Type	Specimen Location Hospital	Ward	Location Type	01/04/2020	30/09/2020
C. diff	All	All	Multiple selections		

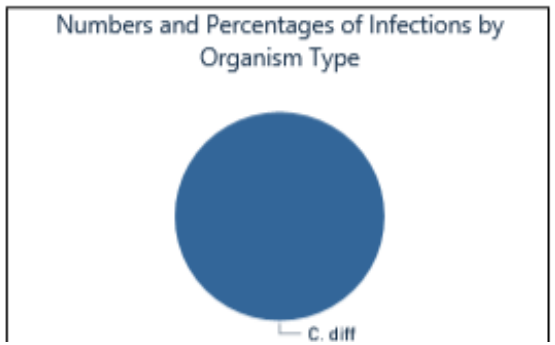
This information is updated from ICNet daily (Mon-Thurs) at 10:00. Any specimens that were imported into ICNet after this time will not appear until the report is updated.



Number of Infections for Selected Criteria

65





Ward	C. diff	Total
LGHBEU Beuno Ward (FMW)	4	4
YGHALA Alaw Ward	4	4
RCHMEN Menlli Ward	3	3
YGC ITU ITU	3	3
YGC09 Ward 9	3	3
DCHBRA Deeside Hosp Branwen Wd	2	2
WMHACU Acute Cardiac Unit	2	2
WMHERD Erddig Ward	2	2
Total	65	65

Quadruple Aim 2: Mental Health Measures

Frequency	Measure	Target	Actual	Trend
Aug 20	Percentage of mental health (Adult) assessments undertaken within 28 days of referral	>= 80%	76.19%	↓
Aug 20	Percentage of therapeutic interventions (Adult) within 28 days of assessment	>= 80%	89.96%	↓
Aug 20	Percentage of mental health (CAMHS) assessments undertaken within 28 days of referral	>= 80%	80.56%	↑
Aug 20	Percentage of therapeutic interventions (CAMHS) within 28 days of assessment	>= 80%	52.11%	↑

Frequency	Measure	Target	Actual	Trend
Sep 20	Percentage of children and young people waiting less than 26 weeks for neurodevelopment assessment	>= 80%	19.57%	↓
Sep 20	Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy	>= 80%	23.78%	↓
Sep 20	Total Number of mental health delayed transfer of care patients	Reduction	52	↓
Sep 20	Total Number of mental health delayed transfer of care bed days	Reduction	2,501	↑

Quadruple Aim 2: Narrative – Mental Health and DToC

CAMHS

Reset plans for routine appointments for all teams approved by BCUHB Clinical Advisory Group

Plans allow for reconfiguration of services should Covid-19 pandemic re-escalate

Increased usage of Attend Anywhere to allow flexibility in provision of service where clinically appropriate

Facilitation of home working for staff where possible to increase capacity in bases – dependent on IT provision with lack of availability in some teams

Initial review of referral figures in September showing an increase on previous months

Ongoing discussion with school to reinstate EIPs services to provide support and manage demand

Recruitment of Family Wellbeing Practitioner posts to support clusters well underway in all teams with some commenced in role

Reduced demand from Apr - Aug allowed for focus on assessment waiting list with MHM Part 1a target met in August at 81%

Adult Mental Health

The MHLD Division continue to improve the Mental Health Measure (MHM) position for assessments within 28 days. A fall in compliance during July and August was attributed to an increase in referrals. The Division continue to deliver therapeutic interventions within 28 days, which is above the national target rate, and part 2 and 3 continue to be compliant.

Delayed Transfers of Care (DToC)

East: 3 – 2 ↑

Centre: 2 - 1 ↑

West: 5 - 1 ↓

Rehab: 5 – no change

LD: 1 – 1 ↓

Of the 16 patients across MLHD awaiting discharge, appropriate placements have been identified for 6 and dates for discharge are being confirmed. 1 Patient is awaiting a bed, 3 awaiting assessment, 1 patient is awaiting tenancy agreement, 1 is on S17 leave, 2 are awaiting a supporting housing placement and 2 funding requests have been presented at CHC panel and awaiting decision, w/c 12.10.20.

Action taken – Divisional Senior Leads continue to monitor and review through daily safety huddles all patients who have a delayed discharge. A weekly DToC briefing is completed for all areas identifying any barriers to discharge, and the actions being taken to progress.

Quadruple Aim 2: Narrative – Mental Health

Neurodevelopment

Current Position:

As of September the waiting list for an neurodevelopment assessment stands at 1895 patients, of which 1515 (East 1000, Centre 300, West 215) have waited in excess of the 26 week target. During the suspension of service and the restart process we have lost approx. 370-400 assessments and have received approx. 330 fewer new referrals than we would have had expected based on previous years. It is envisaged that as schools return these referrals will be sent in addition to the return to our previous referral rate of 130 per month. If correct this will mean our waiting list position will worsen considerably over Qtr3 to approx. 2300, of which 1700-1750 will be in excess of the 26 week target

Re-start Position:

Approval to restart the non urgent neurodevelopment assessment service was received 25th Sept with clinic beginning in October. As activity is adapted to reflect social distancing and access to schools still being negotiated it is envisaged full BCUHB capacity will not be reached until January 2021.

Recovery Position:

Recruitment of staff for the expansion of service has gone well since the Welsh Government increase in Jan 2020. The aim is for our activity to increase by 100% to 120 cases per month.

We have completed the tender process and awaiting the start of our chosen supplier to complete and additional 700 assessments.
We have submitted a recovery bid to fund the lost assessment capacity during service restrictions (an approx. 370-400 assessments)

With current investment the current WL target is estimated to be reached in Qtr. 2 2022/23 or Qtr. 3 2023/24 using our Best/Worst case scenario. Current additional capacity funding will be exhausted Qtr. 4 21/22, by which time our WL prediction is 39% or 30% base against best/worst case scenarios.

Psychological Therapy

The Mental health & Learning Disabilities (MHLD) Division currently has no Divisional leadership role for psychology or psychological therapy in post, to lead upon and consult wider across the workforce, upon the implementation of the Psychological Therapies review.

The Senior Leadership team (SLT) have regrouped in September 2020 following significant churn , to consolidate its resource and focus its work priorities, and are going to meet with the psychologists as a group within the Division in October. This is in order to discuss and begin the recruitment of an interim role to lead the professional coordination of Psychology within the Division.

The first step in reviewing the contribution of psychology, and how we become psychologically minded as a Division (psychological therapies review) are to begin to engage with psychology as a profession, to inform the business strategy of the Division. Beginning this discussion regarding leadership with psychology, is the fundamental step upon which the other actions in the psychological therapies review will be dependant upon and this is not currently in place.

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

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

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%	71.05%	↑
Sep 20	Number New Never Events	0	0	↑
Sep 20	Cumulative Patient Safety Solutions Wales Alerts or Notices that remain open	0	1	N/A
Sep 20	Doctor Appraisal/ revalidation rate	95%	85.60%	↑

Quadruple Aim 4: Narrative

Incidents

In September a total of 2,953 incidents have been reported; 2,232 relate to patient safety. In recent months there has been a levelling in the number of incidents reported, 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 2,354 of 2,951 (80%) incidents reported in August being closed within timeframe. This is slightly up on July (76%).

Serious Incidents (Welsh Government Reportable)

Thirty-eight serious incidents were reported to Welsh Government in September, whilst twenty-one were closed. Six incidents were due for closure in September; of which four remain open and under investigation, two were submitted within timeframe.

Overall closure rate within timeframe for the year is approximately 48%, which is below the national target of 90%. The Health Board has 70 serious incidents open and under investigation of which 20 (29%) are overdue.

Never Events

There were no new Never Events reported in September 2020

Currently there are no never event investigations open internally within the Health Board. The investigation report detailing the findings from a wrong site surgery never event reported in November 2019 in Ysbyty Glan Clwyd is currently being reviewed by an independent expert. Additional informational has recently being requested by this expert and submitted; this never event therefore remains open pending this external expert review.

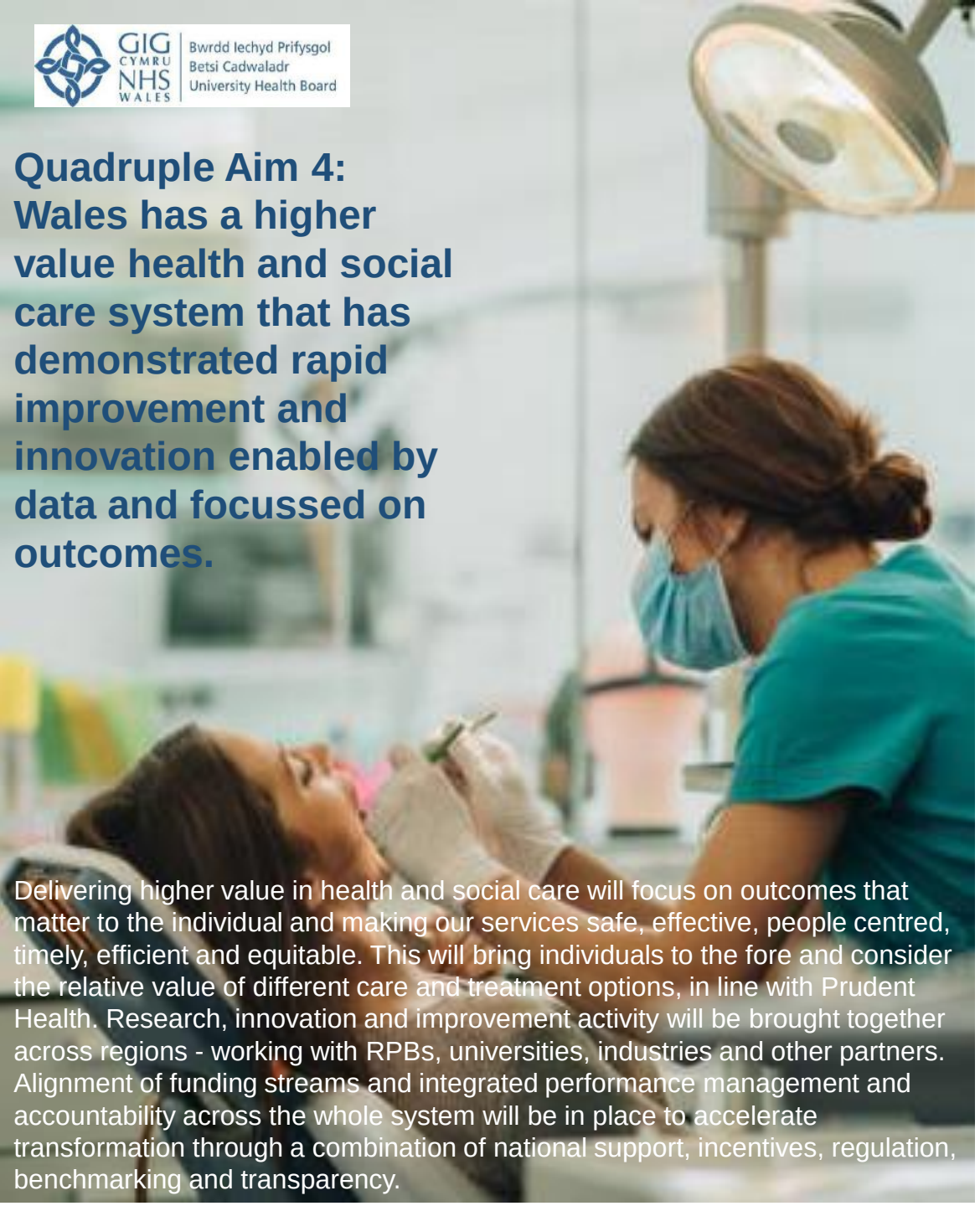
The investigation for the never event in July 2020 (wrong site surgery: injection into wrong eye) has been completed. Key learning from this never event relates to the failure to use a Local Safety Standard for Interventional Procedures (LocSSIP). There is an ongoing improvement plan in development within Secondary Care to address this issue which is a theme from recent never events.

Doctor Appraisals/ Revalidation

Please note that all appraisals have been cancelled for both Primary and Secondary Care doctors up to July 2020. This is logged as an approved missed appraisal.

From 21st July 2020, Secondary care doctors due in Jul – Sept and Oct – Dec quarters are now being encouraged to undertake an appraisal. Failure to complete an appraisal due to COVID19 issues will be logged as an approved missed appraisal. Please note that GP Appraisals between July – Sept 2020 have been cancelled due to the pandemic.

Secondary care doctors due Jul – Sept 2020 have been given until end of October to complete an appraisal as most of July was lost



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.

Key Messages

- Reduction in Mortality Rate, from 1.17% to 0.92% in 1 month
- Increased system working to link Health and Social Care Data
- North Wales Covid -19 Protection and Response Plan Produced

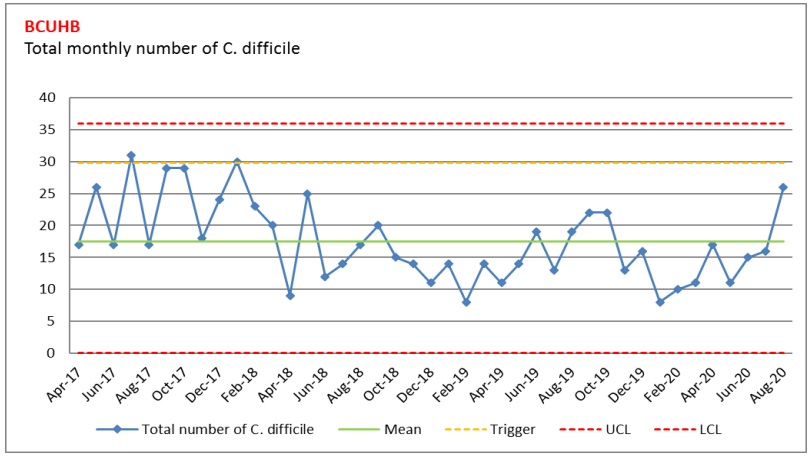
Measures

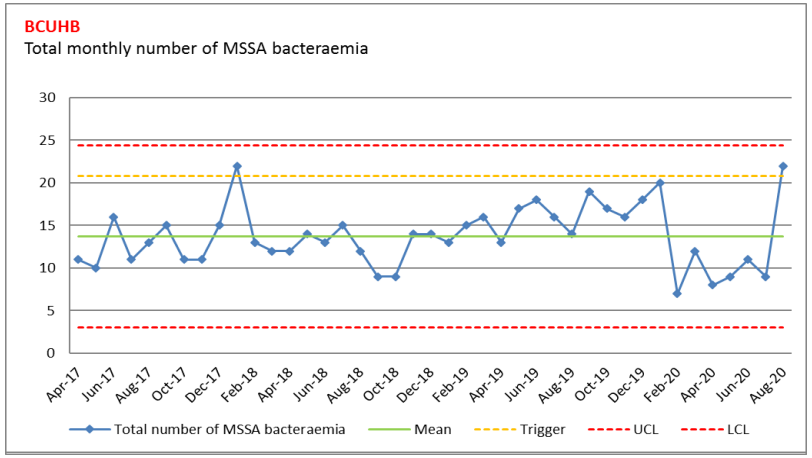
Period	Measure	Target	Actual	Trend
Sep-20	Crude hospital mortality rate (74 years of age or less)	Reduction	0.92%	↑
Sep 20	Percentage of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	Improve	100%	→
Sep-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	56.94%	↑
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%	↑
Sep-20	Percentage of episodes clinically coded within one reporting month post episode discharge end date	>= 95%	94.80%	↑

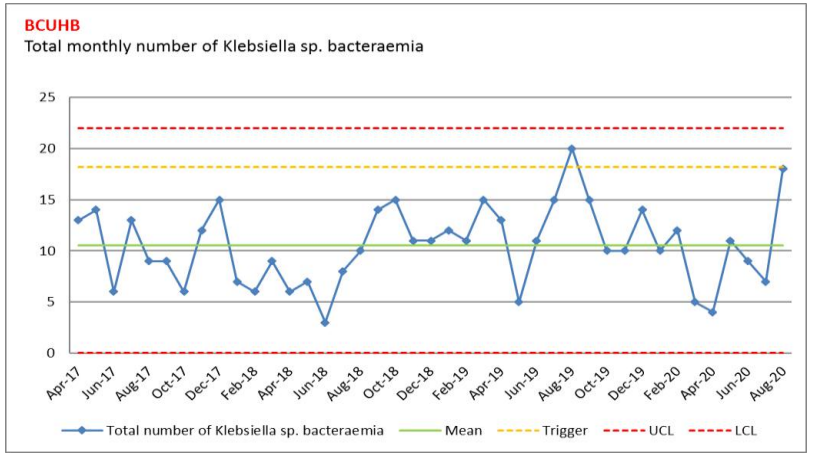
Quadruple Aim 4: Narrative

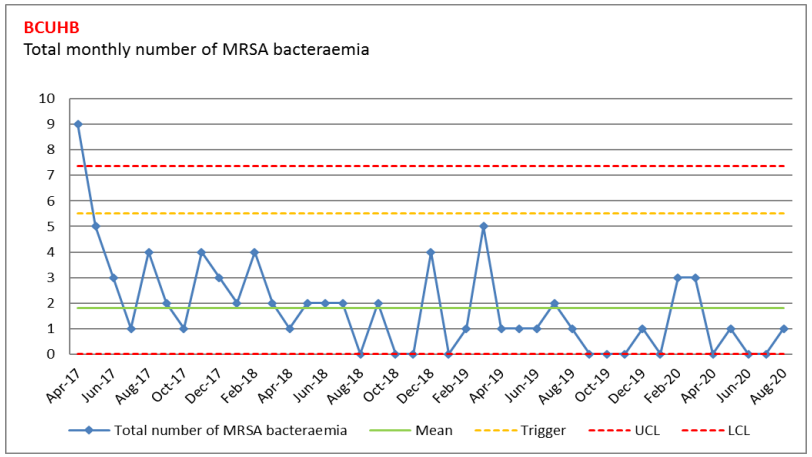
Outcome	Actions	Timeline	Lead	Progress
1. Develop a reducing avoidable mortality strategy	1. Establish a Reducing Avoidable Mortality Steering Group (RAMSG) 2. Develop a surveillance report to identify potential areas for action 3. Develop a strategy	1. Completed 2. Completed 3. March 2021	Melanie Maxwell	1. Established Summer 2019 2. Regular report to RAMSG
2. Redevelop Learning from Deaths policy.	1. Hold workshops with primary & community and secondary care to review and update current process 2. Revise existing policy and process; complete approval process 3. Monitor implementation through the QSE quarterly assurance report	1. November 2020 2. March 2020 3. quarterly	Melanie Maxwell	1. Secondary care workshop held. Primary & Community workshop had to be rearranged 3. Monitoring tool in development – to be presented to QSE in Oct 2020.
3. Ensure BCU processes are aligned with the introduction of the Medical Examiners Service (ME) piloting form Sept 2020 in YGC)	1. Pilot Datix Mortality Module 2. Roll out electronic Datix Mortality Review module 3. Working with ME Officers to agree processes	1. Completed 2. Mar 2021 3. Mar 2021	Mel Baker	1. Piloted and developed 2. YGC Completed; YG in progress; WMH training from Nov 2020; Primary care to be agreed 3. Series of ME/Clinician awareness sessions held • Process to receive ME reports developed • Meeting to explore paperless transfer of case notes to ME to enable centralised working held; paper being produced
4. Reduce mortality through specific improvement collaboratives	1. Sepsis collaborative to improve ED delivery of Sepsis (Sponsor Kate Clark)	1. Delayed	Melanie Maxwell	1. Sepsis collaborative ran 2018/19 - improved data capture; data review meetings (DRIPS) ; improved compliance with 5/6 deliverables; reducing mortality changes not embedded. Due to continue from Mar 2021; rescheduled Oct 2021 stood down due to Covid escalation and lack of resource., *To reconsider how can deliver this improvement without formal collaborative*

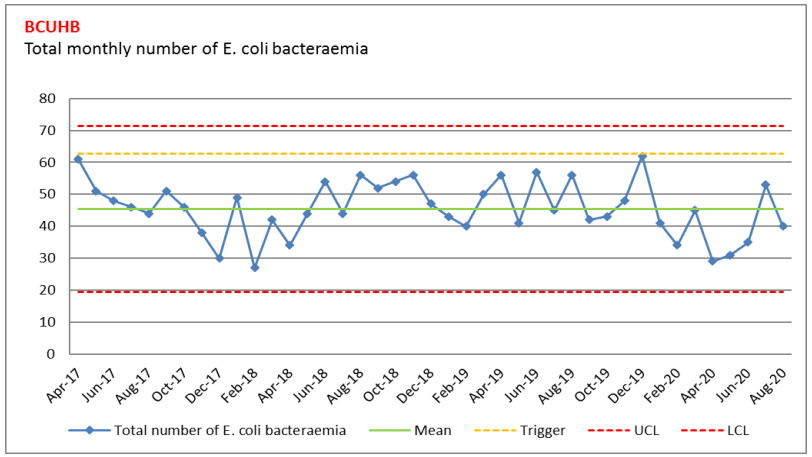
IPC Monthly numbers – To end of September 2020

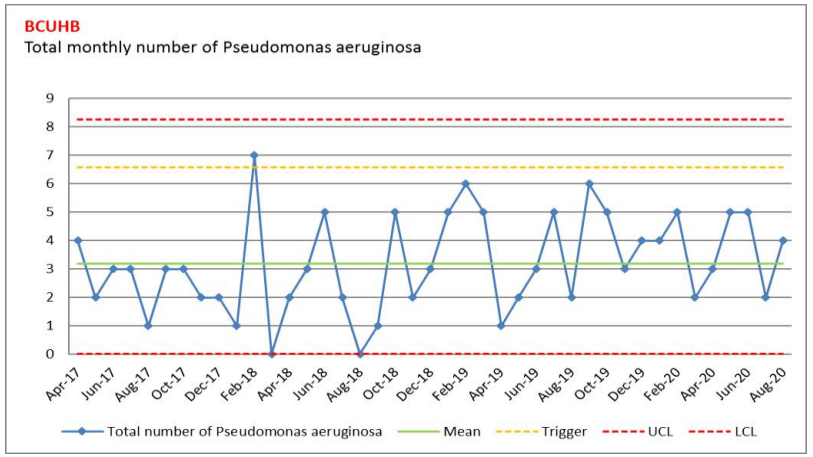




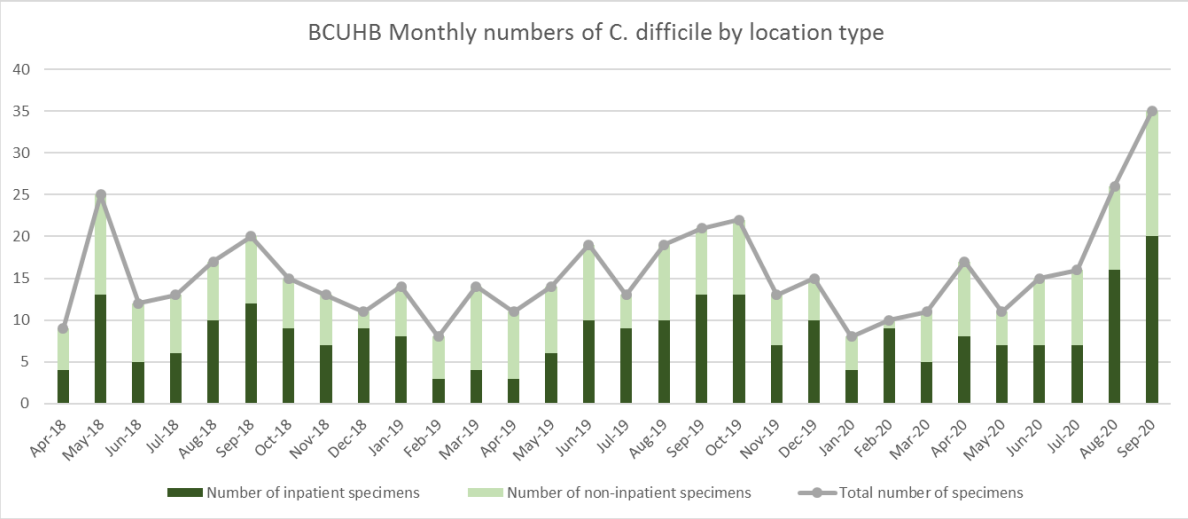


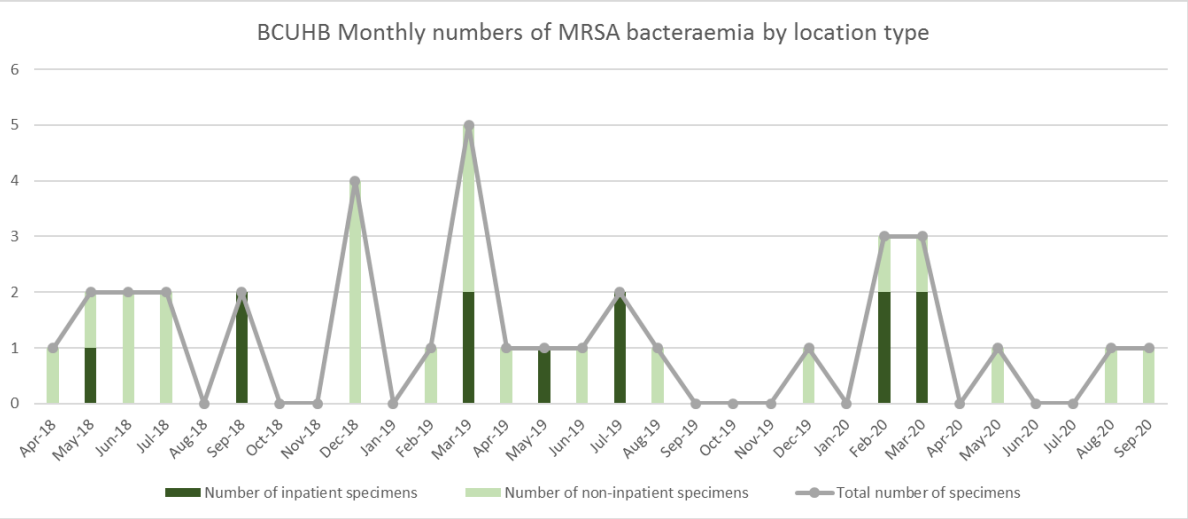


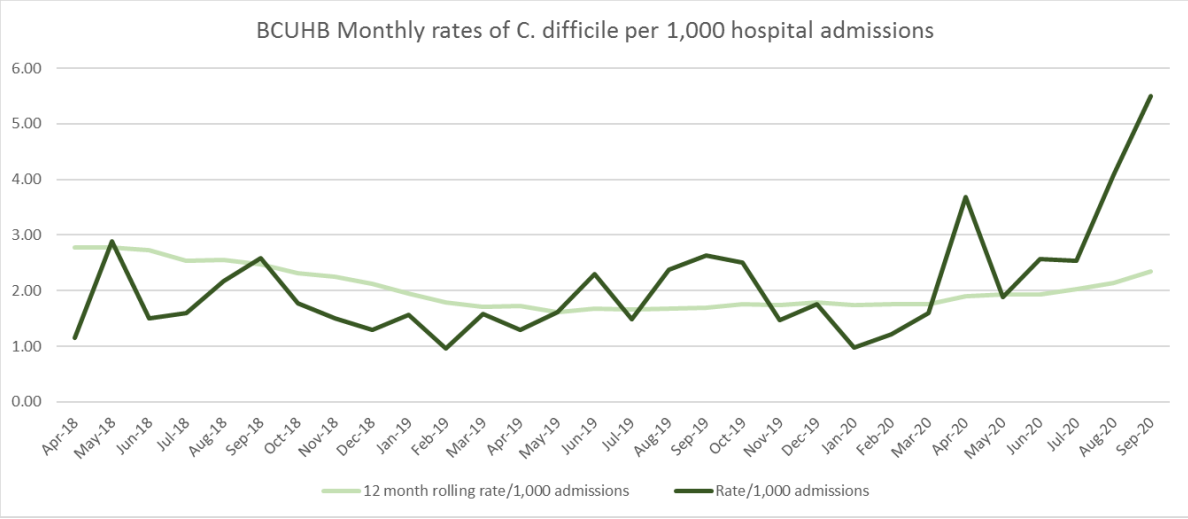


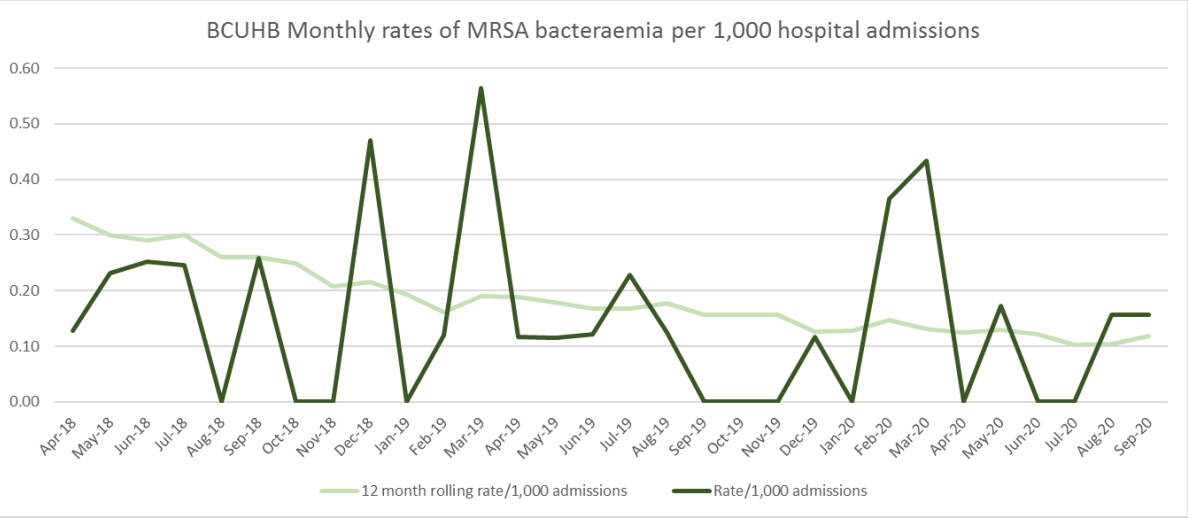


IPC overall comparisons with HO (darker green) and CO (lighter green) split September 2020 and hospital admissions

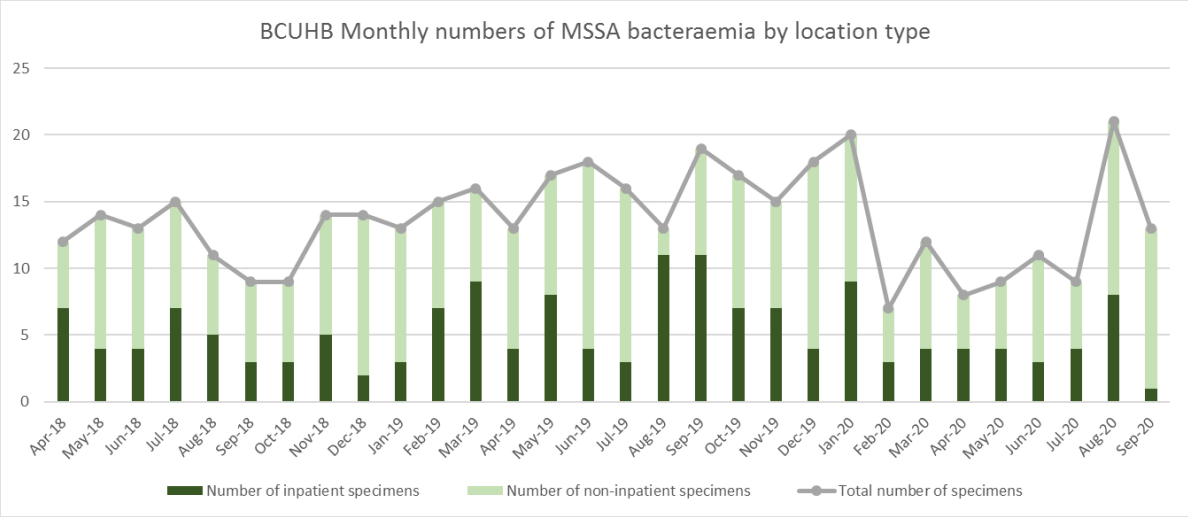


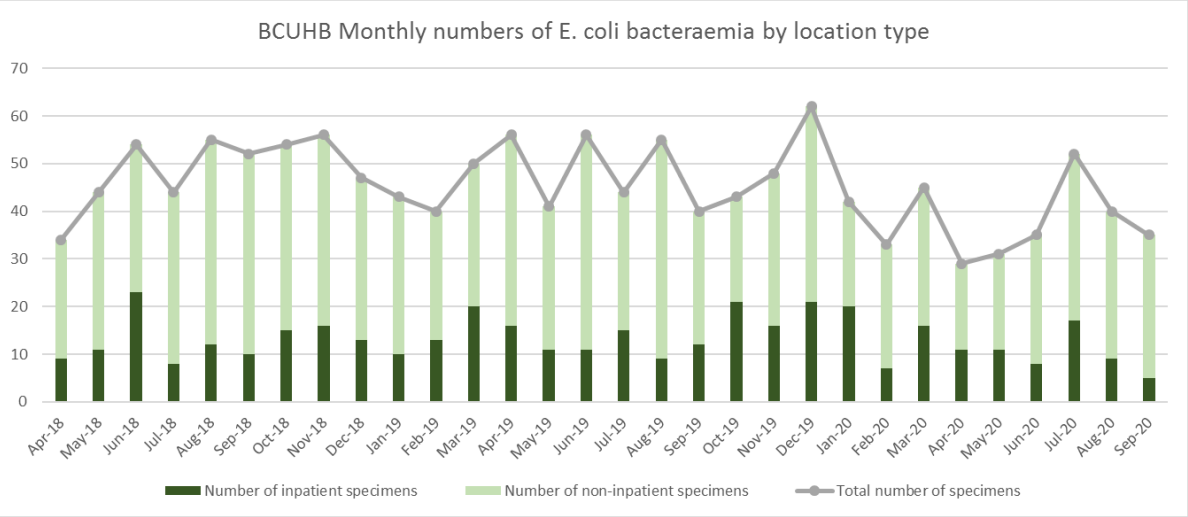


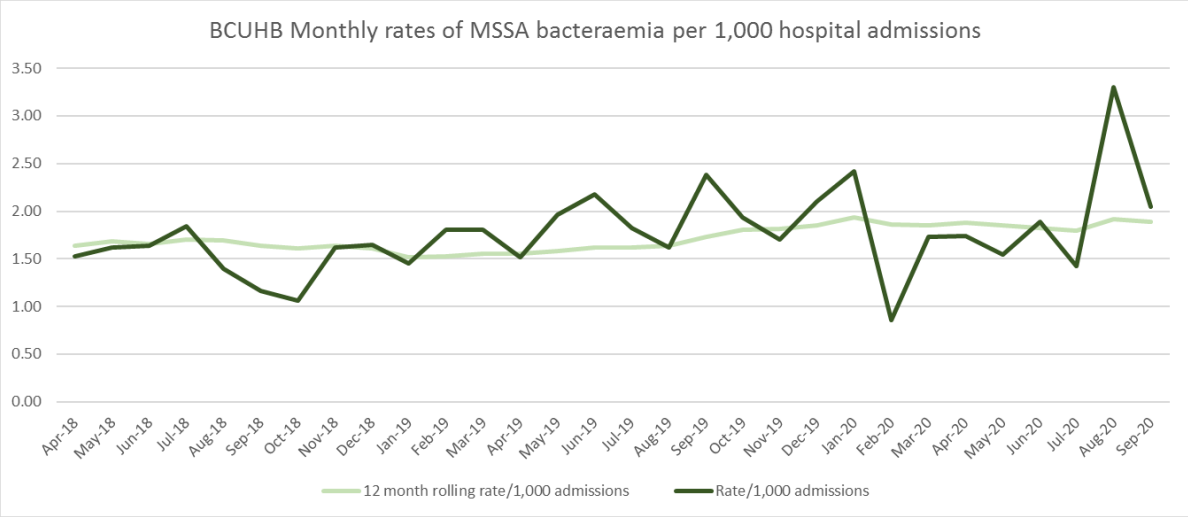


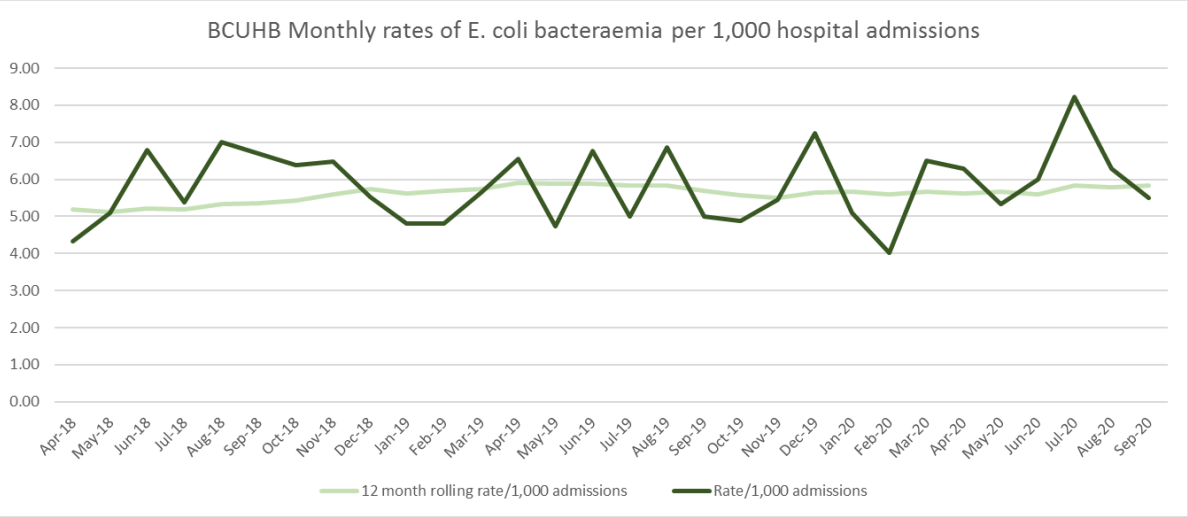


IPC overall comparisons with HO (darker green) and CO (lighter green) split September 2020 and hospital admissions

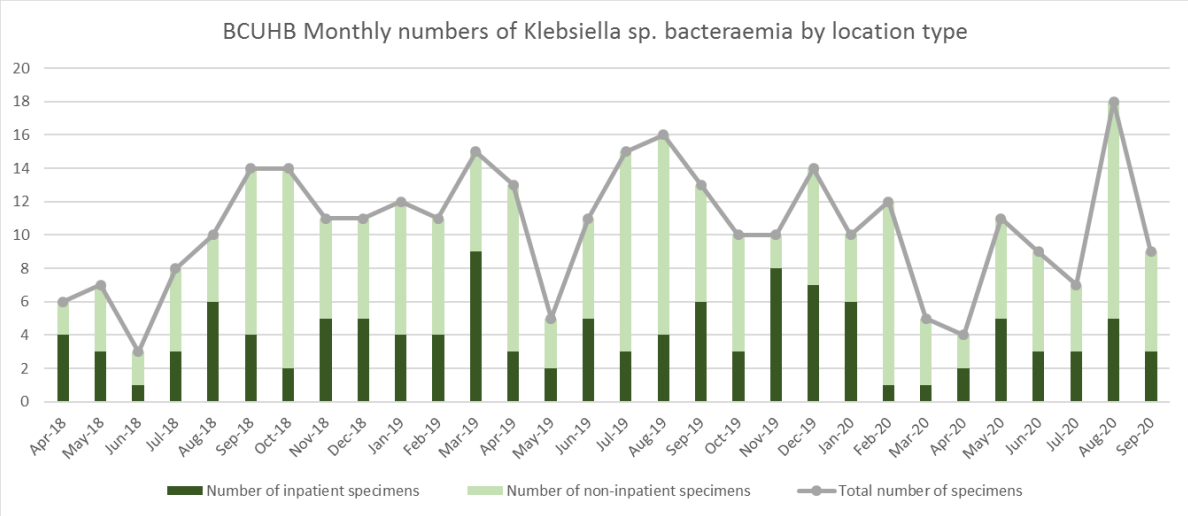


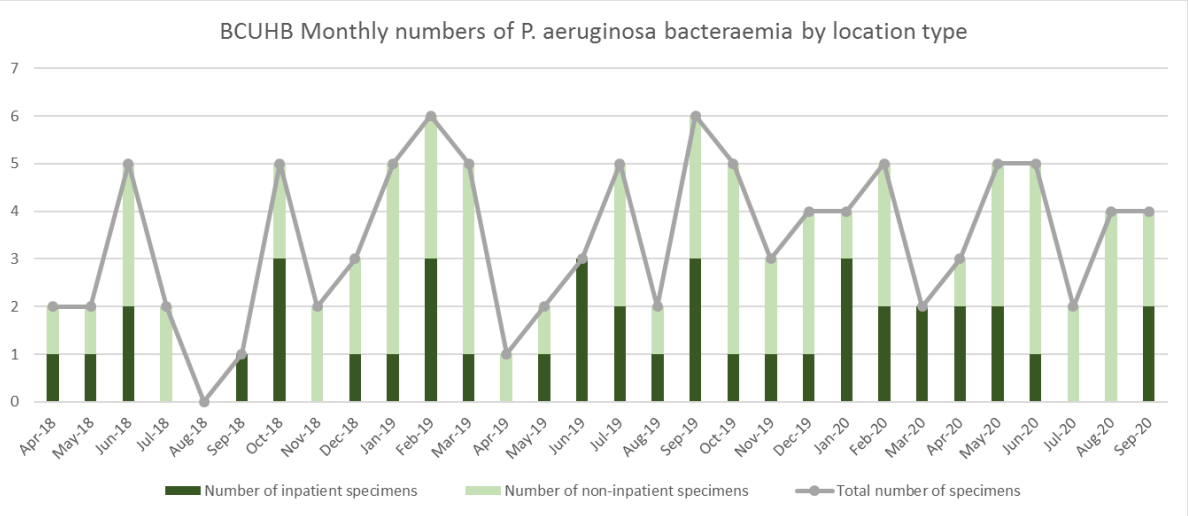


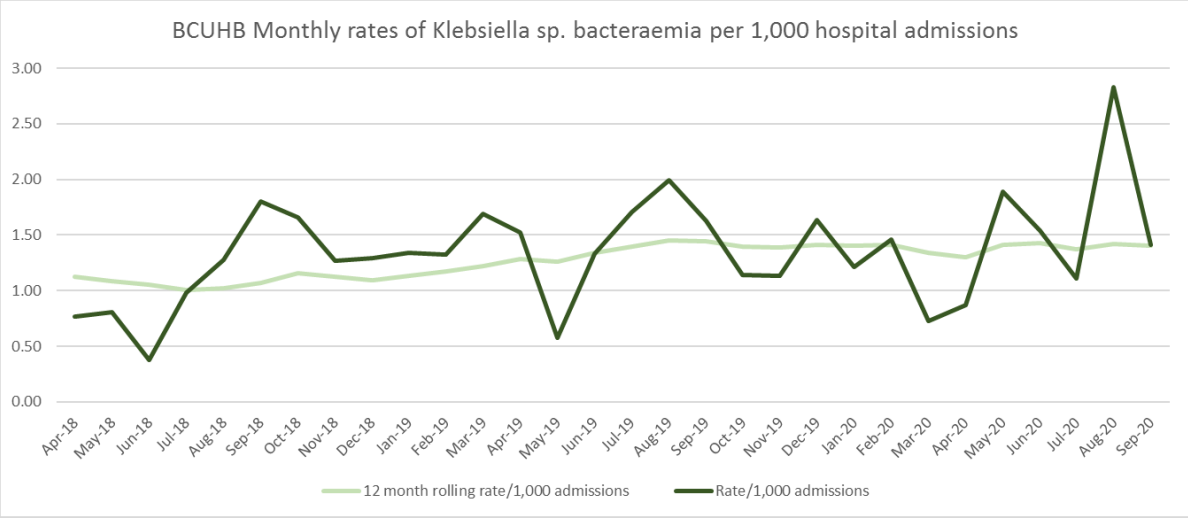


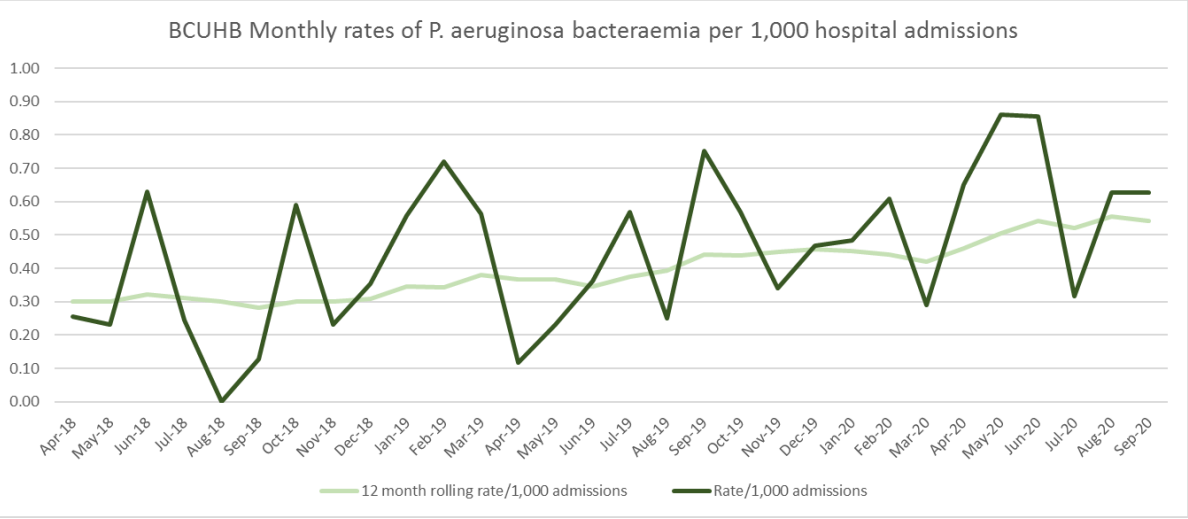


IPC overall comparisons with HO (darker green) and CO (lighter green) split September 2020 and hospital admissions

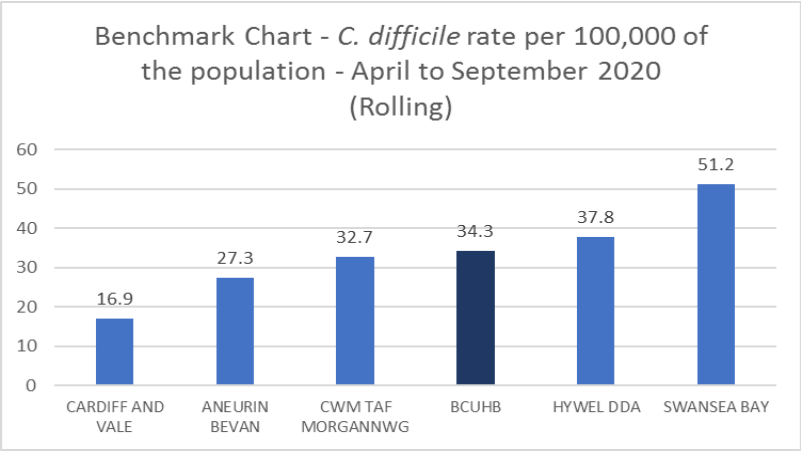


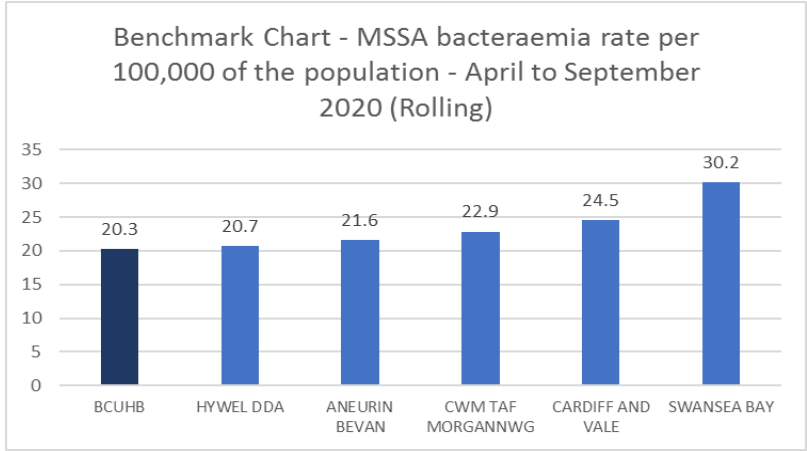


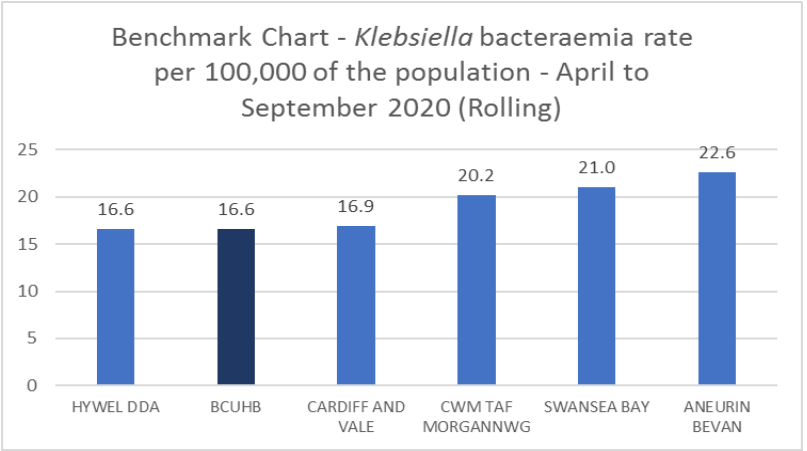


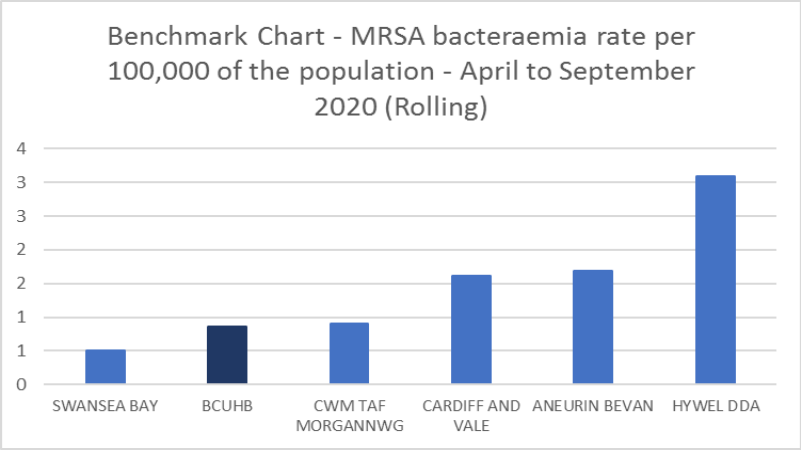


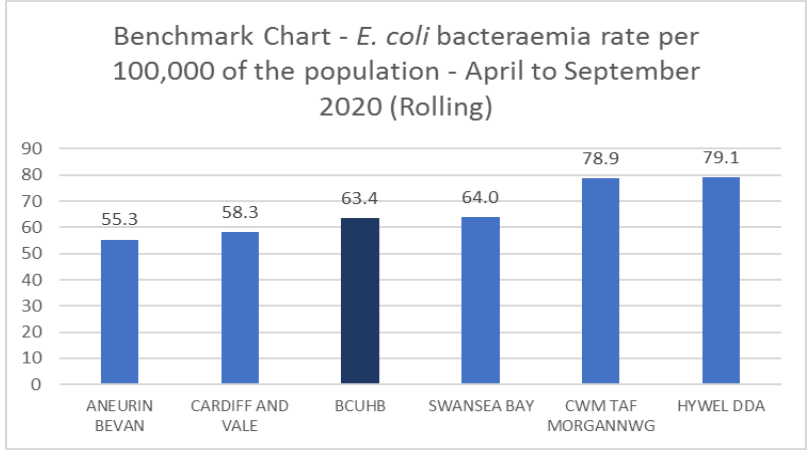
Comparison Charts to other HBs

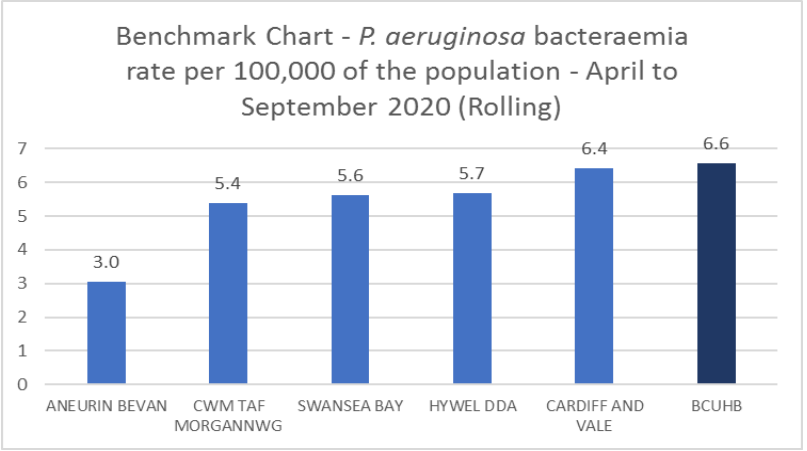




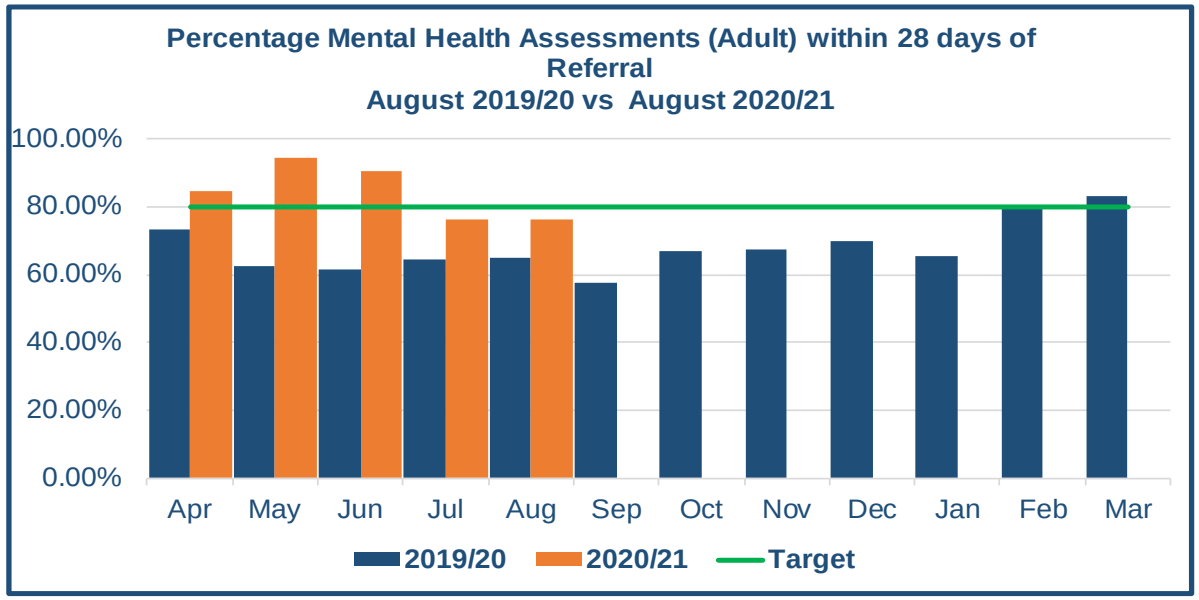


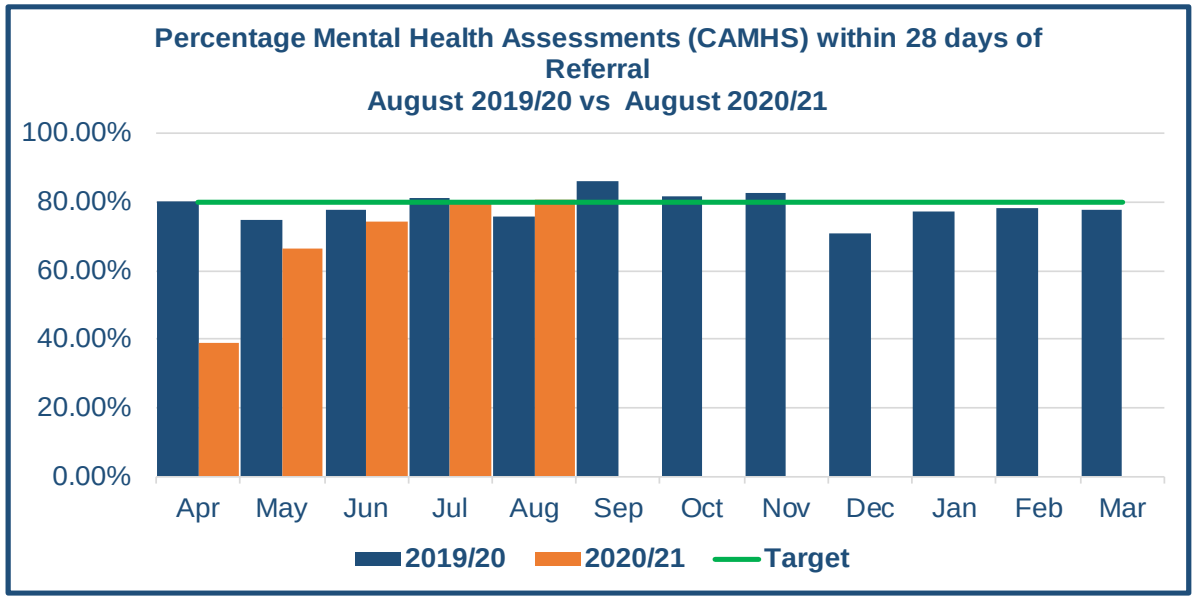


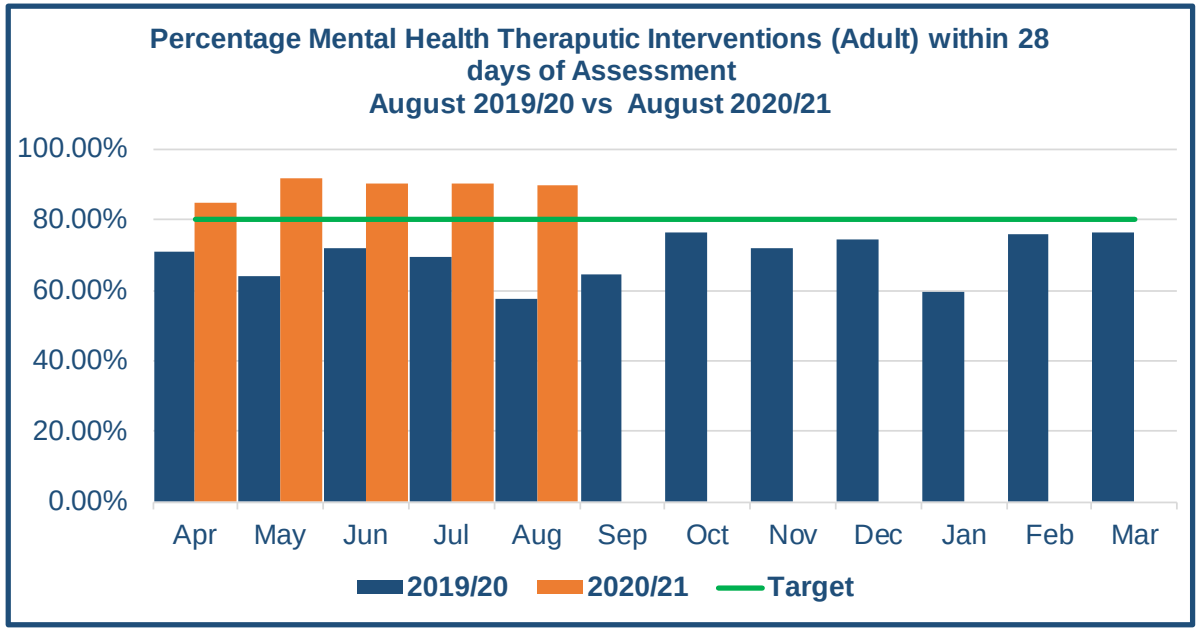


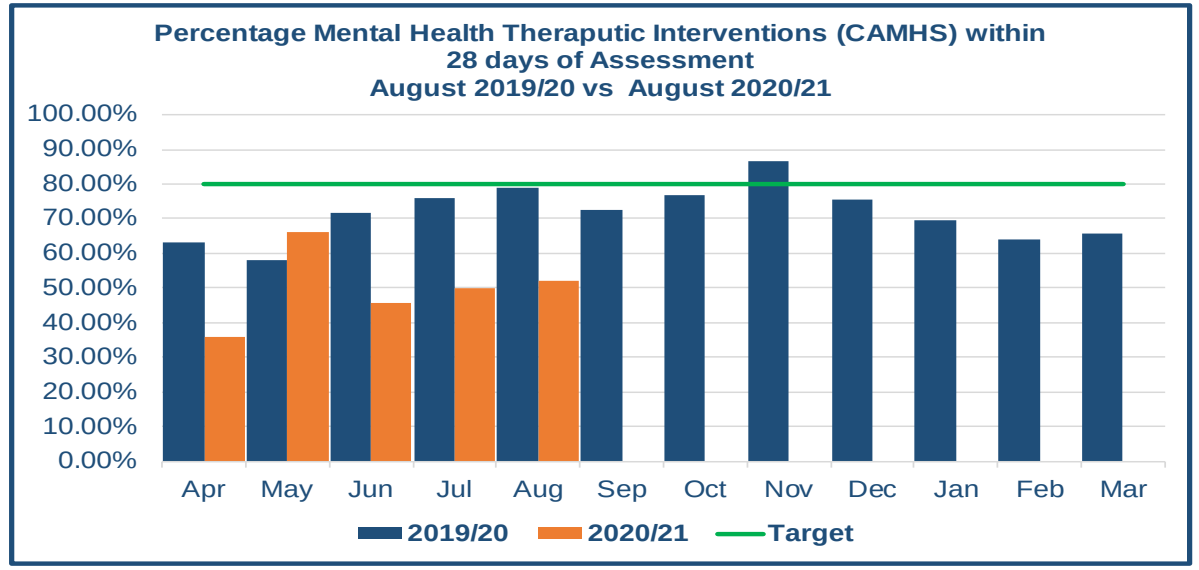


Quadruple Aim 2: Charts Mental Health and CAMHS

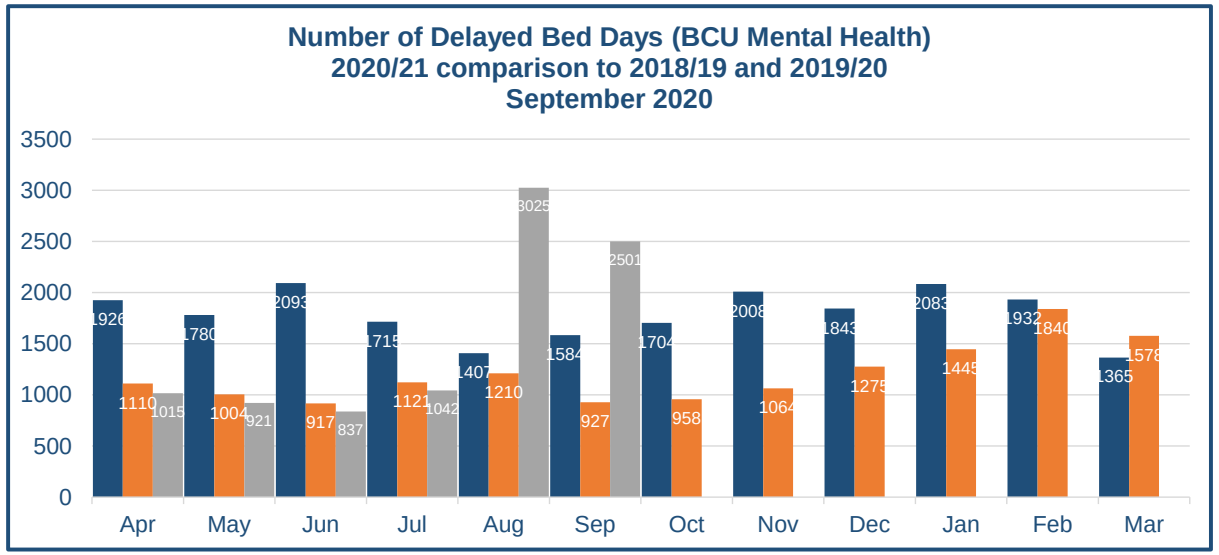


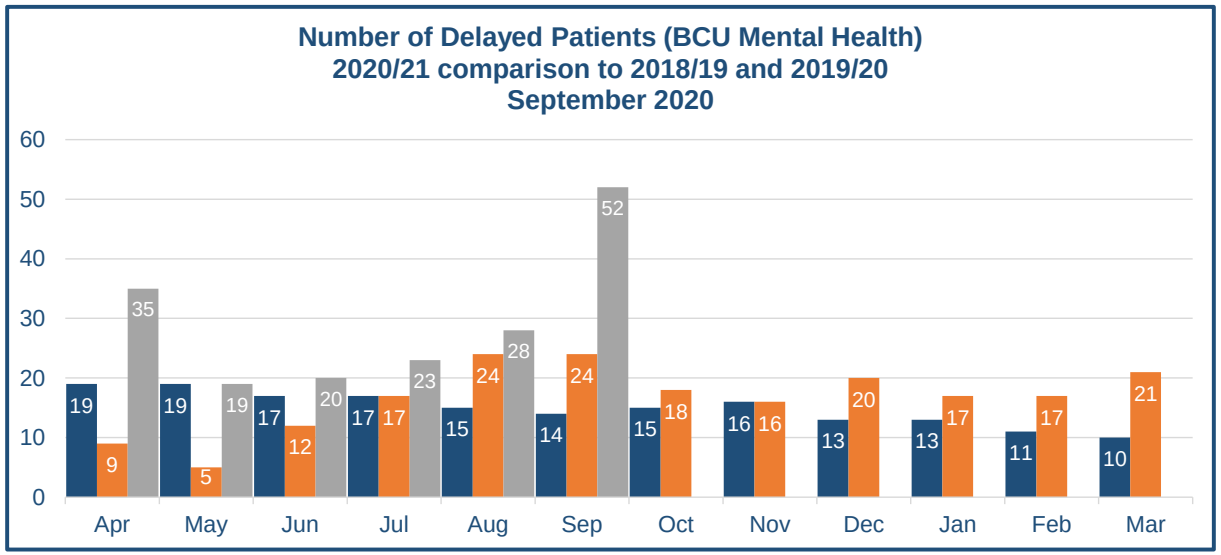






Quadruple Aim 2: Charts Mental Health and CAMHS

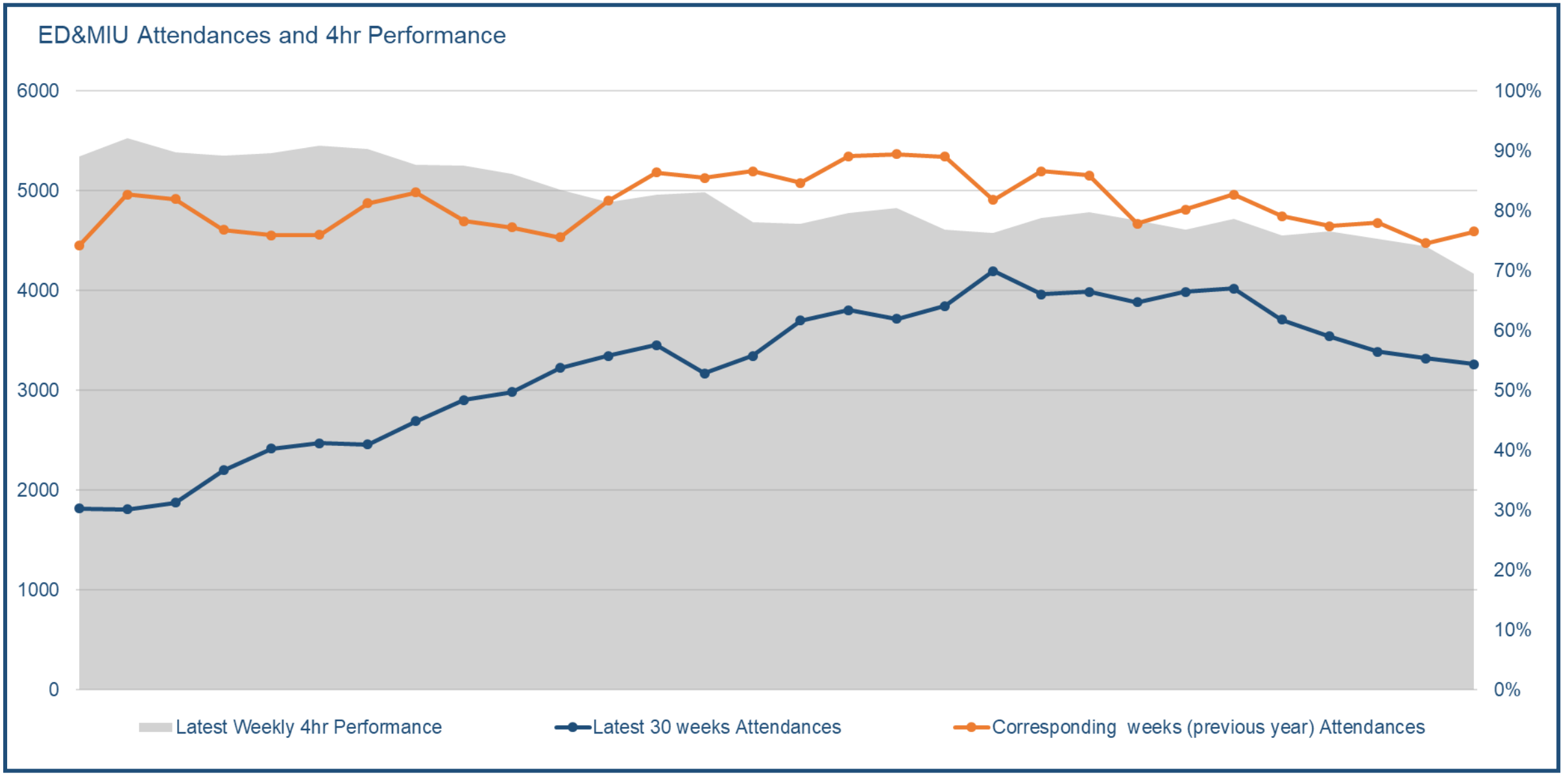




Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1926	1780	2093	1715	1407	1584	1704	2008	1843	2083	1932	1365
2019/20	1110	1004	917	1121	1210	927	958	1064	1275	1445	1840	1578
2020/21	1015	921	837	1042	3025	2501						

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	19	19	17	17	15	14	15	16	13	13	11	10
2019/20	9	5	12	17	24	24	18	16	20	17	17	21
2020/21	35	19	20	23	28	52						

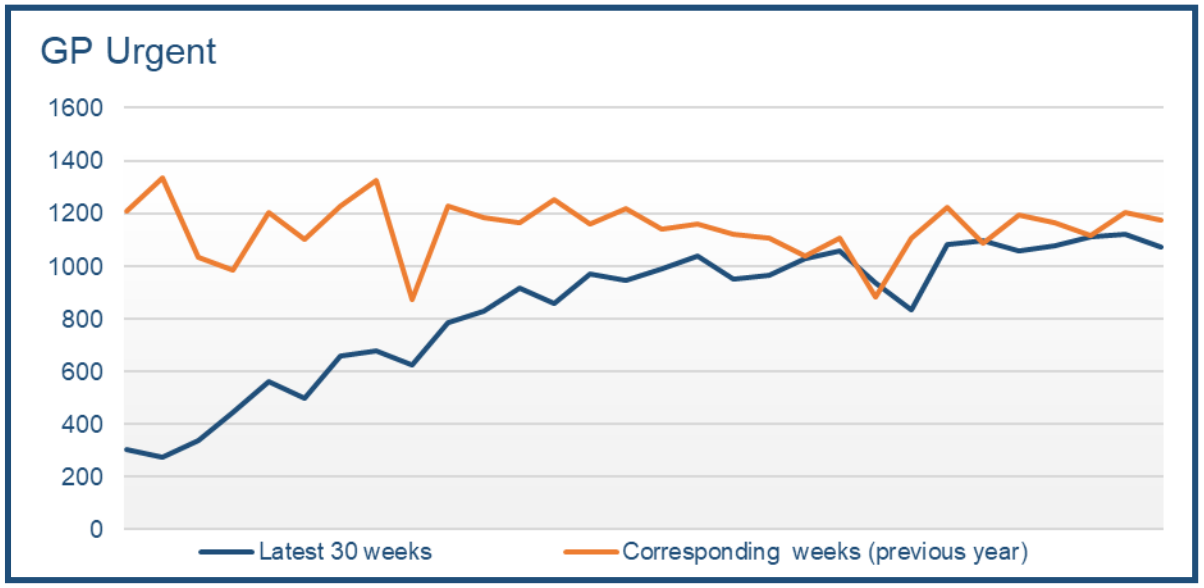
Impact of Covid-19 Pandemic on Unscheduled Care

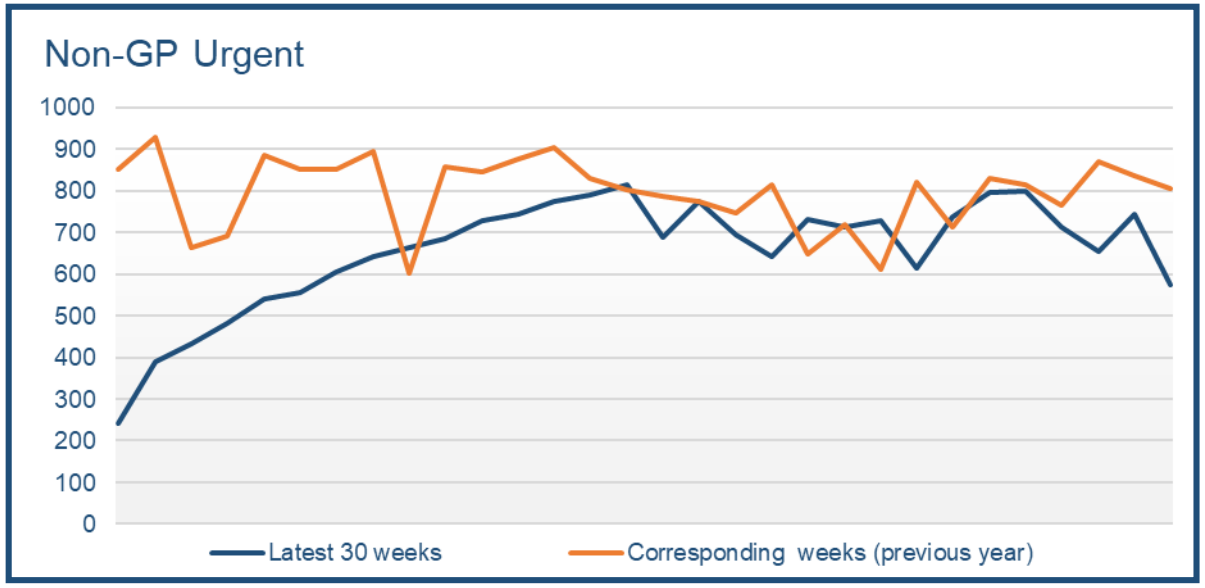


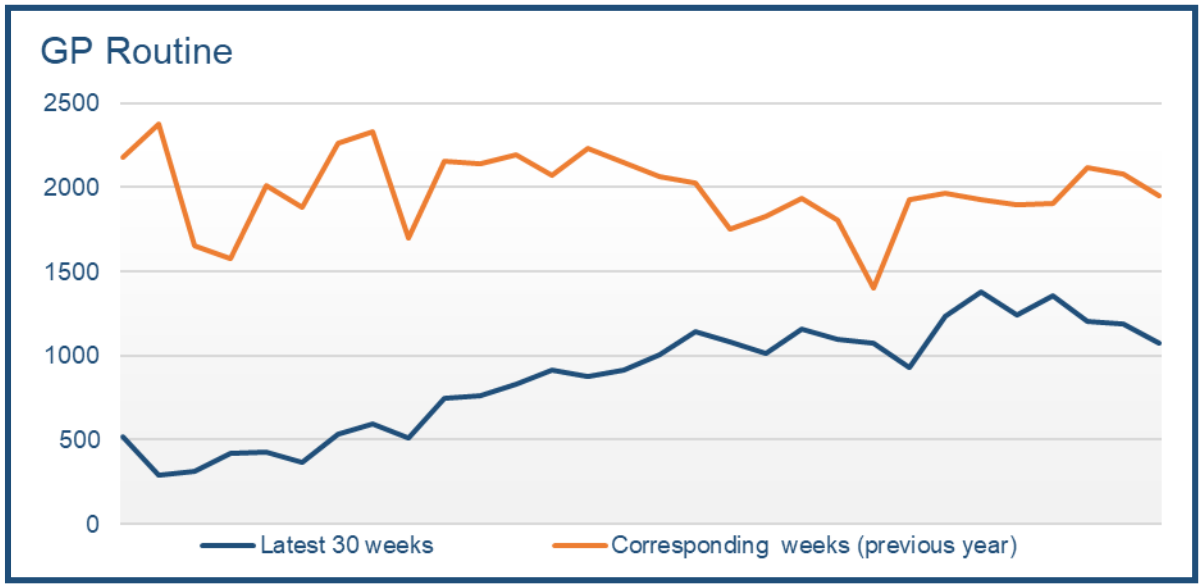
Impact of Covid-19 Pandemic on Unscheduled Care

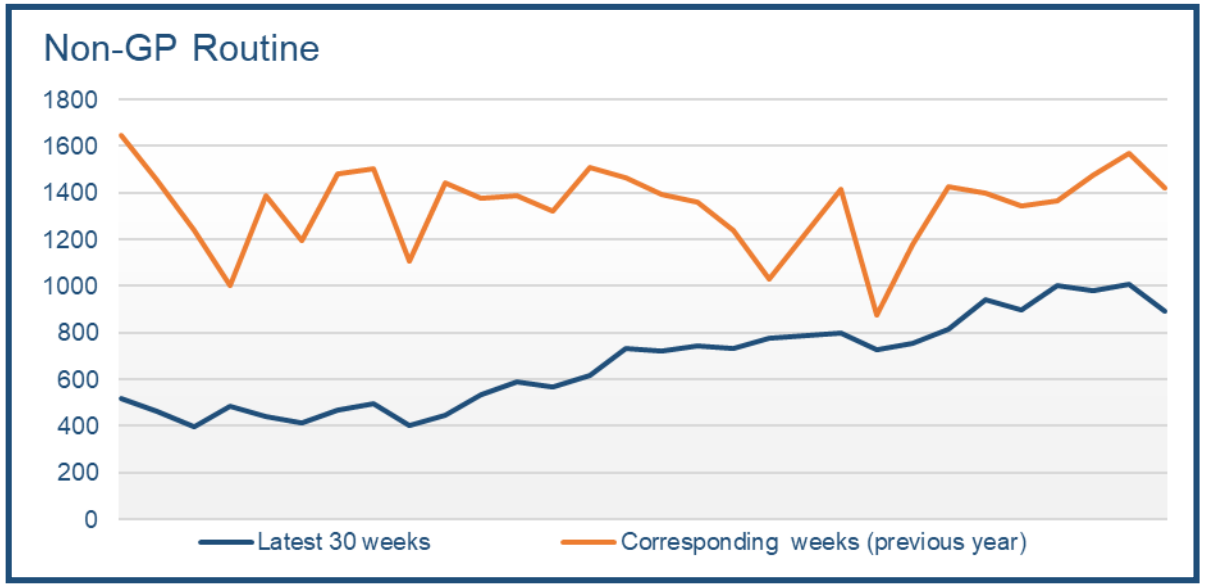
Position as at end of 25th October 2020	Jun 20	Jul 20	Aug 20	Sep 19	Sep 20	October 1st - 25th 2019	October 1st - 25th 2020
ED&MIU 4 Hour Performance	83.61%	79.80%	77.90%	71.64%	77.58%	70.75%	**73.24%**
ED 4 Hour Performance	80.53%	75.24%	71.84%	60.07%	71.39%	59.87%	**66.65%**
ED 12 Hour Performance	442	703	1063	1977	1187	1489	**1178**
1 - 2 Hour Ambulance Handover	127	222	404	574	445	402	**412**
2 - 3 Hour Ambulance Handover	48	83	142	192	198	137	**187**
3 - 4 Hour Ambulance Handover	6	27	53	70	75	46	**117**
4 - 5 Hour Ambulance Handover	4	8	16	35	49	14	**52**
Over 5 Hour Ambulance Handover	2	8	21	24	44	11	**29**
Red 8 Minute	70.06%	65.82%	60.90%	69.37%	61.05%	70.11%	**64.63%**
DToC Census - Total number of patients	20	23	28	111	52	90	
DToC Census - Total number of bed days delayed	1046	1314	3199	2293	3039	2846	

Impact of Covid-19 Pandemic on Referral Rates

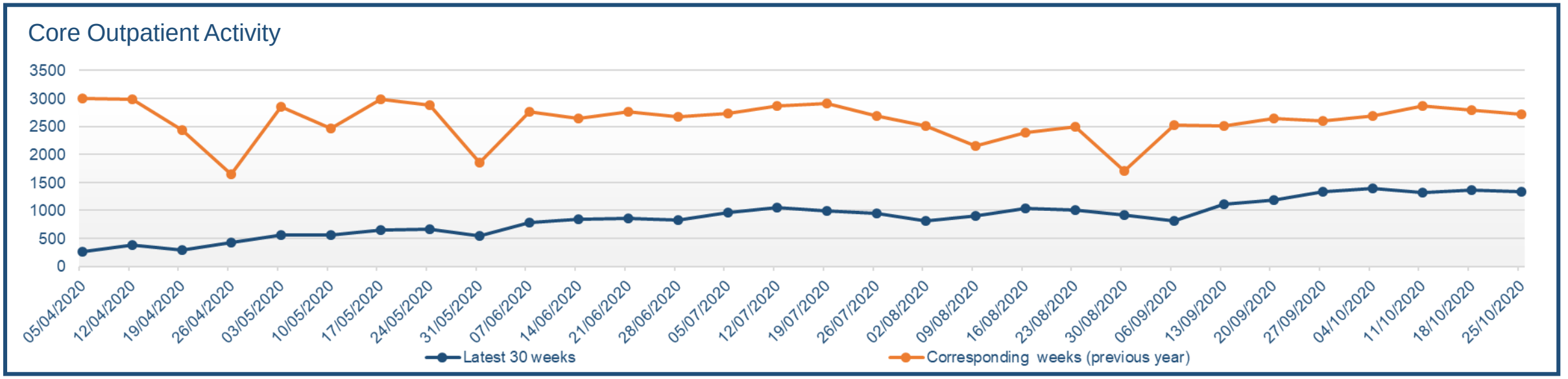


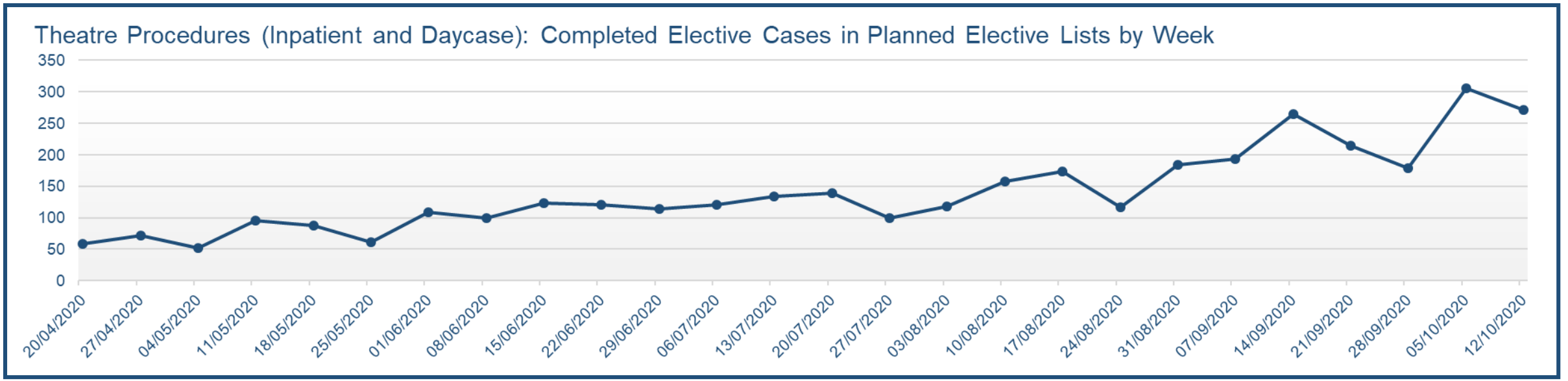






Impact of Covid-19 Pandemic on Planned Activity





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

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 Committee 3rd November 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Essential services and re-start update
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gavin MacDonald, Interim Chief Operating Officer
Awdur yr Adroddiad **Report Author:**	Andrew Kent, Interim Head of Planned Care
Craffu blaenorol: **Prior Scrutiny:**	Interim Chief Operating Officer
Atodiadau **Appendices:**	none

Argymhelliad / Recommendation:

The Committee are asked to note the content of this paper and the progress being made.

Please tick as appropriate

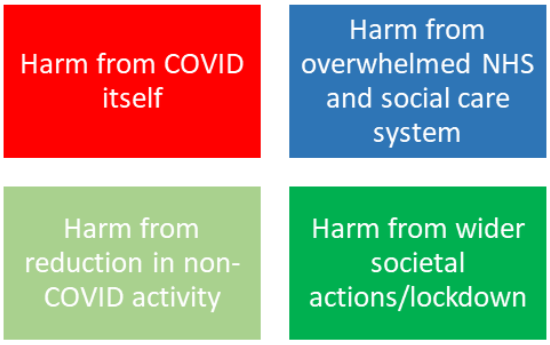
Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**		**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**	**x**	**Er gwybodaeth** **For Information**	

Sefyllfa / Situation:

Planned Care has been severely affected by the restrictions caused by the covid Pandemic, resulting in routine patients waiting longer than ever. The waiting list is seeing over 45,000 patients now waiting over 36 weeks in October of this year.

Cefndir / Background:

Planned care continues to deliver services via risk-stratified patients requiring operations in the next 5 months. This is being undertaken whilst remaining committed to the greatest need based on the four principles below:



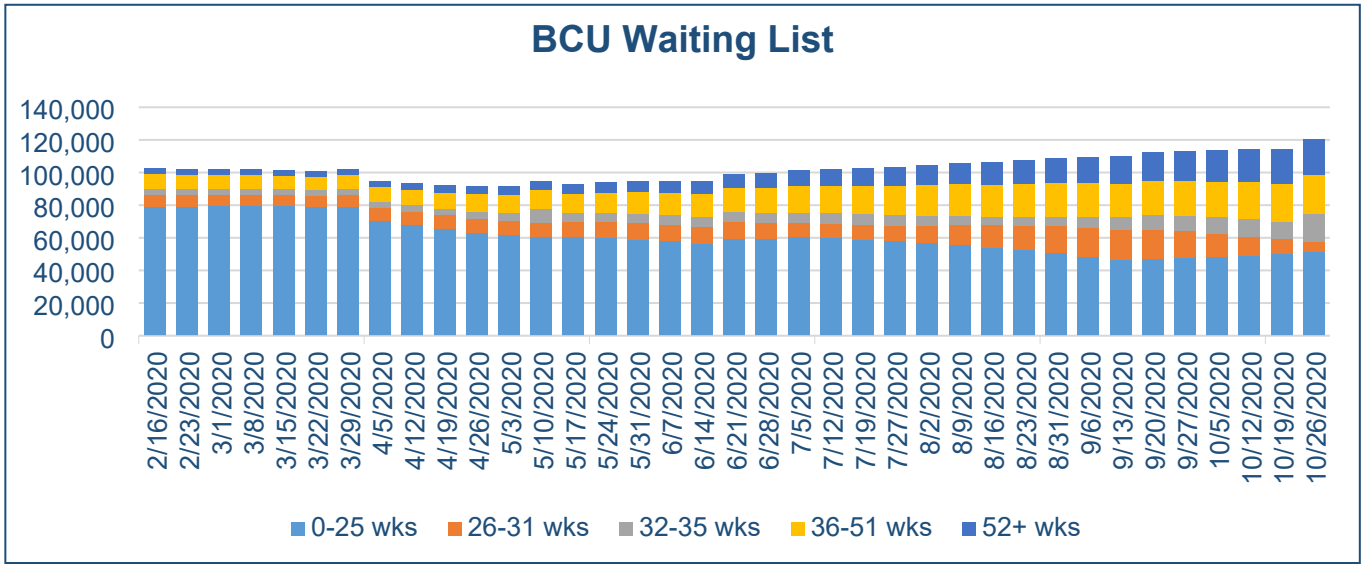
However, it is recognised that capacity is 40% less than the pre-covid activity, leaving patients who would have been regarded as routine, now priority 4, with few treatment options at this moment in time.

Asesiad / Assessment & Analysis

Since the previous paper in August, planned care has developed the Q3/4 plan and the risk stratification process has been undertaken for patients on the waiting list.

History will demonstrate that cancer and elective care will be one of the most affected services of the covid pandemic.

The length of time patients are waiting continues to grow and there is a significant run rate of approximately 4,500 patients per month moving into the over 36 weeks. The graph below represents the current position.



BCU HB Waiting List by cohorts of Weeks Waiting as at 25th October 2020						
Weeks Waiting	0-25	26-31	32-35	36-51	52+	Total on WL
Number on WL	51,343	6,290	10,857	24,223	21,991	**114,704**

Although the total waiting list size has now increased to 114,704 this is attributed to a reduced referral rate for routine patients; the significant concern is the over 36 week waiters and the increase in over 52 + waiters, where no activity is being undertaken due to the reduced capacity in the post covid era.

A simple analysis has been undertaken based on that 4% of a routine list may have an unknown malignancy. This benchmark points that 1,800 patients may come to some form of harm, whilst waiting. We also recognise that morbidity problems for patients awaiting arthroplasty or hand surgery will be occurring as well, not yet clearly understood. Although many other NHS organisations across Wales and the United Kingdom are in a similar situation, this Health Board started behind the curve with a significant backlog at the end of March.

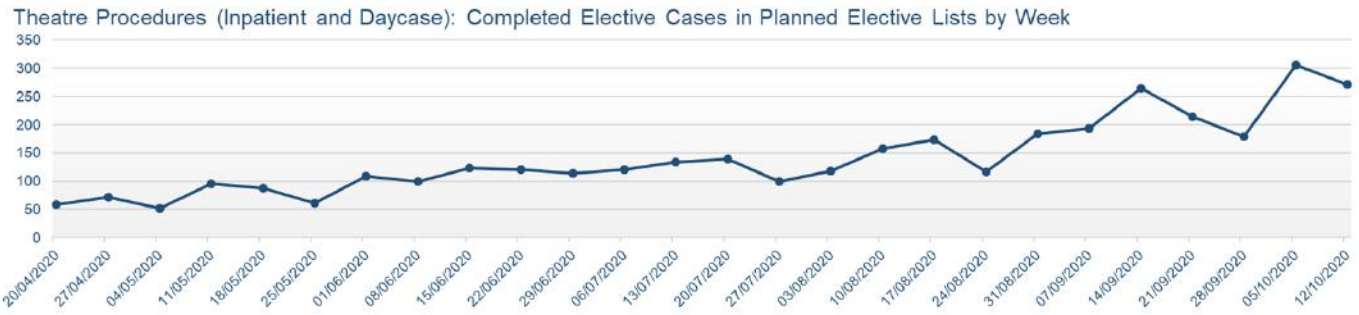
The essential services has now moved into risk stratification for stage 4, as previously described in the August paper :

- 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

The functional capacity plan for Q3/4 supplied by the areas and sites has shown capacity is only available for the Priority 1-3 categories. To this end the organisation introduced the Option 5 “Once for North Wales approach” which shared capacity across the 3 acute sites for key “essential services.” In particular, Ophthalmology, Surgery, Endoscopy, Urology and Orthopaedics. This methodology however does not provide extra capacity but it does level waiting times, as patients are offered the shortest waiting times across North Wales and reduces health inequalities.

With Ophthalmology the Committee need to note that 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 and a newly appointed Managing Director has taken over the leadership role of this service to review and make recommendations via the planned care transformation group.

During the last two months, we are seeing more theatre sessions re-starting, in a resulting increase in activity.

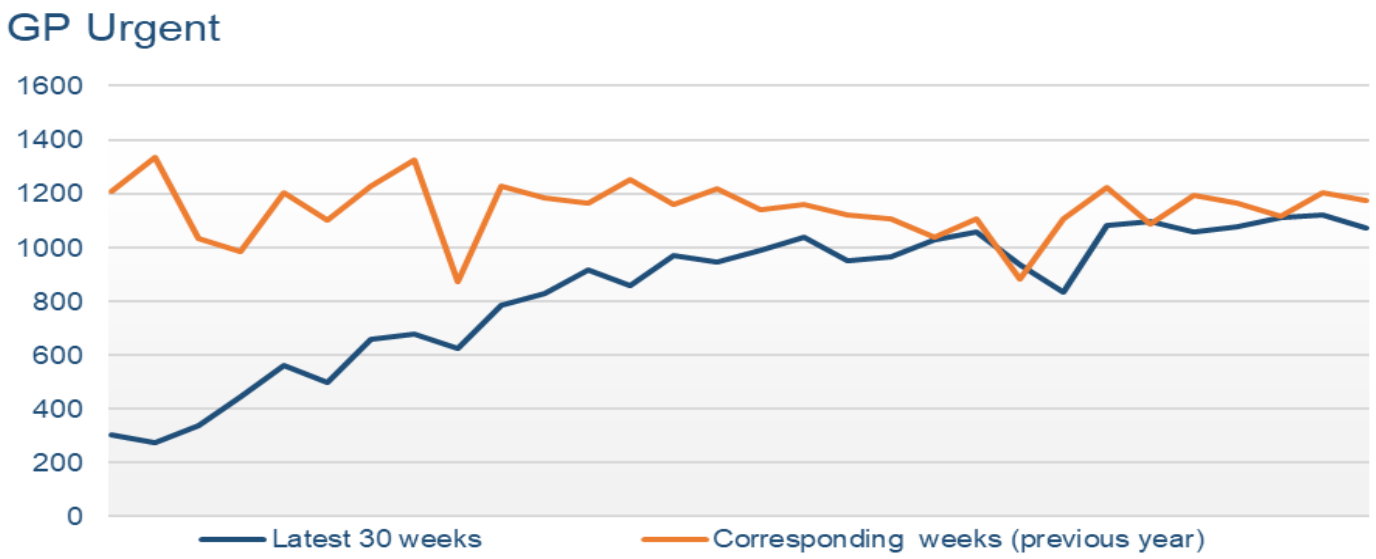


The graph above demonstrates this (measured weekly), however we are still approximately one patient less per list than in the pre-covid utilisation, given we run 10 sessions per week over 12 theatres this equates to approximately 120 patients per week per site is lost.

There is also significant issues around specialties such as Dermatology and Ophthalmology Age-Related Macular Degeneration (AMD) injections due to the loss of capacity.

Cancer Services

As mentioned, the Q3/4 plan is supporting the cancer services, as generally they fall into the Priority 2 risk stratification. Close monitoring is being undertaken and currently the organisation is holding its position. The specialty of concern is Urology, due to the high volume and moderate risk of that specialty. Referrals have now achieved pre-covid levels and there is some early indicators that cancer referral levels are 104% of pre-covid.

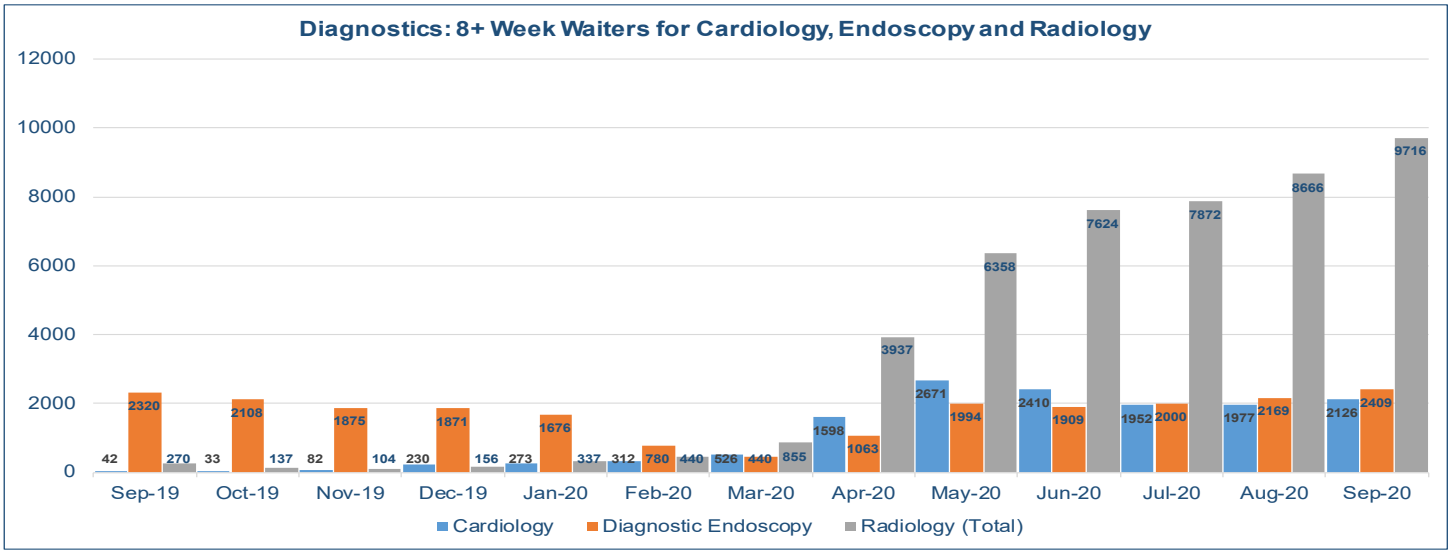


Diagnostics

Diagnostic capacity has been reduced. This is resulting in an increased backlog now standing at approximately 9,000 patients. Priority has been given to suspected cancer patients. Patients are 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 1- 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; this is currently being built as a business case to support the loss of capacity.

The Committee are asked to note that the risk for patients waiting is significant and is increasing. Solutions given the covid situation with social distancing are challenging to implement, particularly when the capacity was built in the pre-covid situation and the physical space for patients and staff safety is reduced.

However, a number of initiatives are being rapidly explored whilst observing the needs to support staff under extra pressure and keeping the possibility of Covid surge capacity in mind.

The schemes can be summarised as :

- Validation
- Demand management
- Roll out of virtual capacity
- Non-surgical treatment of long waiters
- Extra activity in existing capacity - Waiting List Initiatives (WLIs) and Insourcing
- Providing ring fenced modular ward and theatres on each site to deliver backlog clearance using WLI or insourcing

Each of these programmes are currently being reviewed and Welsh Government funding has been requested through the Referral to Treatment (RTT)/planned care plan for top five schemes.

The final scheme would give a more sustainable solution, providing the capacity gap from pre-covid to post covid. It would also provide a possible pre-requisite to another concept, known as the diagnostic and treatment centre for North wales.

Conclusion

The end of October will give a good benchmark on where planned care lies against its Q3/4 plan. It will give an indication on whether or not we are continuing to see the high-risk patients and what other actions may need to be taken. There is a growing quality and safety risk as patients wait longer for their procedures due to the covid pandemic. Steps are being introduced to help support patients whilst waiting which will also include a communication strategy. The growing backlog is of significant concern for planned care and options are being looked at over the long term on how we can provide a sustainable solution for the Health board that would fit into the short and midterm measures described in this paper.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 3rd November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Infection Prevention (IP) Report Quarter 2 (July - September 2020/21)
Cyfarwyddwr Cyfrifol: Responsible Director:	Debra Hickman – Acting Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Amanda Miskell – Associate Director of Nursing (ADN) – Infection Prevention & Decontamination
Craffu blaenorol: Prior Scrutiny:	Acting Executive Director of Nursing and Midwifery
Atodiadau Appendices:	1. Performance slides delivered to Infection Prevention Sub Group (IPSG) for September 2020

Argymhelliad / Recommendation:

The Committee is asked to take assurance from the Infection Prevention report.

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

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

Sefyllfa / Situation:

The IP report will update the Committee on the position of IP performance and the associated risks relating to IP. For this report a summary is provided on:

1. 2020/21 trajectories, performance, gaps and actions required
2. COVID 19

Cefndir / Background:

Infection Prevention performance and reporting is a mandated requirement for the Health Board. This report will provide a position statement in relation to trajectories, quality improvements, harms and exception reporting.

The significantly under resourced Infection Prevention Control Team (IPCT) has been challenged in delivering the 2020/21 work programme. The breadth of responsibilities within the IPCT have had an impact on the stability of the team. The resource for expert and specialist IPC nurses across the UK and Wales is now significantly diminished as organisations have their business cases approved and recruited in Winter 2019/20 and since.

Asesiad / Assessment & Analysis:

Introduction

BCU has a zero tolerance to any avoidable infection that is either Community Onset (CO), Hospital Onset (HO) or Health Care Associated (HCA). Any avoidable infection is subject to scrutiny, a Post Infection Review (PIR) that is multi-faceted and additionally may be presented to the Corporate Led Health Care Associated Infection (HCAI) panel. This process also applies to ALL Meticillin Resistant Staphyloccocus Aureus (MRSA) Blood Stream Infections (BSI) and Clostridium Difficile Infections (CDIs).

Learning from any of these outcomes results in changes and further innovations wherever possible to prevent any reoccurrence. All infections are reported via the laboratory into a system called ICnet. In addition to this, the IPCT perform a “deep dive” on every infection, cluster and outbreak. This determines whether an infection is Community or Hospital onset, Health Care Acquired or not and if it is avoidable or not.

Since 6th July 2020 all Covid 19 infections greater than 2 days after admission also have a post infection review (PIR) carried out and since September 2020 all these are subject to a panel compromising of the Executive Director of Nursing & Midwifery, Associate Director of Nursing for IP and both Directors of Nursing for that Health Economy (Area and Site). The IPCT are responsible for maintaining the “line list” as one version of the truth in relation to Covid 19 infections and if these are CO or HO and HCAIs.

Examples for **avoidables** would include device management where there has been a breach in Aseptic Non Touch Technique (ANTT), contaminated blood cultures or delay in change or removal of a device. **Unavoidables** would include Intravenous Drug Users, noncompliance with health care advice, or no healthcare intervention i.e urinary tract infections, hot gallbladders, some endogenous infections and liver abscess. The numbers the IPCT report are exact to those reported back from Public Health Wales (PHW), which uses an additional lab reference system called LIMS. Where there are any anomalies these are addressed urgently.

In terms of our position to other Health Boards, please see appendix 1 and below in terms of Health Board positions and comparisons. These slides also include year to date data in relation to trajectory infections, narrative and data in terms of community and hospital onset, and those infections that may or may not be HCAIs. In addition, there is information to show the rationale for concern in terms of the increase in HO CDIs.

The Infection Prevention Sub Group (IPSG)

The IPSG has undergone several changes since April 2020, which focuses the group on accountability, senior clinical engagement and quality improvement. This has led to the most recent changes in the Terms of Reference and governance arrangements including:

- Mandatory epidemiology updates in relation to performance
- Set report format with mandatory sub headings from area and site directors
- Independent member
- Primary care membership
- Dentistry membership
- Medical membership in addition to Microbiology and Consultant in Communicable Disease Control (CCDC)
- Senior colleagues reporting into IPSG from Health Economies and Local Infection Prevention Groups (IPGs)
- Focus on going further faster

Current position at end of Quarter 2.

Clostridium Difficile:
Cases have increased across all of Wales by 18% compared to BCUHB, 24%. There are far more HO infections than CO. This may be related (ongoing consideration across Wales and the UK) to remote prescribing in the community and audits are underway in the acute hospitals. There is also ongoing epidemiology, antimicrobial and Whole Genome Sequencing (WGS) work ongoing which is part of the innovative and collaborative approach coordinated by the AND for IP. There also appears to be an environmental risk (previous admission) to some new infections and an increase in those patients receiving oncology services. This is also being studied with colleagues in Haematology services. Over use of inappropriate antimicrobials is definitely an influence. Particularly when we consider those infections, being treated with broad-spectrum antimicrobials and those that are multi resistant organisms.

The Health Board is over trajectory, 120/74. The largest increases are in Ysbyty Wrexham Maelor (YWM) and Ysbyty Glan Clwyd (YGC).

In addition to the approach described above, the IPCT are also working with colleagues in Estates and Facilities and ongoing work includes:

1. ARK must be embedded into the YGC site as a priority with support from Medical, Nursing and Pharmacy senior colleagues and commitment to training and challenge were non-compliance with the formulary is witnessed.
2. Antimicrobial Pharmacists and the ongoing work required in the Community, Dentistry, MH/LD MUST NOT be underestimated in relation to the impact on infection rates and the TARGET tool must be reinforced. This requires a commitment from pharmacy and area to support the need for antimicrobial stewardship.
3. Pilot a discharge/transfer team to deep clean all the bed space including furniture, bed, mattresses and curtain change. The use of sporicidal wipes for any faecal contaminated items and spaces.
4. Decontamination of equipment is now a standing item on the Local (LIPGs) and any issues of significance need to be escalated to the Decontamination Group and IPSG.

5. There is a mandatory need for a sufficient decant area in each hospital to allow for an uninterrupted and robust hydrogen peroxide vapour (HPV) or ultraviolet (UV) programme.
6. The IPCT are working with estates and facilities colleagues to trail and implement new technologies in the Health Board. This will commence in East where the environment is the most challenging to clean due to age and lack of isolation facilities.
7. Prioritise Admission areas, Haematology and Gastrological wards where CDI may be grossly contaminating the environments.
8. Ensure there is access to hand wipes for every patient at mealtimes. The finances for this were agreed week commencing 12th October 2020.
9. Continue surveillance and monitoring of WGS and PIRs

Methicillin Resistant Staphyloccocus Aureus (MRSA)
There have been 3 MRSA BSI to date as described in appendix 1. All of Wales is showing a 30% reduction compared to year to date 2019/20. BCU have seen a 50% reduction. One in East was CO, and not deemed a HCAI. The one case in West is avoidable and a contaminated blood culture which has IPC, Medical Director and Director of Nursing involvement, leadership and challenge. One in Central was thought to be CO; however, the PIR shows the patient was catheterised in ED 10 days previously and returned to the care home where they live.

In addition to above actions:

1. Further work is ongoing to understand, GP, Community Nursing and Care Home expertise in caring for a urinary device.
2. The community catheter audit was postponed due to the ongoing reduced capacity and resource in the IPCT. However a task and finish group has now being coordinated (started w/c 12.10.2020) in driving forward the mandatory work to understand how many urinary devices there are in the wider community, including; how many of these patients have healthcare interventions, from whom, how many patients have been screened for MRSA and if positive, decolonised.
3. Increase access to continence assessments, Transurethral Resections of Prostate (TURPs) and Trail without Catheters (TWOCs).
4. Approval of and coordination of distributing new vascular devices documents, which are concise bundles and concentrate on monitoring as well as excellent insertion.
5. The ongoing need to establish and fund a specialist intravenous (IV) service, which will oversee Outpatient parental Antimicrobial Treatment (OPAT), line insertion and blood culture collection. From PIRs and the Deep Dive scrutiny process there is a priority to drive forward the completion of blood culture collection documentation. This work was commenced last year led by Dr Brian Tehan, IV Specialist Nurse and the IPCT; however, this has been delayed due to capacity and prioritisation of the pandemic. This will be continued within the work programme of the Infection Prevention Sub Group (IPSG) for 2020/21.

Methicillin Sensitive Staphyloccocus Aureus (MSSA)
Although BCU is in 1st position in terms of least infections per 100K population for MSSA, there is no room for complacency. The previous ongoing work is impacting on certain organisms but there is more to do. All Wales are reporting a 9% reduction on infections compared to last year and BCU is reporting a 24% reduction. The majority of infections (46 of 74 year to date) are unavoidable (62%) with only 11% determined avoidable and the rest are undetermined from the deep dives and PIRs. However any infection causes harm to patients and we need to continue to do all we can in minimising and stopping infections where at all possible. Out of the 13 MSSA infections in October, 1 was HO and 12 were CO. A small number were related to devices (2) however, the majority were due to endogenous and/or other unavoidable infection. However, the Health Board is over trajectory at 73/65.

All of the actions described above are of paramount importance for these infections and in addition:

1. The IPCT have worked closely with the Renal Dialysis clinical lead and now ALL dialysis patients are screened for MRSA and MSSA due to the risk of BSIs in this group of patients.

E. coli
BCU is under trajectory for E.coli infections, 223/236. However, this number is significant and the impact on patients is not to be taken too lightly. Clinical research, evidence and PIRs show a significant number of these infections are related to Urinary Tract Infections (UTI) and or inter abdominal infections. Some are Catheter Associated (CAUTIs). The need for a further IPC resource for the non-acute population is of the utmost importance as again we see the significance of CO cases, 30 in September compared to HO, 5.

As before, for gram negative infections (*E.coli, Klebsiella and Pseudomonas)*, all of the actions above will continue to impact on reducing and avoiding any avoidable infections.

Klebsiella
Klebsiella infections per 100K population have decreased across Wales by 13% and herein BCU by 21%. Again, the majority are unavoidable and some are related to devices. 66% (6) are CO compared to 33% (3) HO. The Health Board is in 2nd position in terms of least number of infections per 100K population across Wales. Due to the significant prevalence in East and the antimicrobial resistance in East the IPCT are focusing with epidemiology on those cases.
However, the Health Board are over trajectory 58/48.

Pseudomonas
Pseudomonas infection as well as CDI is of concern to the AND – IP and I - EDoN. Pseudomonas infections although small have a high mortality rate. These were noted early in 2020 and responded to in terms of surveillance, scrutiny and in depth PIRs with GPs, Care Homes, Community Nursing and others. These infections numbers although small in comparison to other gram negative infections are mostly related to very sick patients, with associated Carcinomas, Pneumonias, Wounds and Catheters/Urology complications.

Covid 19

The outbreak in East and particularly in YWM was concluded and declared over on 17th September 2020, following at least 28 days since the last associated HCAI affecting a patient or member of staff. This summary was presented to IPSG and QSE. There were many lessons learnt and many actions noted and escalated. These included:

- An inadequately resourced IPCT
- Bed spacing
- Lack of ventilation
- Lack of Isolation facilities
- Inability to meet demand
- The capacity to screen all admissions
- Patient and staff movement
- Breaches in IPC practices

The IPCT is actively involved in coordinating and contributing to the considerable work ongoing, consisting of:

- Delivery Group
- On-going outbreak control teams (OCTs)

- Review of policies and a number of new Standing Operating Procedures (SOPs) and checklists for COVID 19
- Development of a webpage/resource for Personal Protective Equipment (PPE)/IPC and Covid 19
- Ongoing PPE Steering Group
- Operational support for Ward Managers and handover/SBAR processes
- PPE and IPC champions
- Donning and Doffing training
- Fit Testing
- Coordination of Hoods, training and SOPs for decontamination
- Support in following up all Covid 19 staff
- Cluster and contact management with PHW and Test, Trace & Protect (TTP)
- Covid testing and vaccination groups
- Enfys Hospitals usage
- Covid 19 positive patient reporting and monitoring arrangements
- Opening and closing wards
- Advice in remobilisation to Clinicians, Departments, Divisions and Strategic meetings

This is in response to the thematics described in the previous IPC report to QSE. All of this has accumulated in a potentially different epidemiologically outcome to the Outbreak in Central Area and at YGC which is ongoing and delivered to the QSE separately.

Infection Prevention is not just for the IP service to deliver on and visibility, challenge and praise from all colleagues is of paramount importance in consistent messages and support.

Financial Implications

1. Expand and financially support the significant gaps in the IPCT, including decontamination and antimicrobial stewardship
2. Staff absence for self-isolating, shielding and symptom management.

Risk Analysis

Infection prevention and the ability to deliver the work programme, policy review, preventative and innovation work, and development of the IPCT is currently on the Risk Register. A Delivery Group and PPE risk register has been developed chaired by The Executive Director of Nursing.

Legal and Compliance

Reporting to Incidents for any COVID 19 clusters/ward closures and deaths confirmed on death certificates.

HCAI including Covid 19. Reporting to HSE via RIDDOR for any dangerous occurrences relating to staff infections.

Bed Spacing and Air exchange monitoring.

Impact Assessment

No impact applicable to this report.

Appendices

1. Performance slides delivered to Infection Prevention Sub Group (IPSG) for September 2020

Infection Prevention Performance Summary for September IPSG 2020/2021

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 September 2020 and year to date is not compared as 'like-for-like' to previous months/ years performance.

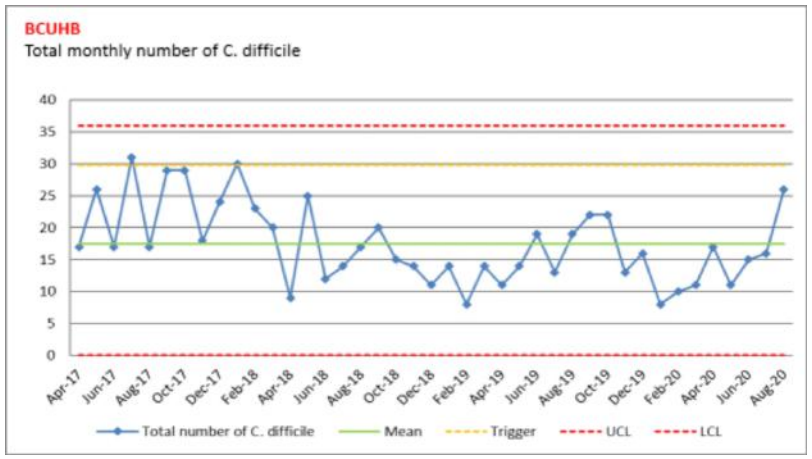
- Normal fluctuations in Infection numbers are to be expected month on month. The year to date figures in terms of performance to trajectory are important in relation to improvement. **All Welsh Health Boards have seen increases in *Clostridium Difficile* Infections (CDI).**

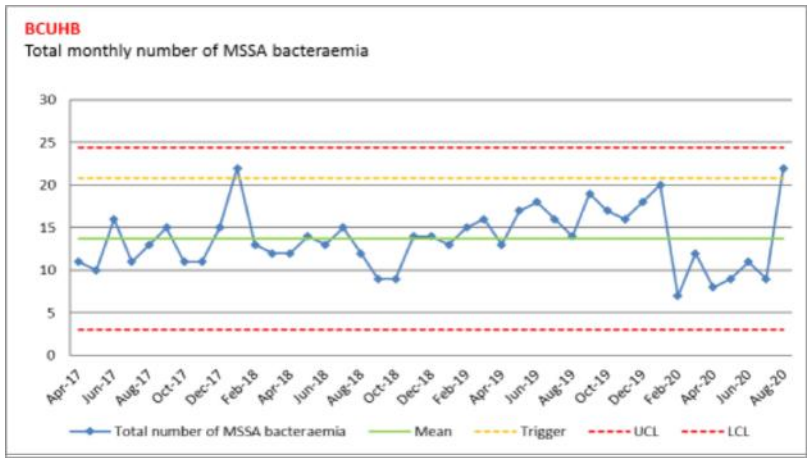
BCU are over trajectory for all organisms except for *E.coli. However this is due to Central numbers. West over trajectory for CDI and East Pseudomonas ONLY. Community Onset (CO) remain significantly higher than Hospital Onset (HO).*

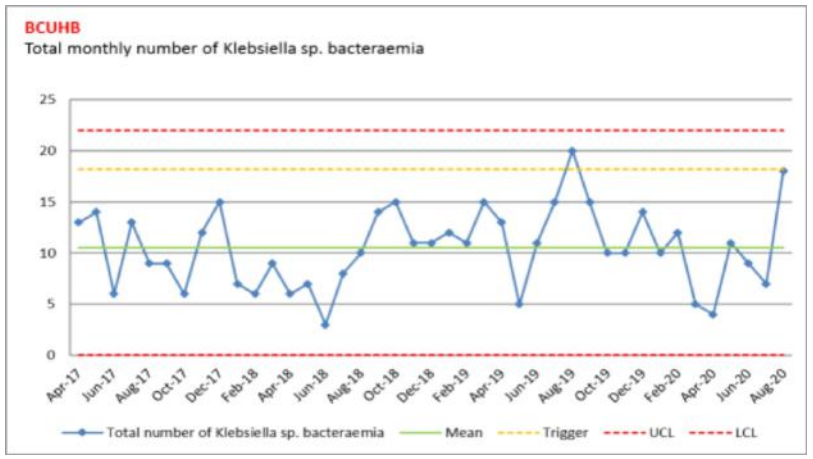
- *Clostridium Difficile* Infections have increased with more HO than previously (Sept' 20/15). CDI infections are the biggest concern with a significant rise in Wales but more in BCU. Currently audits being completed in to an increase in CDI potentially due to treatment for Covid 19. Central, and West are both above trajectory. The HPV programme and antimicrobial stewardship (ARK) for Central and area must be prioritised with more HO to CO.
- *Meticillin Resistant Staphylococcus Aureus* (MRSA) 3 cases YTD. 1 CO unavoidable East, IVDU, 1 CO avoidable MRSA Blood Stream Infection (BSI) West as Contaminated Blood Culture and 1 ? Avoidable CO, catheterised in ED 10 days earlier and in a Care Home. In comparison to last year to date (September 2020) BCU has 50% fewer infections. All Wales are down 30%.
- *Meticillin Sensitive Staphylococcus Aureus* (MSSA) 26% fewer infections from last year, and all Wales down 9%. Most are Community Onset (CO) 12 compared to 1 Hospital Onset (HO).

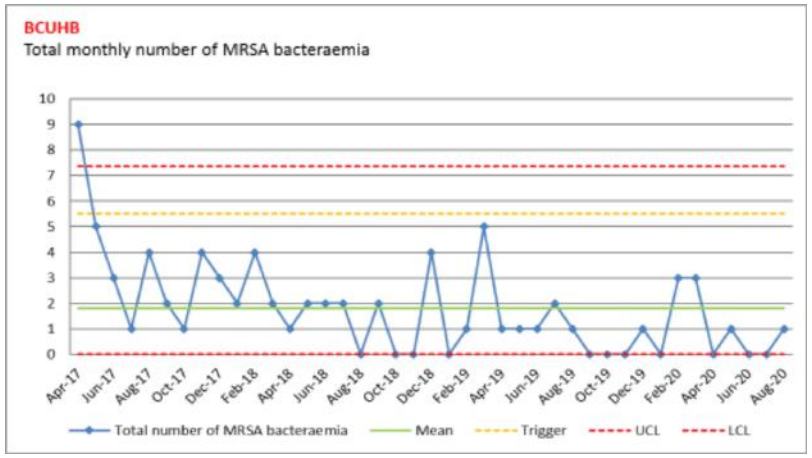
- *E.coli* - The majority are CO, 30/5 and overall BCU have seen 24% fewer infections year to date. The majority remain unavoidable and for others devices remain a potential cause. The increase in TURPs and TWOCs is an important consideration.
- *Klebsiella* infections are down 21% to last year compared to all Wales 13%. IPC and Epidemiology colleagues are reviewing all these. Majority unavoidable, and CO (6/3) and devices appear to play a part too.
- *Pseudomonas* BSIs have also increased in numbers, 21% compared to all Wales down 15%. 4 cases were confirmed in September 2 CO and 2 HO). These infections numbers although small are mostly avoidable and related to very unwell patients, with Carcinoma, Pneumonias, Wounds and Catheters/Urology complications.

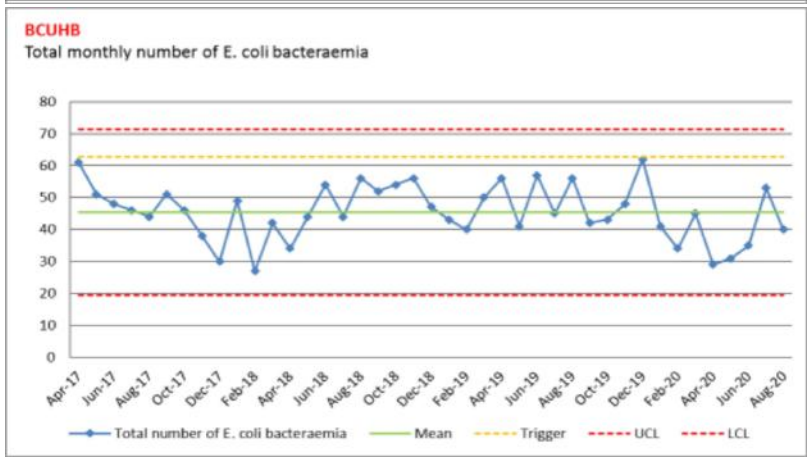
IPC Monthly numbers – To end of September 2020

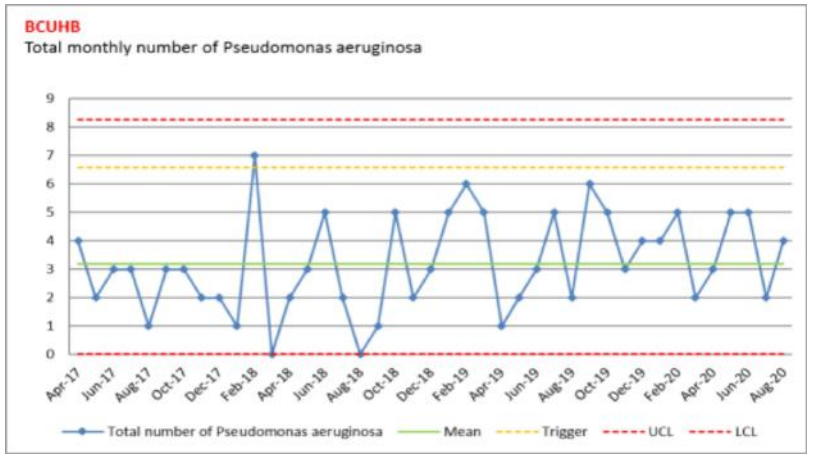












BCUHB Year to date Trajectory Performance – September 2020

BCUHB Trajectories vs Actual Numbers of Infections 2020-21

NB. The data shown below is CUMULATIVE

Whilst targets from WG for 2020-21 are awaited, the trajectories shown below are based on 2019-20 targets

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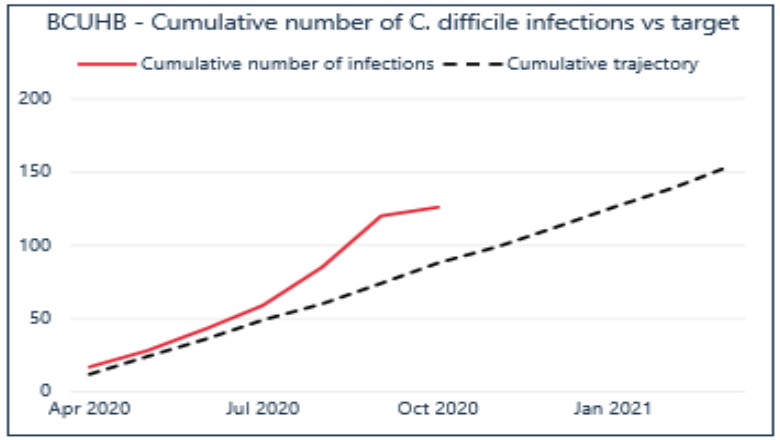
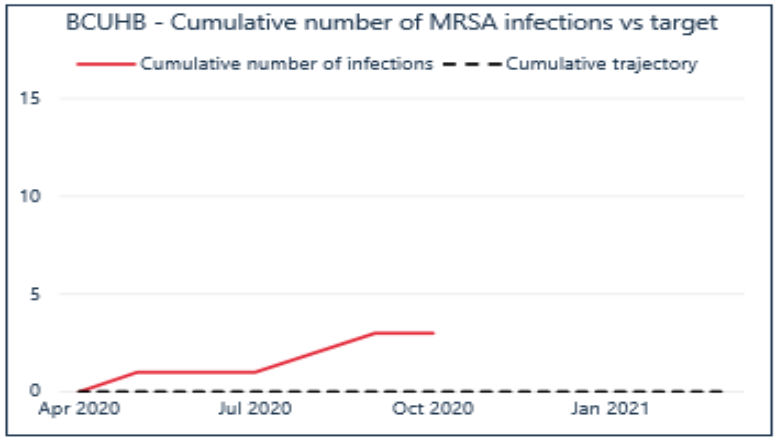
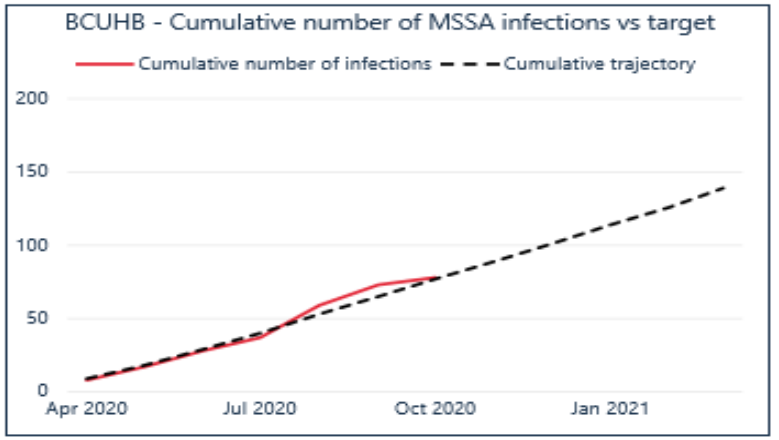
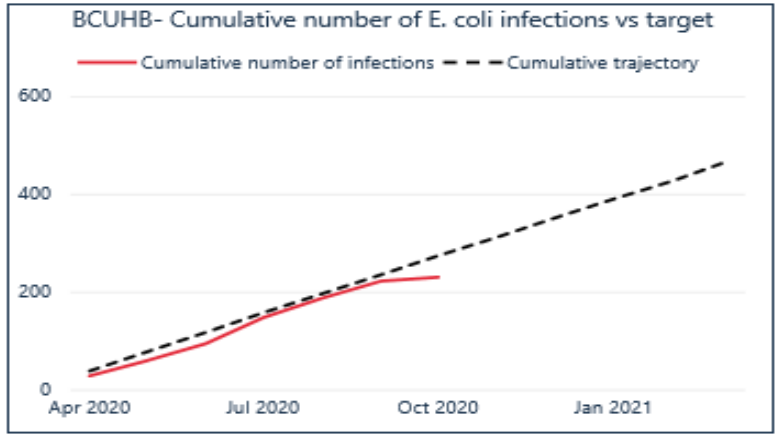
Numbers below are totals for Acute Hospital, Community Hospitals and GP Practices

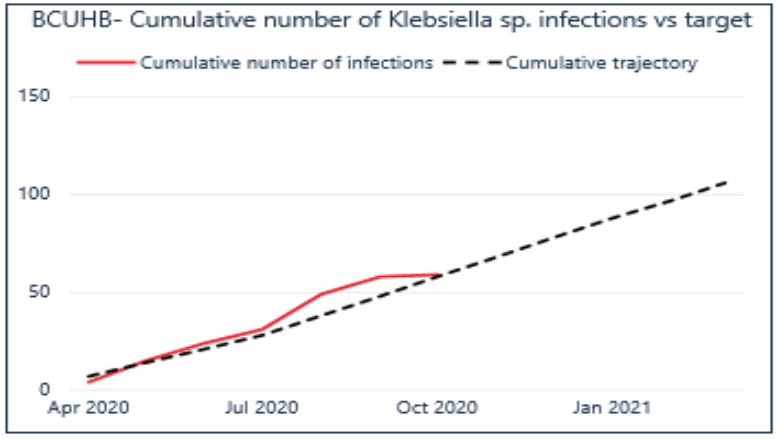
Please be aware that data below also includes incomplete months. If the total for the current month seems low, it may because that month has not yet ended.

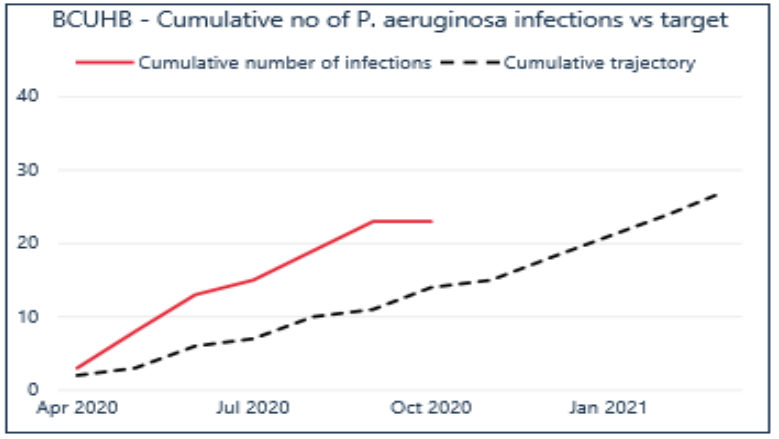












September 2020 activity HO and CO

Infection Numbers - BCUHB

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Organism Type

All

- [x] Select all
- [x] C. diff
- [x] E. Coli
- [x] Klebsiella
- [x] MRSA
- [x] MSSA
- [x] Pseudomonas aeruginosa

Specimen Location Hospital

All

Ward

All

Location Type

All

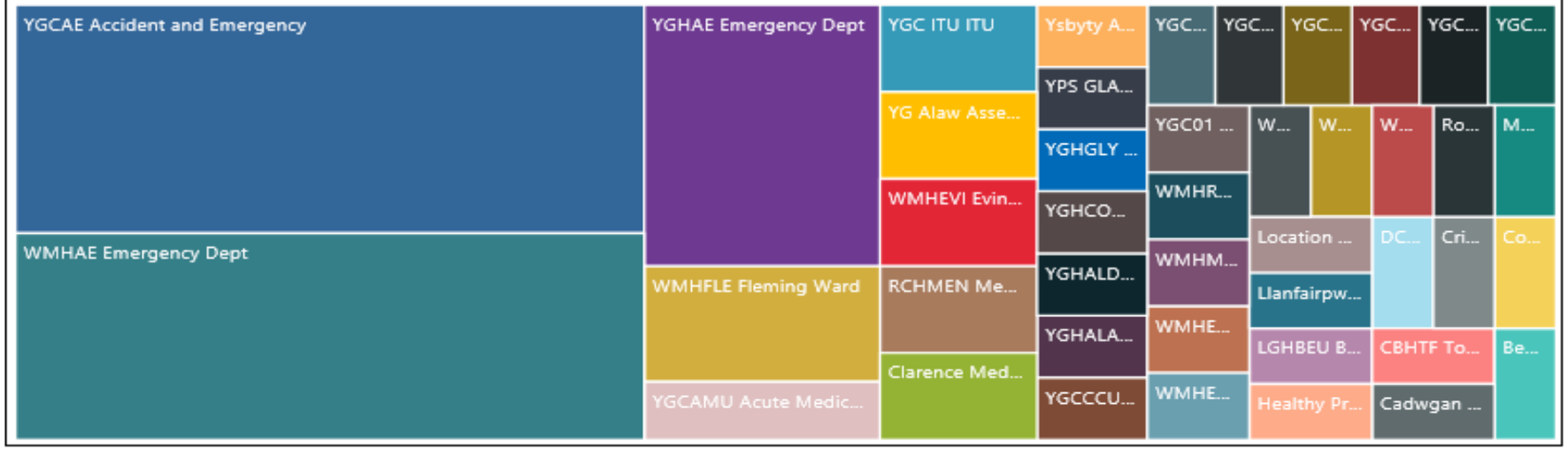
01/09/2020 30/09/2020

l from ICNet daily (Mon-Thurs) at 10:00. Any specimens that were imported into ICNet after this time will not appear until the report is updated.

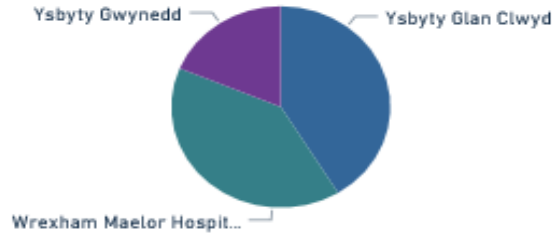
Number of Infections for Selected Criteria

98

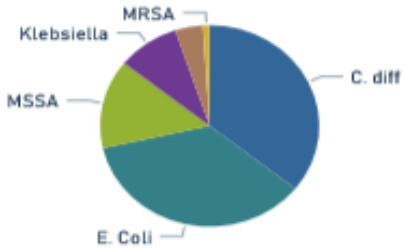
Number of Infections per Ward - Hover mouse over coloured boxes to see full Ward names and numbers of patients



Numbers and Percentages of Infections at Acute Sites



Numbers and Percentages of Infections by Organism Type



Ward	C. diff	E. Coli	Klebsiella	MRSA	MSSA	Pseudomonas aeruginosa	Total
YGCAE Accident and Emergency	1	13	2	1	3	1	21
WMHAE Emergency Dept		12	4		2	1	19
YGHAE Emergency Dept	1	4			4		9
WMHFLE Fleming Ward	2	1	1				4
Clarence Medical Centre	2						2
RCHMEN Menlli Ward	2						2
WMHEVI Evington Ward		1			1		2
YG Alaw Assessment Unit	2						2
YGC ITU ITU	1					1	2
Total	**35**	**35**	**9**	**1**	**14**	**4**	**98**

Primary, Community & Admission point specimens

Infection Numbers - BCUHB

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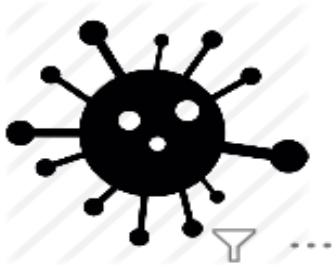
Organism Type	Specimen Location Hospital	Ward	Location Type	01/09/2020	30/09/2020
All	All	All	Multiple selections		

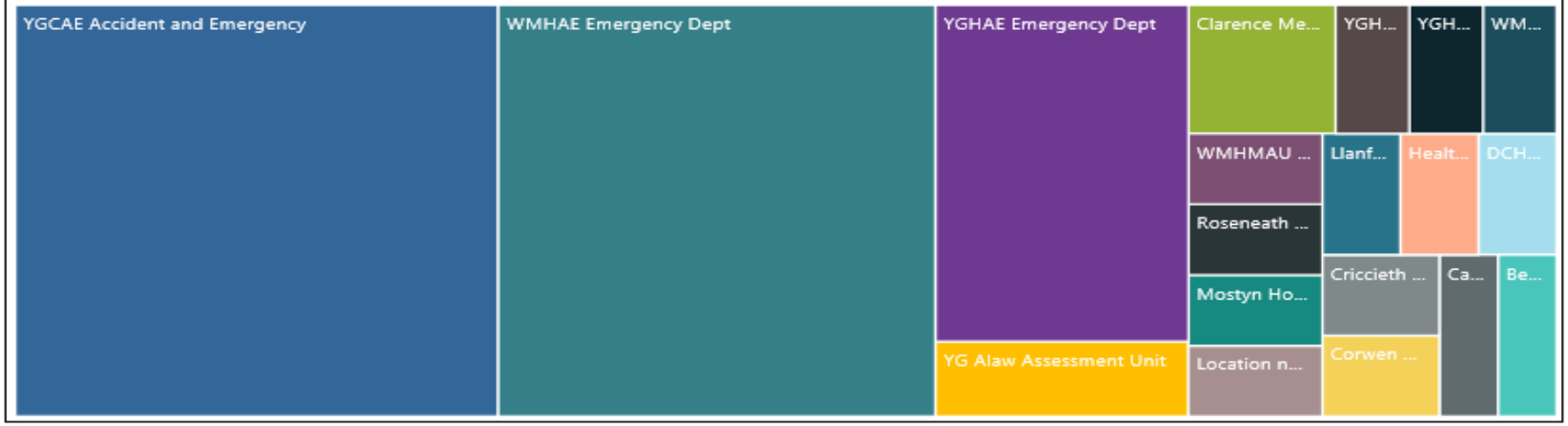
This information is updated from ICNet daily (Mon-Thurs) at 10:00. Any specimens that were imported into ICNet after this time will not appear until the report is updated.



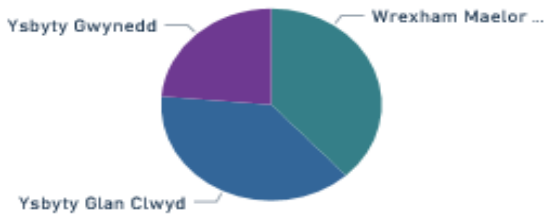
Number of Infections for Selected Criteria

67

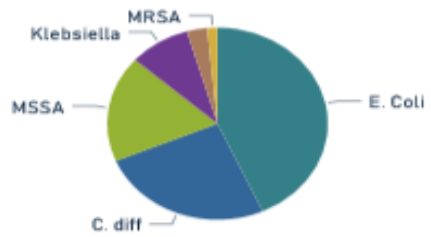
Number of Infections per Ward - Hover mouse over coloured boxes to see full Ward names and numbers of patients



Numbers and Percentages of Infections at Acute Sites



Numbers and Percentages of Infections by Organism Type

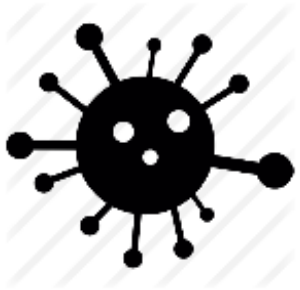


Ward	C. diff	E. Coli	Klebsiella	MRSA	MSSA	Pseudomonas aeruginosa	Total
YGCAE Accident and Emergency	1	13	2	1	3	1	21
WMHAE Emergency Dept		12	4		2	1	19
YGHAE Emergency Dept	1	4			4		9
Clarence Medical Centre	2						2
YG Alaw Assessment Unit	2						2
Beech Avenue Clinic (Wrexham)	1						1
Cadwgan Surgery	1						1
Corwen Health Centre (Corwen)	1						1
Criccieth Health Centre	1						1
Total	**17**	**29**	**6**	**1**	**12**	**2**	**67**

Comparison Numbers for CDI infections YTD Inpatient areas

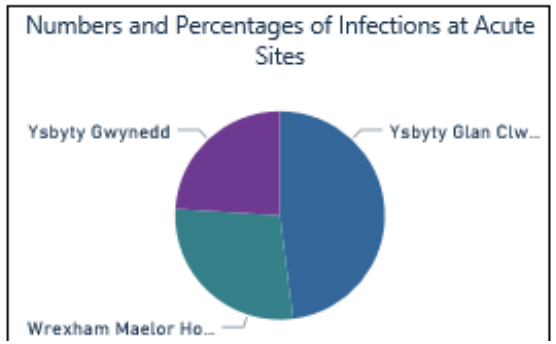
Organism Type	Specimen Location Hospital	Ward	Location Type	01/04/2020	30/09/2020
C. diff	All	All	Multiple selections		

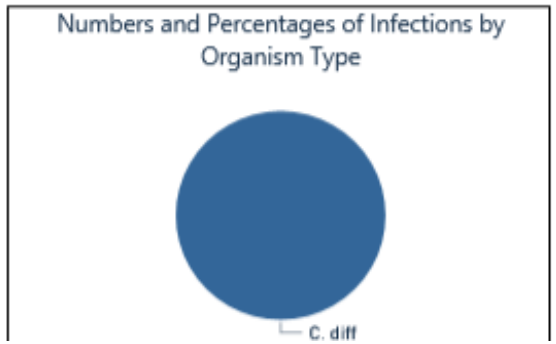
This information is updated from ICNet daily (Mon-Thurs) at 10:00. Any specimens that were imported into ICNet after this time will not appear until the report is updated.



Number of Infections for Selected Criteria

65





Ward	C. diff	Total
LGHBEU Beuno Ward (FMW)	4	4
YGHALA Alaw Ward	4	4
RCHMEN Menlli Ward	3	3
YGC ITU ITU	3	3
YGC09 Ward 9	3	3
DCHBRA Deeside Hosp Branwen Wd	2	2
WMHACU Acute Cardiac Unit	2	2
WMHERD Erddig Ward	2	2
Total	65	65

All Wales Health Board comparison performance Board

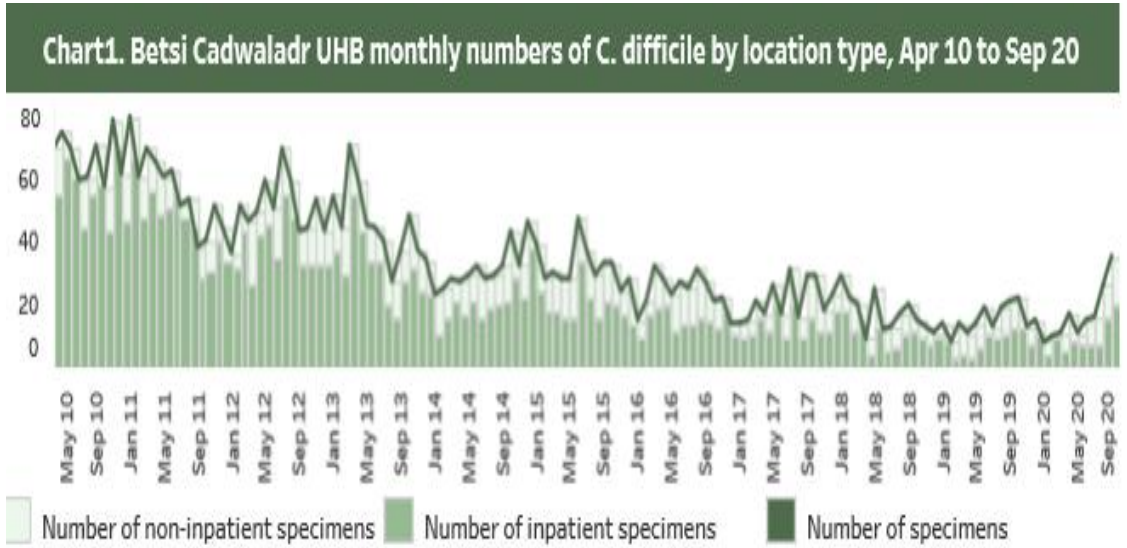
Wales 2020/21 HCAI mandatory surveillance summary, Sep 20

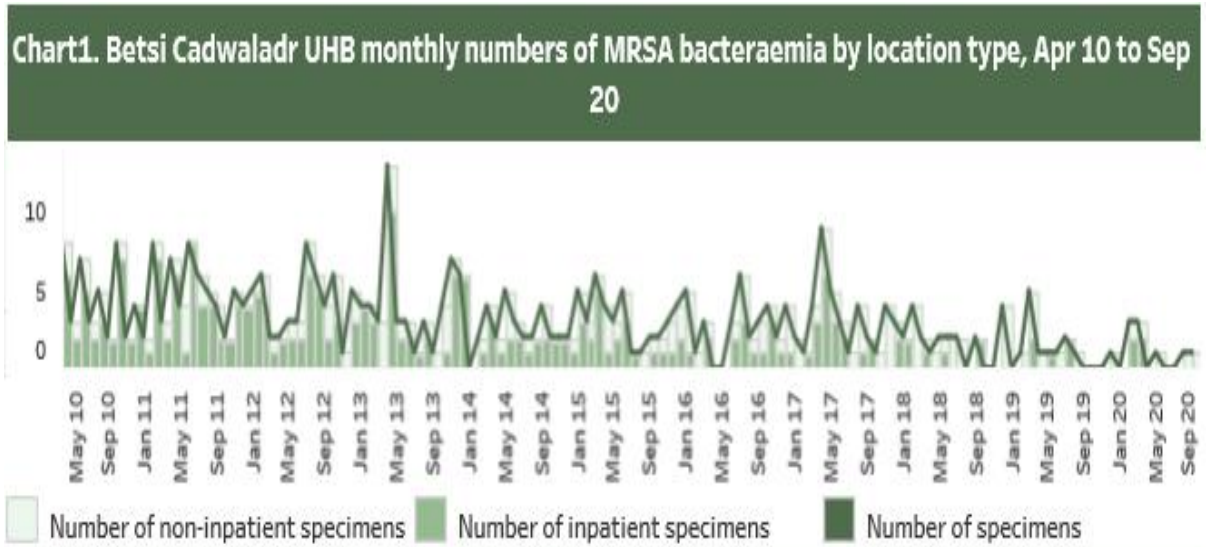
GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

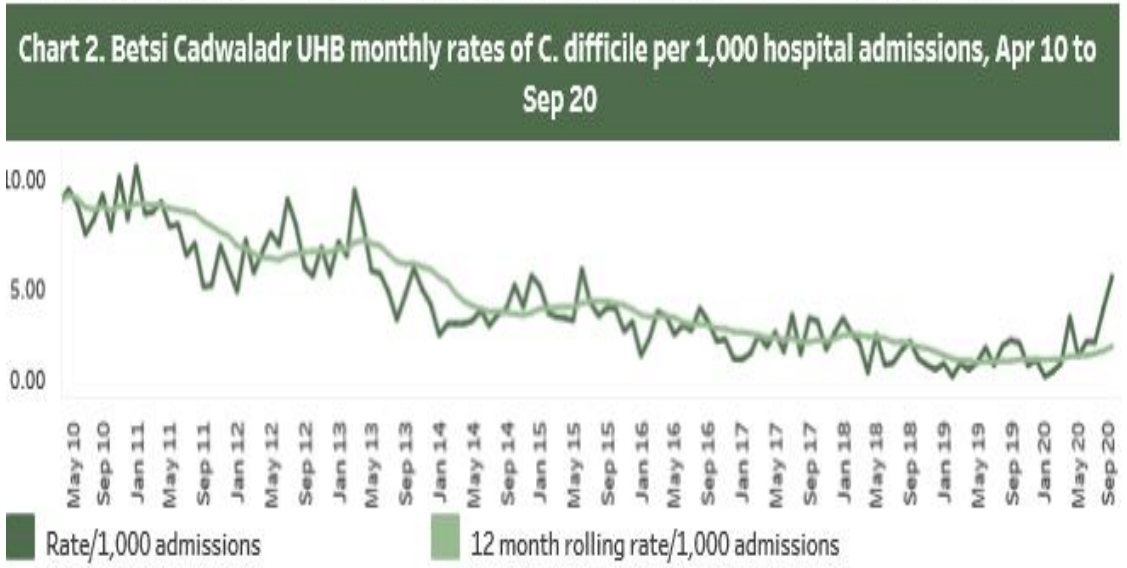
Higher than previous month | Same as previous month | Lower than previous month

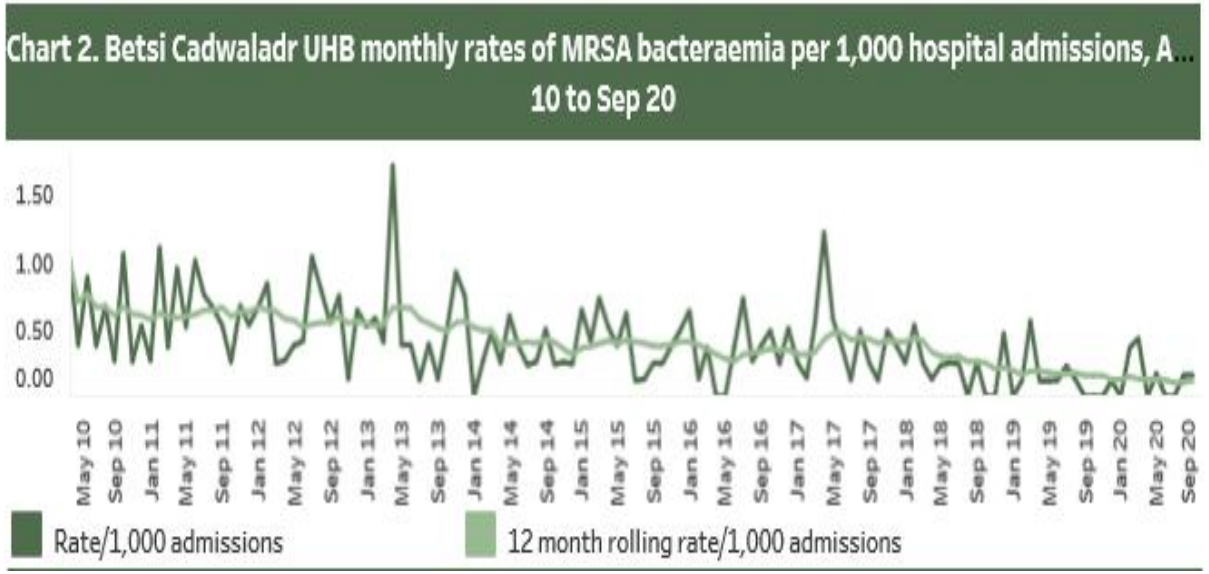
	C. difficile		MRSA bacteraemia		MSSA bacteraemia		S. aureus bacteraemia		E. coli bacteraemia		Klebsiella sp bacteraemia		P. aeruginosa bacteraemia		Gram negative bacteraemia	
	Month number	Month rate	Month number	Month rate	Month number	Month rate	Month number	Month rate	Month number	Month rate	Month number	Month rate	Month number	Month rate	Month number	Month rate
Aneurin Bevan UHB	11	22.64	1	2.06	6	12.35	7	14.41	37	76.14	11	22.64	0	0.00	48	98.78
Betsi Cadwaladr UHB	35	60.98	1	1.74	13	22.65	14	24.39	35	60.98	9	15.68	4	6.97	48	83.62
Cardiff and Vale UHB	9	22.06	0	0.00	9	22.06	9	22.06	26	63.72	6	14.71	2	4.90	34	83.33
Cwm Taf Morgannwg UHB	17	46.46	0	0.00	8	21.86	8	21.86	31	84.72	9	24.60	1	2.73	41	112.05
Hywel Dda UHB	8	25.24	0	0.00	7	22.09	7	22.09	33	104.12	7	22.09	4	12.62	44	138.83
Powys THB	1	9.19	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Swansea Bay UHB	18	56.24	0	0.00	14	43.75	14	43.75	23	71.87	5	15.62	0	0.00	28	87.49
Velindre NHST	2		0		0		0		0		0		0		0	
Wales	**101**	**39.15**	**2**	**0.78**	**57**	**22.10**	**59**	**22.87**	**185**	**71.71**	**47**	**18.22**	**11**	**4.26**	**243**	**94.20**

IPC overall comparisons with HO (darker green) and CO (lighter green) split September 2020 and hospital admissions

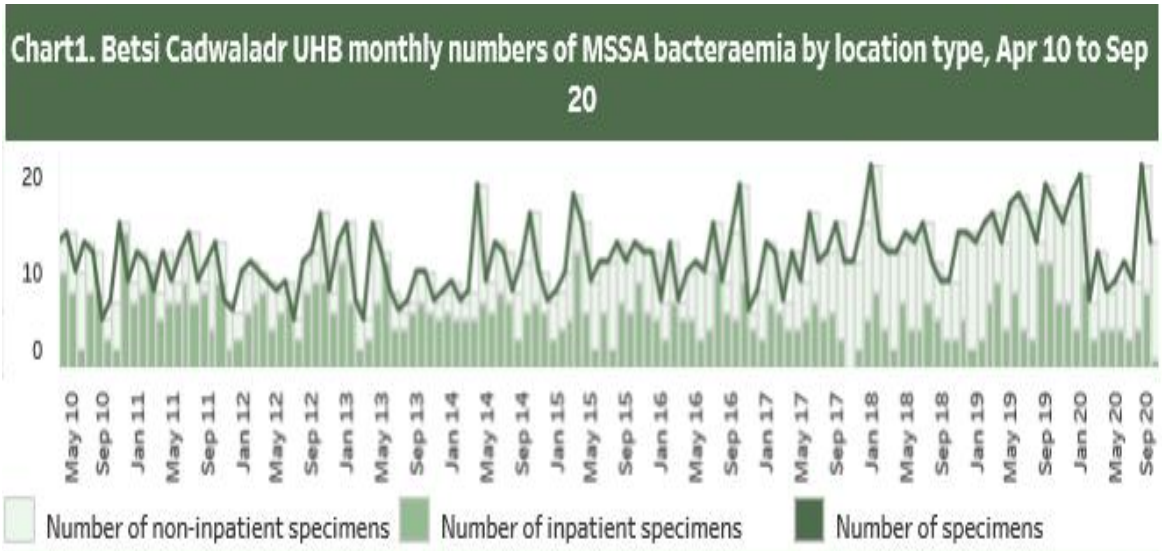


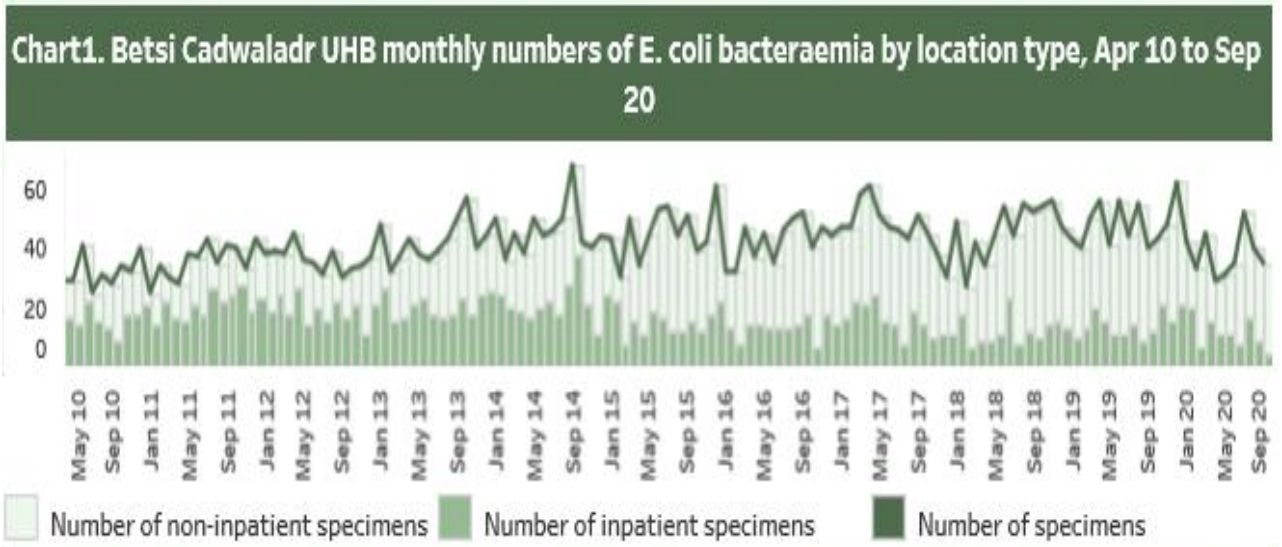


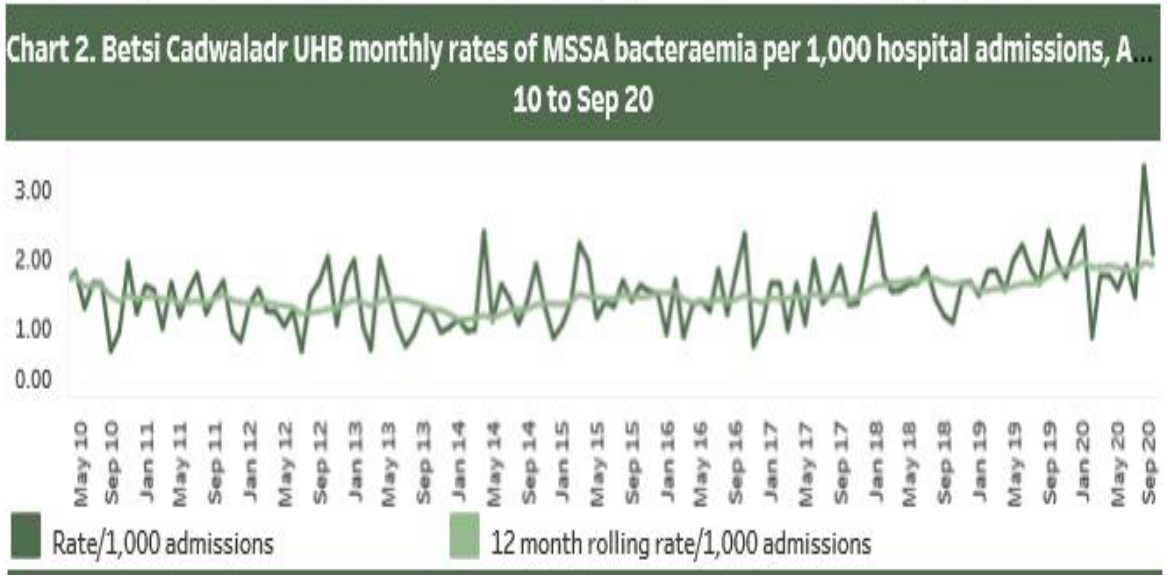


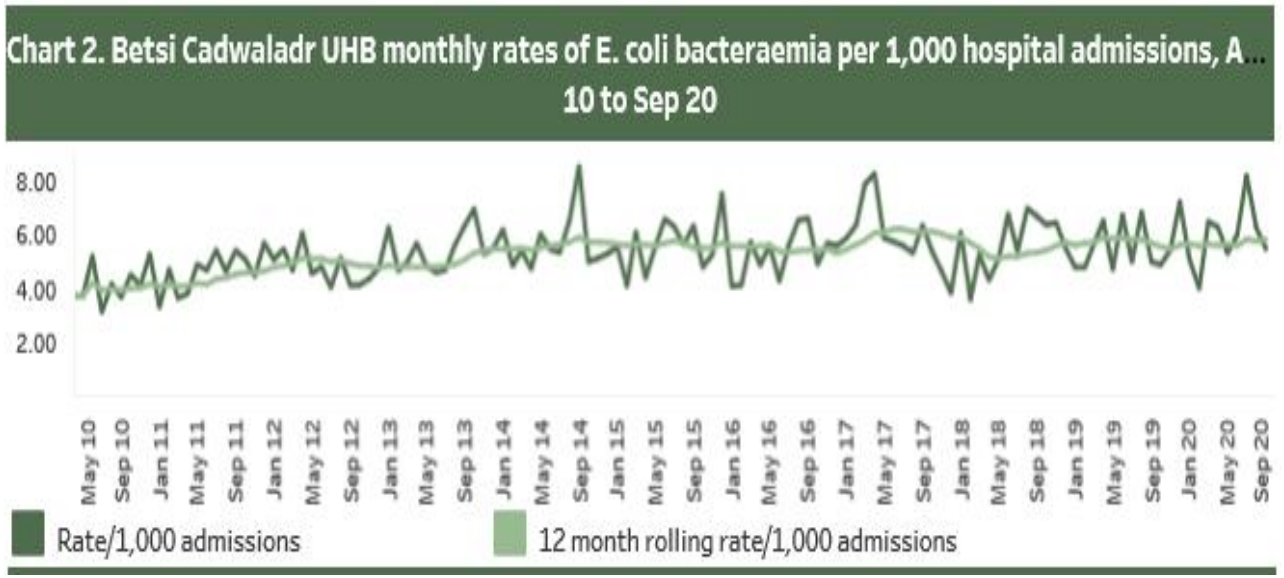


IPC overall comparisons with HO (darker green) and CO (lighter green) split September 2020 and hospital admissions

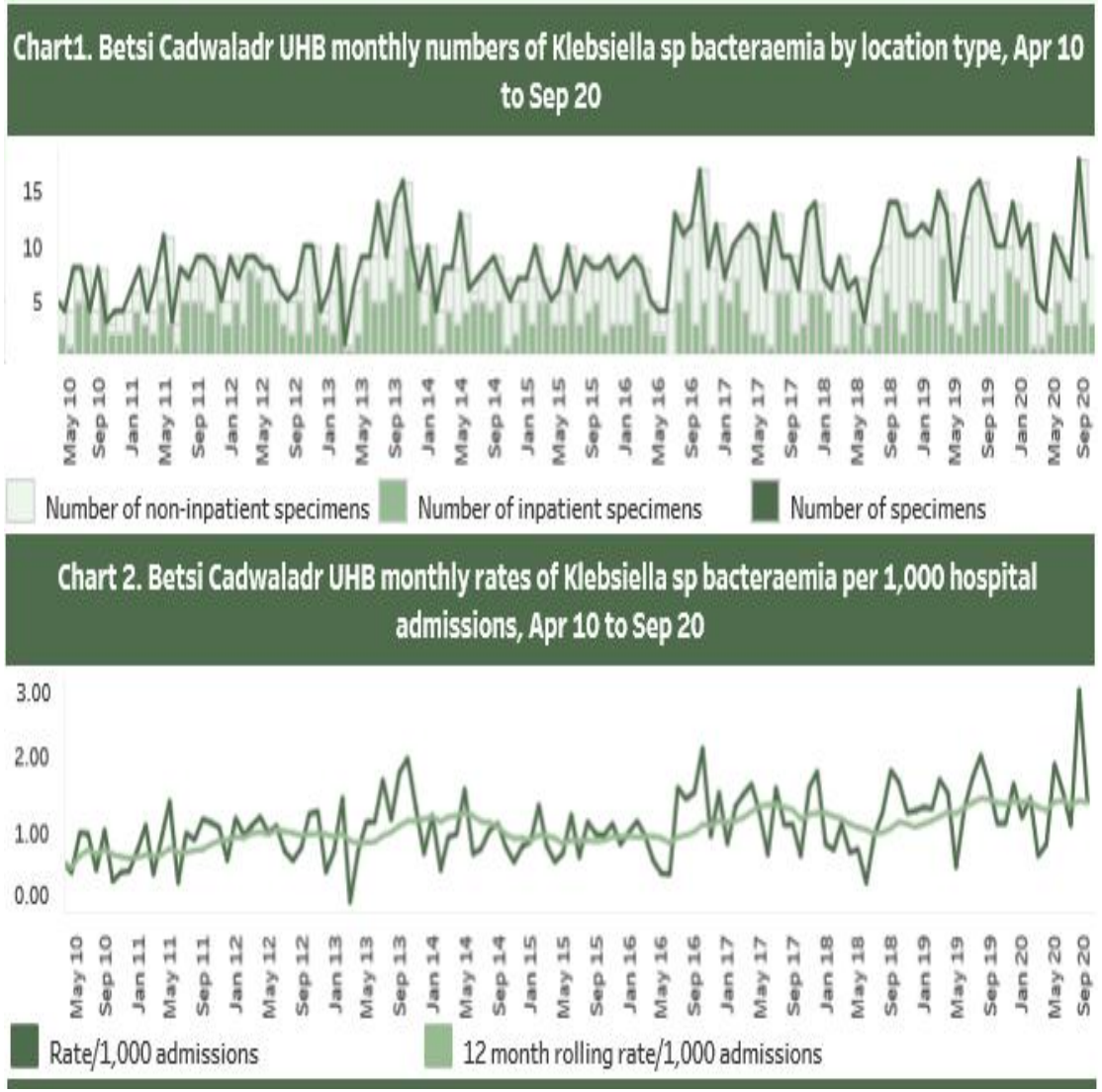


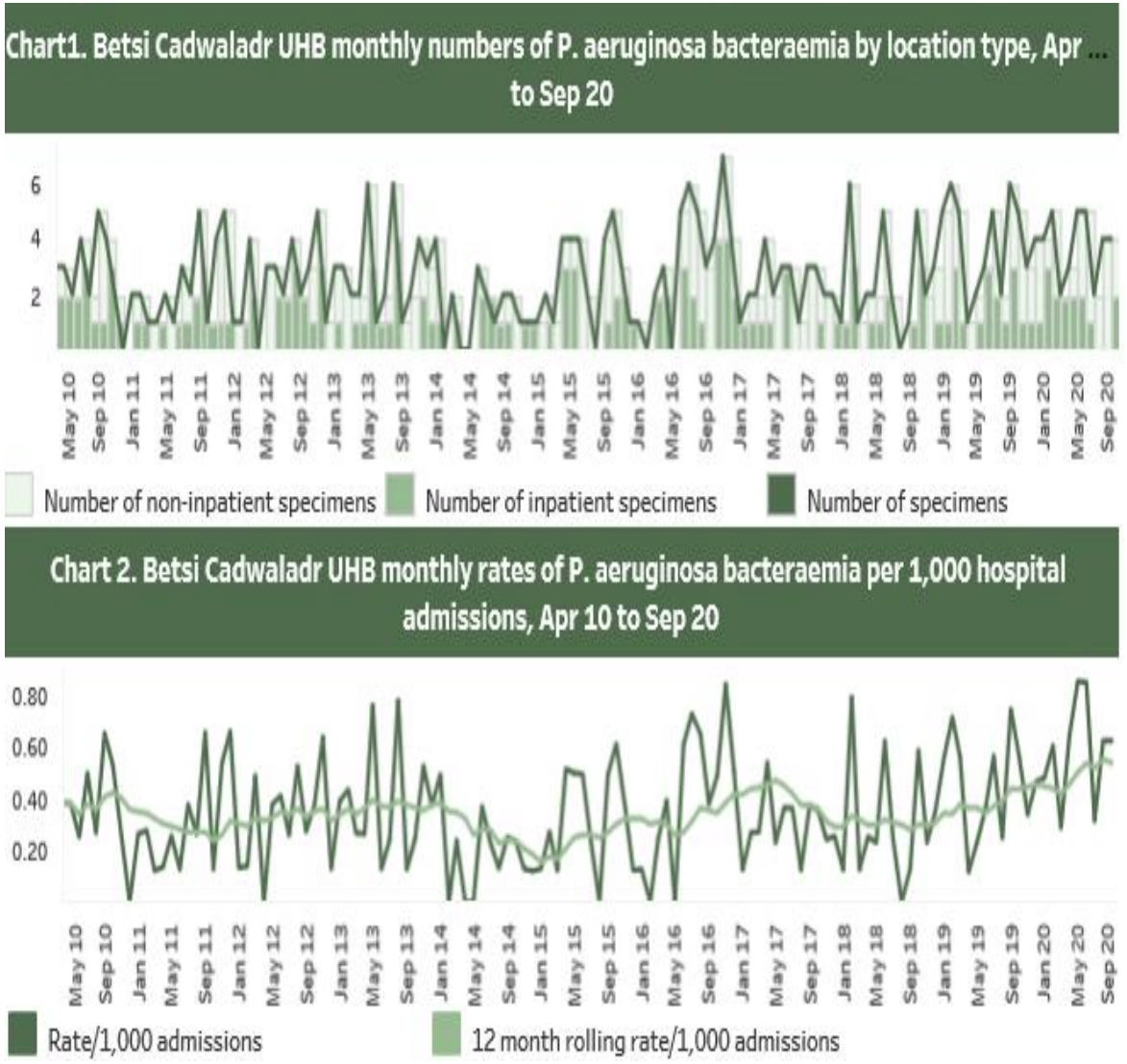




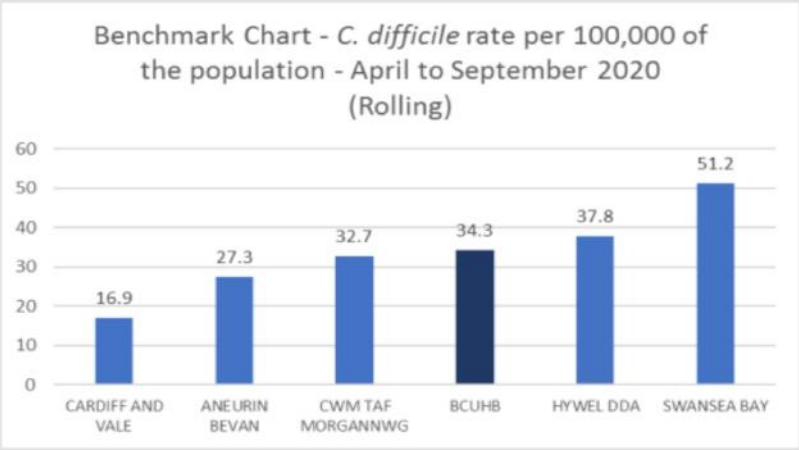


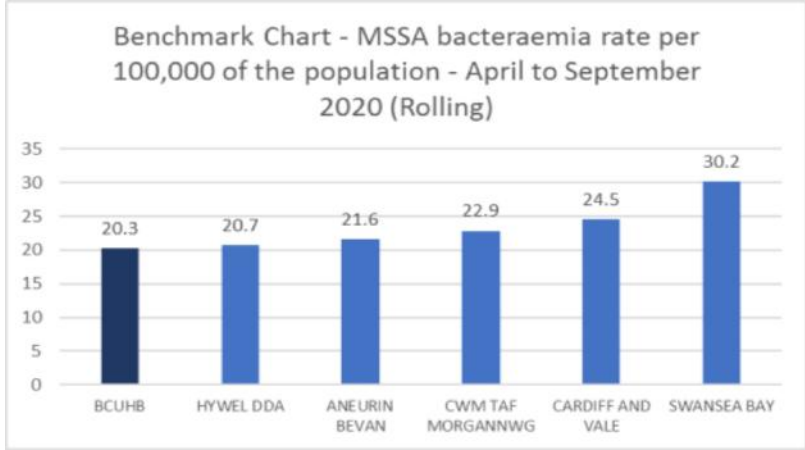
IPC overall comparisons with HO (darker green) and CO (lighter green) split September 2020 and hospital admissions

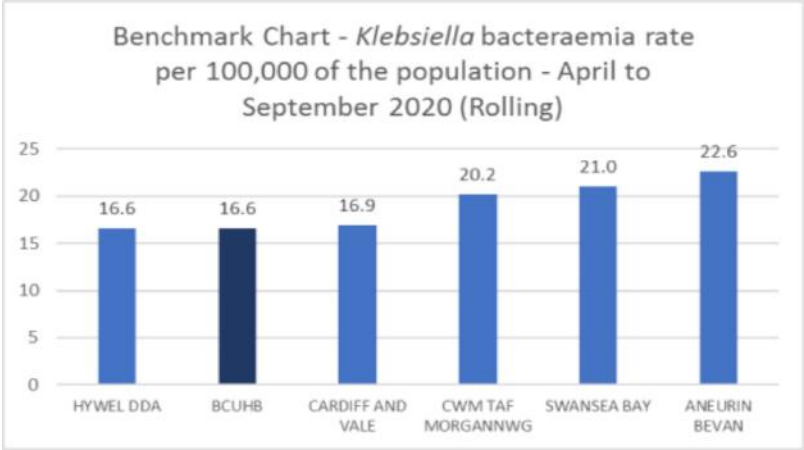


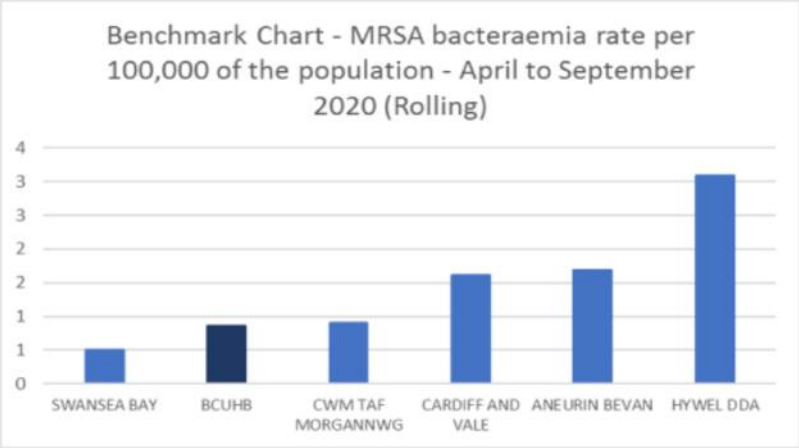


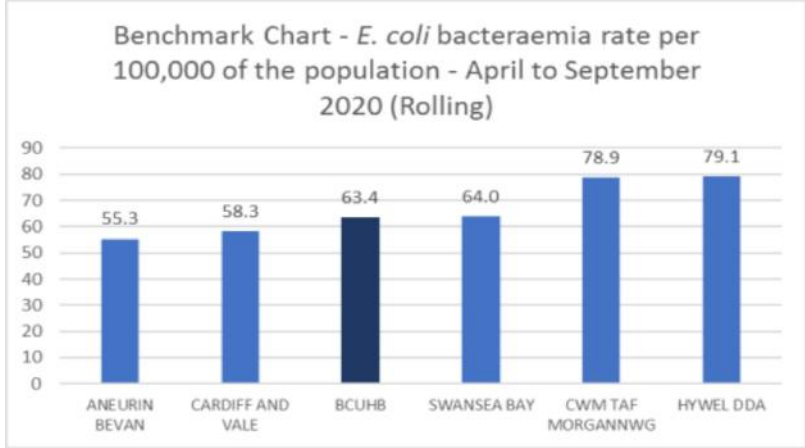
Comparison Charts to other HBs

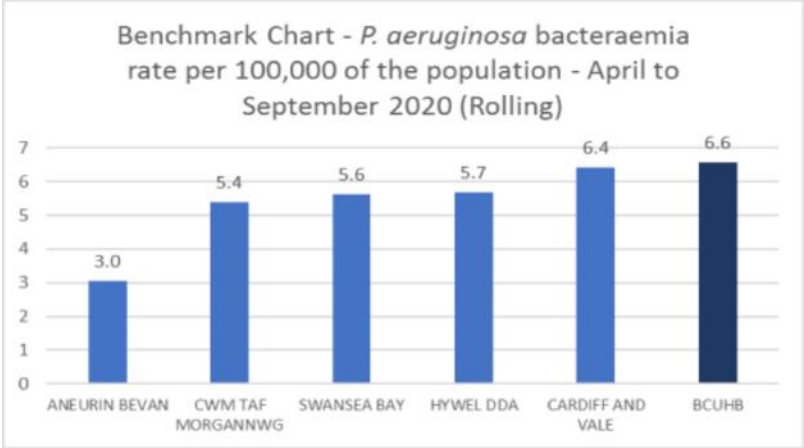












Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 3rd November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Hospital Acquired Infection – COVID-19 Review
Cyfarwyddwr Cyfrifol: Responsible Director:	Prof Arpan Guha, Acting Executive Medical Director
Awdur yr Adroddiad Report Author:	Lynne Grundy, Associate Director of Research & Innovation Melanie Maxwell, Senior Associate Medical Director/ Improvement Cymru Clinical Lead
Craffu blaenorol: Prior Scrutiny:	Covid Delivery Group
Atodiadau Appendices:	Appendix 1 HAI Covid-19 Review Terms of Reference Appendix 2 PHW Screenshots Appendix 3 Supporting Documents

Argymhelliad / Recommendation:

The Committee is asked to receive the paper.

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:

This Healthcare Acquired Infection (HAI) review was requested by the Board to understand how hospital acquired COVID-19 infections have arisen across hospital sites and been managed.
The objectives of the review are to identify the factors that contributed to healthcare acquired COVID-19 infections with a view to inform appropriate mitigating actions and lessons learnt. Specifically:

1. Why there was a delay in recognising the volume of HAIs within the Health Board.
2. What actions were in place to mitigate HAIs for both patients and staff
3. Whether those actions were implemented effectively
4. Whether there is any evidence of patient harm as a result of HAIs
5. What lessons learnt were identified from post infection reviews and previous outbreak investigations; whether these were communicated and implemented
6. Recommendations arising from findings of this review that will inform future practice to safeguard patients, public and staff.

There have been many contributors to this review, all of whom were generous and helpful with their time, experience and knowledge. What has been clear throughout this exercise is the commitment and desire to give the very best they can by all involved.

Cefndir / Background:

COVID-19 has presented a global challenge, and health care across the world has had to learn and adapt very quickly to this previously unknown SARS-CoV-2 virus. Research has been ongoing and evidence and knowledge has developed rapidly, leading to frequent changes of guidance.

Determining Healthcare Acquired Infections

Outbreak criteria: Two or more test-confirmed or clinically suspected cases of COVID-19 among individuals (for example patients, health care workers, other hospital staff and regular visitors, for example volunteers and chaplains) associated with a specific setting (for example bay, ward or shared space), where at least one case (if a patient) has been identified as having the onset of illness after 8 days of admission to hospital.[i]

A standard definition for 'healthcare onset' COVID-19, has been agreed across the 4-Nations, which has enabled rates of nosocomial transmission to be identified and tracked weekly.[ii]

- *Community-onset –First positive specimen up to 2 days after admission to a healthcare setting.*
- *Hospital-onset, indeterminate hospital-associated COVID infection: COVID-19 positive sample taken between 2 days and 7 days after admission;*
- *Hospital-onset, probable hospital-associated COVID infection: COVID-19 positive sample taken 8 days and 14 days after admission;*
- *Hospital-onset, definite hospital-acquired COVID infection: COVID-19 positive sample taken 15 days or more after admission.*

This standard definition was communicated on 12th June 2020 via email from the Infection, Prevention and Control (IPC) team to the four Operational Control Centres (OCC) in place at that time. The definition was also contained within the Principles Framework, June 2020[iii].

The definition has been retrospectively applied by Public Health Wales (PHW) to analyse hospital and community onset cases in hospital settings since the start of the pandemic. This is included within the electronic dashboard and first published by PHW at the beginning of July.[iv] Fig 1 is a screenshot from the PHW dashboard showing numbers of probable and definite HAIs identified over time for BCU, Fig 2 shows the weekly percentage of probable and definite hospital onset confirmed cases by HB and Fig 3 breaks those down to acute hospitals in BCUHB to 16 August 2020. (See Appendix 2 for further graphs demonstrating the incidence of HAIs across BCU.)

NB: Caution should be used as testing protocols have changed frequently over the pandemic period in terms of indications for testing, which will inevitably have impacted on the data and subsequent analysis at that time.

Fig 1:

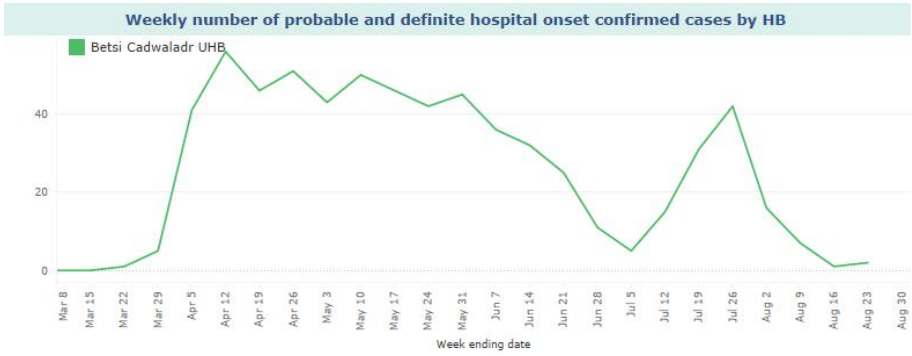


Fig 2:

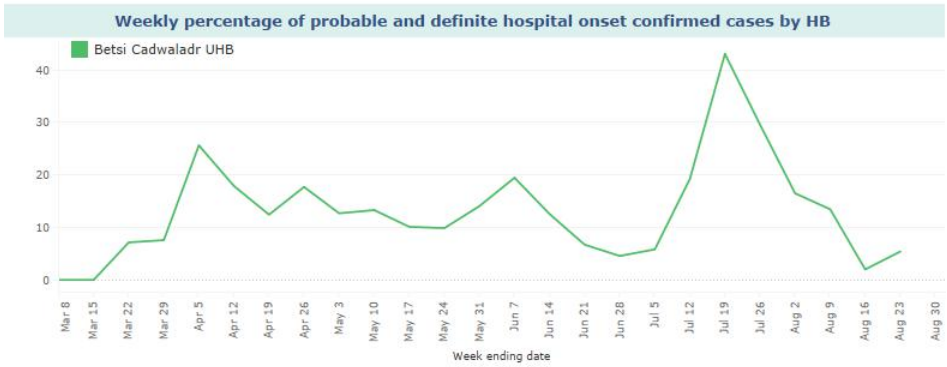
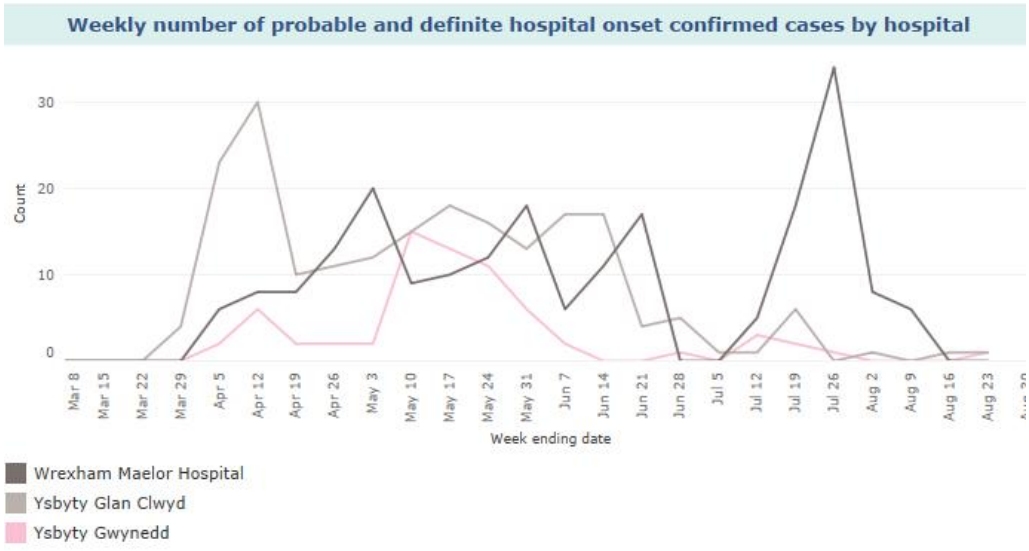


Fig 3:



We are aware that during the pandemic a number of HAI outbreaks have occurred across our acute and community hospital sites.

The first recorded HAI was in the week ending 29th March 2020, when 4 patients (2 probable; 2 definite) were identified in Ysbyty Glan Clwyd (YGC) and 1 probable in Ysbyty Gwynedd (YG). Between the week ending 29th March 2020 and 30th August 2020 there have been 587 HAIs (352 definite;236 probable) identified for admissions within the Health Board; 103 in community inpatient beds and 484 in acute sites.[v]

Fig 3 indicates dates of clusters in HAIs for each acute site. Table 1 shows total HAIs per acute site and community between the week ending 29th March 2020 and 30th August 2020.

Table 1: Total HAIs per acute site and community between the week ending 29th March 2020 and 30th August 2020.

Site	Definite	Probable	Total
WMH	128	81	209
YGC	102	101	203
YG	40	32	72
Other BCU sites	81	22	103
Total	351	236	587

Some of the outbreaks were identified at the time with a rapid review Make it Safe report being completed for the outbreak. Most of these clusters were prior to the agreed definition to identify Covid19 HAIs.

The Quality Assurance Corporate Team has identified a number of rapid review Make it Safe Reports identified below:

Ysbyty Glan Clwyd

- Renal Dialysis Unit 18/4/2020 review date 21/4/2020 16 patients, 9 staff, 3 spouses affected
- Ward 14 21/5/2020, review 17/6/20, reports 14 staff and possibly up to 53 patients affected

Community and Mental Health

- Mold District Nurses 15/4/2020, review 15/5/2020, 6 staff affected
- Ablett Unit 17/4/2020, review 2/7/2020, 8 staff affected
- Eryri Hospital 28/4/2020, review 30/04/2020, 14 staff affected
- Alltwen 28/4/2020 review 30/04/2020, 7 staff affected
- Bryn Beryl Hospital 28/4/2020, review 1/5/2020, 2 patients, 20 staff affected

Wrexham Maelor Hospital

- Commenced 22/07/20 Morris ward, Evington ward, SAU/Glyndwr ward, Onnen ward, Branwen ward
- Deeside 22/7/2020 – not yet completed and submitted

NB: These outbreaks need to be 15 days without a new case before closure (WHO guidelines)

Fig 4 shows the rapid reviews undertaken in relation to identified HAIs

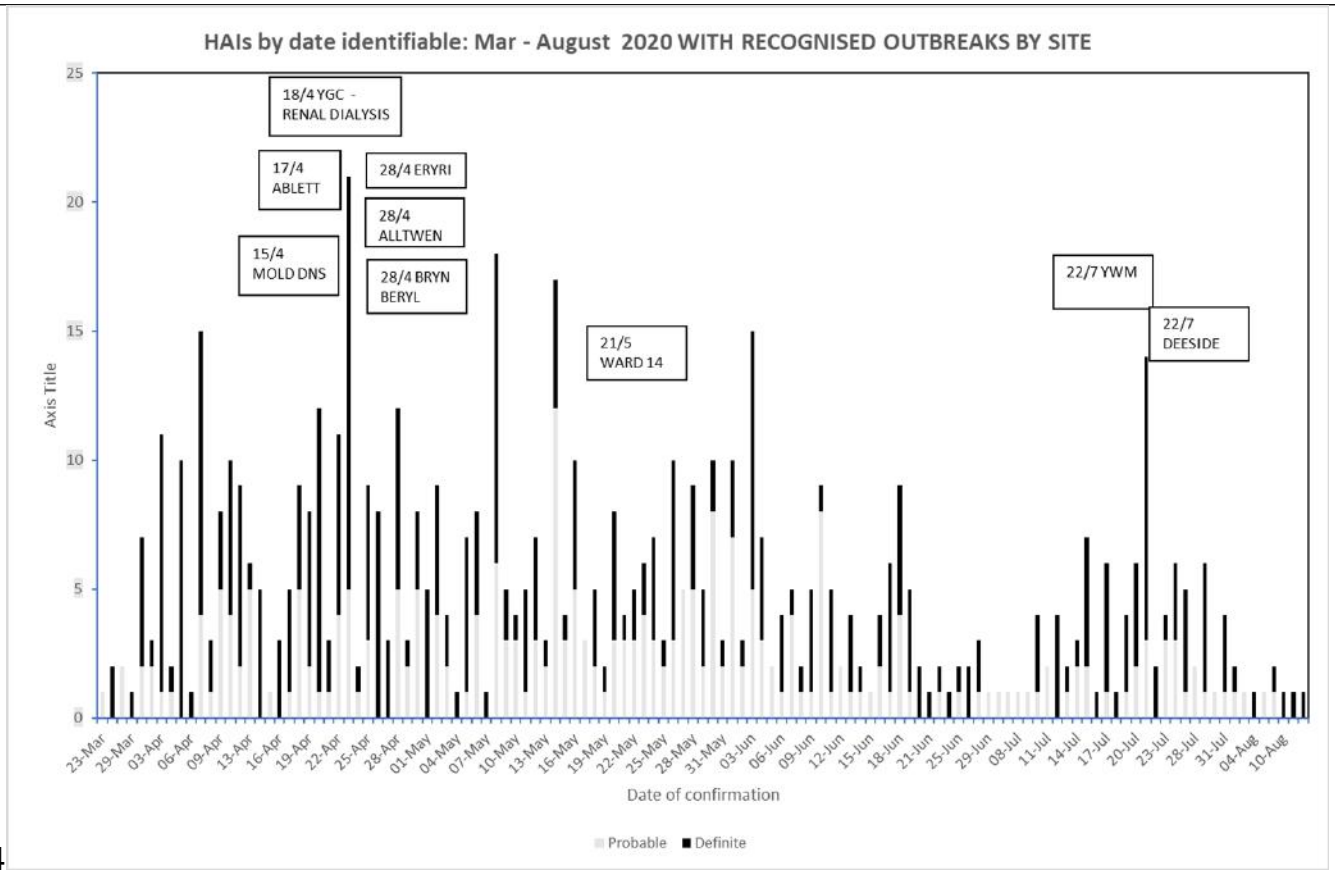


Fig 4

Asesiad / Assessment & Analysis

In order to address the terms of reference (see Appendix 1) the following actions were undertaken:

- Virtual interviews with 21 senior members of the hospital management teams (HMTs), Infection Prevention and Control Teams (IPC), clinicians and relevant corporate teams, lasting between 40 – 90 minutes
- Meetings with ward and site teams, to which 12 staff contributed
- Examination of available policies, procedures
- Examination of supporting documentation made available by interviewees (appendix iii)
- Examination of available data sources – ICNET, BCU COVID Dashboard, PHW COVID Dashboard, BCU internal tableau

The focus of interviews was based on the objectives of the review. Notes were taken and validated with interviewees and then responses themed using the SHELL framework.[vi] Findings are set out in Fig 5.

Fig 5: Interview Themes

Software – procedures, policies, rules	**Hardware – equipment, technology**
• No Standard Operating Processes(SOPs) for COVID wards • Poor cohorting, absence of associated policies • Health & Safety/risk assessments not visible • Lack of policies agreed with clinicians, policies out of date, not fit for purpose • Frequent changed to Personal Protective Equipment (PPE) requirements • Planning data not available to local teams • Not enough information on staff testing • Poor compliance with incident reporting process for staff testing positive • Bed spacing guidance changed • Testing protocols changed frequently – difficult to keep pace with changes	• Data systems – lots of data held in different places, does not drive generation of information • IT infrastructure not good for communication • No flag/early warning system in place • PPE equipment not always used correctly • Patient Administration Systems reliant on timely input of patient movement and discharge – not always updated.

Environment – physical, organisational, political, economic	**Liveware – individual and others, leadership, communications, knowledge, attitudes, culture, norms, teamwork**
• Not enough cubicles to enable isolation of possible cases in WMH • Frequent patient and staff movements, particularly out of hours and at weekends (WMH) • Social distancing not possible in some environments but often no masks worn • Social distancing not adhered to • Difficulty discharging medically fit patients, unable to follow COVID guidelines for discharge • Lots of clutter in corridors, poor signage – increasing pubic footfall	• Hospital Management Team (HMT) meetings paused in WMH • Key personnel left • Patient flow over-rode safety • Clinician concerns not escalated • Incident reports not completed in timely way • Staff movements, sometimes mid shift, between wards • Incorrect information in media • At onset of pandemic local management team very responsive and empowered, this reduced over time • Protocols changing frequently, difficult to keep up with changes • PPE messages inconsistent • No increase in IPC resource • Limited learning from previous/ other COVID outbreaks • Planned care pressures to manage backlogs • Complacency in non COVID areas and as restrictions started to lift • Slow response to outbreaks • Media attention perceived to drive change rather than staff safety • Perceived gap between HMT and Board

In summary key factors believed to have contributed to HAIs are:

- Significant patient movement between wards and bays (WMH) with no BCUHB Infection Prevention and Control (IPC) policies and protocols in place particular in relation to cohorting and patient and staff movements. Local practice in YG and YGC was for no non-clinical patient movement. It is reported that this was not possible in Wrexham Maelor Hospital (WMH) due to increasing activity and front door pressures, and lack of isolation cubicles.

- Significant volume of guidance that changed frequently. It was challenging to ensure effective communication and hard to keep up with the changes
- Too much data in lots of different places, not enough analysis/information, with a number of people interviewed stating we were data rich and information poor
- Capacity and flow pressures when essential services started to resume in WMH, reacting to increasing numbers rather than proactively managing the risk
- Sense of possible complacency, for example not social distancing in non patient areas, when restrictions started to ease. Inconsistent behaviours when staff to patient and staff to staff, e.g. following IPC guidelines when caring for patients and then close staff to staff contact in non-patient facing settings.

Assessment

1 Why there was a delay in recognising the volume of HAIs within the Health Board?

It was reported during interviews that managers and staff were aware of the potential risk of HAIs early in the pandemic. However, the focus of data reporting was on numbers of patients testing positive with no data available to identify hospital and community onset. Daily sit rep reporting remains focussed on numbers of inpatients testing positive and do not report HAIs. At the end of June PHW made available the first comparison of hospital and community onset HAIs before publication in early July.

COVID-19 data are available from multiple sources, which may also have subtle differences in the parameters they use to generate reports. Many people spoken to think that data are not translated into information/intelligence, and are not used to project forward, rather are used to look back.

There are no COVID-19 trigger systems currently within the data systems used, for example to flag changes in numbers, possible outbreaks. Patient data quality and accuracy is reliant on timely input into the system, which does not always happen. This can potentially lead to mistrust of data.

ICNET is the IPC team's data source. Date of admission and discharge and previous hospital stays sits in ICNET, and the IPC team look at this to determine if any infection is healthcare associated. Following the PHW report, the team report that they now identify which COVID-19 positive tests are HAIs. They report that there is no specific SOP for ICNET use; the results that come through are those agreed by the Infection Prevention Teams across Wales. How each site in BCU uses ICNET may vary but each IPC team member can access ICNET as routine practice. None of the site HMT teams can access ICNET and their local IPC teams report information to them. There are currently no outbreak triggers built into ICNET for COVID-19.

There is evidence that actions were put in place to address concerns locally at WMH from 6th July when daily meetings commenced. A site wide incident report (Datix) was completed on 27 July, as of 26 August 2020 a rapid review had not been submitted.

In summary, a standard definition for healthcare onset Covid-19 was not in place at the start of the pandemic. Monitoring HAIs was not a defined role within the IPC team but part of all roles, and surveillance systems were not in place to identify HAIs until there was a cluster. The reporting systems were not sighted on HAIs and so they were not the focus of attention.

2 What actions were in place to mitigate HAIs for both patients and staff?

Many of the general actions taken to reduce the transmission of COVID-19 also mitigate the risk of HAIs for both patients and staff. These include:

- Promotion of positive behaviours such as hand washing, social distancing, wearing appropriate PPE, not car sharing. It was noted by one staff member that the enforcement of these behaviours was stricter in supermarkets than on hospital sites at the start of the pandemic. Communications were sent to staff about the importance of PPE, however it was reported that guidance was changing at pace and it was hard to keep up with the changes and ensure the right message was communicated at the right time. There was a perception that staff may have been confused with the changes, and due to high anxiety particularly at the start of the pandemic, may have chosen to use greater PPE than was in guidance at that time. For example, there is evidence of concerns initially with regard to guidance specifying no requirements to wear masks when clinically staff thought they should be worn.
- Reducing footfall in hospital sites was implemented early in the pandemic, with, for example, visitor restrictions, staff working from home if not required on site, introducing one way systems.
- Daily Briefings and FAQs promoting the latest advice and guidance
- Public Health Wales colleagues collating and rapidly disseminating changes, for example PPE requirements.
- Local plans in place identifying red and green areas on sites, with pathways from the front door. All sites had a plan to direct patients along an appropriate COVID-19/non COVID-19 pathway from the front door of the hospital, by identifying red and green routes and areas, and as positive COVID-19 patient numbers increased additional areas were identified.
- Testing and self-isolating policies. Whilst self-isolating policies were in place from the start; testing policies have been driven by access to tests and have changed repeatedly for both staff and patients. Universal screening of admissions has now been implemented, from 24th July in WMH and possibly earlier at other sites. Many reported they thought this should have been implemented earlier.
- Training in IPC measures are provided to staff, including the correct use of PPE (including a face fit test if wearing a filtering face piece (FFP3), respirator, and the correct technique for putting on and removing (donning/doffing) safely, with additional training in high risk areas.
- Increased bed spacing has only recently been introduced; again, the guidance is changing and the loss of beds within the sites and community has added to the burden on admitting services.
- Decluttering to reduce touch points.
- Strongly advising wearing of masks on HB premises in public areas within the sites has recently been introduced; this is not always enforced. Some staff spoken to thought there was a delay in mask wearing and suggested we should be mandating the wearing of masks rather than strongly advising.

- Reducing movement of staff and patients (cohorting policy/ nurse staffing policy). In WMH it is reported that bed/patient movement has been normal practice for some time in an attempt to manage the front door pressures and patient flow. Whilst this was acknowledged as something that needed to be avoided during the pandemic, as non COVID pressures increased it is reported that more and more patient moves were undertaken, often out of hours, to cope with bed pressures when essential services started to recommence. Clinicians report raising concerns with the HMT about the movement of patients in May. However, they believe the pressure of maintaining flow through the hospital was prioritised over the risks associated with possible hospital transmission. There was also some concern about the cohorting guidance being advocated which led to tensions between the IPC team and clinical staff. For example, the IPC team report they were advising the cohorting of exposed patients with similar dates of exposure. The clinical teams were reporting incidents of patients who had tested positive to COVID-19 being placed next to patients who had tested negative.
- Dashboard providing COVID-19 related data to monitor COVID positive patients and staff, along with staff testing. However, this did not specifically monitor HAIs
- Monitoring of IPC practices and ensuring the resources are available to implement good practice.
- Standard reporting procedures, for example using incident reporting (Datix) to report staff testing positive and other COVID related incidents.

Many of these actions were implemented at the beginning of the pandemic, with others introduced at different stages. Whilst the information is available from different sources there does not seem to be a single point definitive timeline during the pandemic, so this would require further work to interrogate information sources if required.

Rapid review Make it Safe reports were written for earlier clusters in YGC, community and mental health sites. Although at this time HAI data were not available, there was a recognition of environmental, PPE and ICT factors contributing to transmission. During these clusters, it is reported that non-clinical patient movement was stopped, and wards were closed to admissions until the outbreak had been managed. It was reported that this was able to be done due to the availability of beds and isolation cubicles and the reduced non-COVID demand at that time. Make it Safe Reports were required to be submitted to the corporate team, and site teams report that they shared lessons with each other at secondary care meetings. There does not appear to be a systematic organisational approach to sharing lessons learnt.

It has also been suggested during discussion that as restrictions started to lift, staff may have become complacent, thinking the pandemic was over. Examples of staff maintaining IPC precautions on the ward, but not outside the ward areas was given, along with socialising at break times and car sharing. There was also a view that possibly staff working in non COVID areas may have become complacent.

3 Whether those actions were implemented effectively

Communications were sent out regularly in Daily Briefings and via HECC and OCCs. However, staff reported lots of messaging which was reliant on electronic communications with frequently changing guidance contributing to confusion. There was also a perceived delay in decision-making at times reported, due to the process. COVID-19 pages on the intranet were also introduced to keep information in one place. The cascade of information was cited as daily local briefings and safety huddles. Some staff reported these to be effective ways of receiving information, whilst others did not.

A key factor cited by many of the people spoken to was lack of isolation cubicles in WMH (29) and of those cubicles many not having suitable en-suite toilet and handwashing facilities. This is compared to 120+ side rooms in YGC and 30-40 side rooms in YG. Staff also reported the availability of additional ward space was a factor that helped these sites to deal with their outbreaks. This made mitigation a particular challenge in WMH.

A further key factor regarding patient movement for non-clinical reasons was also cited by WMH staff spoken to. This was reported to cease when a recent executive directive was made. A BCUHB Patient Transfer Procedure (July 2018, for review 2019) has now been adopted and implemented in WMH.

Ensuring appropriate staff behaviours such as social distancing, wearing appropriate PPE and handwashing was also key and teams at all sites report walk about and spot audits, with reconfirmation of guidance to staff in an attempt to ensure adherence, however the impact and effectiveness of these interventions is not clear.

Timely reporting of incidents does not seem to have been carried out in all cases. There are reports of delays in reporting staff positive COVID-19 tests, and delays in reporting incidents and completing and submitting rapid reviews.

Universal screening of inpatient admissions has now been implemented and all supported this action and believe it is an effective intervention. All sites report a level of management at the front door now to remind people, both staff and visitors, entering the sites about appropriate behaviour such as hand sanitising, wearing masks and social distancing. Some thought this this was a little slow in coming, and that we should be investing more in this front door presence. Currently it is reliant on volunteers and bank staff.

4 Whether there is any evidence of patient harm as a result of HAIs

Any nosocomial infection can be classed as harm (even if it leads to negligible actual harm, it is still in itself a potentially avoidable adverse outcome for the patient that has affected their health).
The absolute number of patients who have died from COVID-19 where the infection was healthcare acquired is unknown. In some cases, COVID-19 will have been a contributory factor. An audit is underway in Wrexham to quantify this for the current outbreak and 37 records are being reviewed.
PHW does not publish HAI deaths data. Using the PHW definitions on our own internal dataset noting there are two assumptions:

- Patients discharged from one site and admitted into another within 12 hours are transfers within the same spell
- Patients have the same local patient identification number on transfer between sites

190 deaths were identified during this time period (and 619 HAIs as internally more transfers are identified). Office of National Statistics (ONS) death certification data was available for 179 deaths. Of these 121 (58 probable/63 definite) have a diagnosis of COVID-19 or suspected COVID-19 included on their death certificates (Note ONS data is approximately 2 weeks delayed due to the time taken to register a death) – 67.5%. There are 21 patients where the death certificate information was not yet available, of these 8 patients (2 probable/6 definite) had an enhanced COVID-19 surveillance form completed indicating they were a direct COVID-19 death. Therefore, 129 deaths from this cohort have been identified as COVID-19 related to date.
A number of complaints and concerns (16) which are COVID-19 related have been received relating to WMH, between 21 July 2020 and 20 August 2020. The on the spot, formal and Member of Senedd/Member of Parliament concerns include being placed in a COVID-19 area when tested negative, concerns about poor PPE practice, and concerns about possibly contracting COVID-19 whilst in hospital.

Eighteen datix reports have been identified specifically relating to the WMH outbreak, dating from 15 July to 23 August. These record COVID-19 and outbreak specific incidents.
For the bereaved there is the Coroners inquests to come that will cause some psychological trauma - unquantifiable.

5 What lessons learnt were identified from post infection reviews and previous outbreak investigations, whether these were communicated and implemented

Staff spoken to were able to describe how their Make it Safe reports were disseminated locally. There is evidence that incident reporting, reviews and investigations of outbreaks was not a timely as it could have been, and there remains outstanding reports and actions.

Communication through safety huddles was cited as the main way of disseminating learning as people realised that reliance of electronic communications was not effective or timely. People were able to describe dissemination predominantly through their local teams. No systematic organisational process was found during this review for identifying and sharing lessons learned.

Post Infection Reviews (PIRs) were implemented in WMH from 15 July. PIR slides were subsequently presented at Outbreak meetings in WMH, generally giving a context to the transmission. At the time of doing this review, it is reported that an analysis of all PIRs with lessons learnt is being produced.

Since the PHW report, YG and YGC now do a post infection report (PIR) for Healthcare associated COVID 19. The PIR tool is completed with the clinical team, and a monthly meeting is held during which PIRs are scrutinised and discussed. The scrutiny meeting is chaired by the Medical Director

with the antimicrobial pharmacist, head of nursing as well as IPC Team present with the clinical team.

A number of people cited lack of adequate IPC team resource, with the teams being under resourced to cover all sites, as well as train and manage other aspects of the outbreak, and monitoring ICNET. It was reported that there are vacancies in the team at WMH and YGC.

Some thought that more importance and focus should have been put into training such as donning and doffing. Some staff in WMH reported no training, and it was reported that a clinician began to offer training to staff, however it fell outside the guidance at that time which caused some tensions locally. Other sites also reported that not all staff were trained.

6 Recommendations arising from findings of the review to inform future practice to safeguard patients, public and staff, using SHELL format

SOFTWARE – procedures, policies, rules		
Recommendation	**Responsibility**	**Enabler**
1. Full understanding of Health Board expectations around the prevention and management of HAIs with clear in date policies that are refreshed and amended in a timely way to reflect situation.	Executive team Infection Prevention & Control Team	
2. Clear co-produced protocols in place to support safe patient and staff movements across the sites. Protocols have rationale that is understood by all and developed with clinical input. These are robustly implemented, with clear escalation routes and are monitored closely.	Executive team Infection Prevention & Control Team	Relevant Quality & Safety Group(s)
3. Staff need to follow the complaints and incident process to ensure with timely reporting and rapid reviews to inform any immediate actions and learning.	Wards Divisions HMTs and area teams	Corporate Patient Safety & Experience Department
HARDWARE – equipment and technology		
Recommendation	**Responsibility**	**Enabler**
4. To set up a dedicated data intelligence unit to provide formalised analytical support to any future event: o Providing a single source of all data related to that event	Gold Command	Informatics Workforce and Organisational Development (WOD Finance Public Health Wales

○ Ensuring data is captured, analysed and shared with all relevant parties in a meaningful way ○ Providing information to monitor outcomes such as HAIs ○ Responsive to the needs of the health community- locally/pan Wales ○ Clarity about the responsibility and ownership of data		Infection Prevention & Control Team Information Governance
5. Take action to improve data quality either providing a digital solution or administrative resource. In this case, accurate timely (within 1 hour) input of patient admission and discharge data to support identification of HAIs.	Wards Divisions HMTs and area teams	Informatics
ENVIRONMENT – physical, organisational, political, economic		
6. Consider the estates infrastructure particularly in WMH to increase capacity to isolate; explore innovative solutions to the current ward lay out.	HMT/Estates	Estates, Infection Prevention & Control Team
7. Ensure key teams are adequately resourced (IPCT)	Corporate Nursing	WOD Finance
LIVEWARE – individual and others, leadership, communications, attitude, culture, norms		
8. Implement a systematic organisational approach and process to identifying and sharing learning	Clinical Executive Directors	Workforce and Organisational Development (WOD)

		Office of the Medical Director (OMD) Corporate Nursing
9. Develop a cultural norm that encourages questioning and challenge from ward to Board. Identifying improvements and rapid sharing across organisation should be the norm	Executive team Infection Prevention & Control Team	Workforce and Organisational Development (WOD) Office of the Medical Director (OMD) Corporate Nursing
10. Training Plan in place for all staff groups and areas to ensure appropriate training is accessed by all	Clinical Executive Directors	Workforce and Organisational Development (WOD)
11. System to enable theming of rapid reviews at corporate level to quickly identify and communicate emerging themes, share learning	Corporate Patient Safety & Experience Department	Relevant Quality & Safety Group(s) Corporate Communications
12. Ensure escalation routes and triggers are clear to all, with full engagement and compliance with reporting requirements and escalation of concerns in a timely way	Wards Divisions HMTs and area teams	Relevant Quality & Safety Group(s) Corporate Communications
13. Clear document management system and version control to enable investigation of any major incident/pandemic, with live timelines maintained to show changes	Infection Prevention & Control Team	Information Governance
14. Simple concise ways of messaging that can assure that information is reaching the right people at the right time. This is particularly important when changes are	Corporate Communications	

fast moving. One example suggested was screened messages throughout sites that were clear, impactful and understood by all		
15. Single information pool able to be accessed rapidly when needed.	Corporate Communications	
16. In depth clinically led investigation takes place for the WMH outbreak which has specific site related issues related to communication.	Wrexham HMT	Clinicians

[i] https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/epidemiological-definitions-of-outbreaks-and-clusters-in-particular-settings

[ii] NHSEI CNO Letter (Ref No 001559) 19 May 2020 Interim data collection – hospital-onset COVID-19.

[iii] A Principles Framework to assist the NHS in Wales to return urgent and planned services in hospital settings during COVID-19. Welsh Government. 02nd June 2020

[iv] https://rytu6srvtabl001.cymru.nhs.uk/views/COVID-19hospitaladmissionindicators/Onsetdashboard-HB?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no

[v] PHW Rapid COVID -19 Surveillance https://rytu6srvtabl001.cymru.nhs.uk/views/COVID-19hospitaladmissionindicators/Onsetdashboard-HB?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no

[vi] http://aviationknowledge.wikidot.com/aviation:shell-model

Appendix 1:

Betsi Cadwaladr University Health Board

HAI REVIEW: Covid 19

TERMS OF REFERENCE

1. Constitution

1.1 The HAI review was requested by the Board to understand how hospital acquired COVID-19 infections have arisen across hospital sites and what action is required to mitigate this.

2. Investigation Team

2.1 The membership of the HAI Review shall comprise:

TITLE
Lead investigators: Melanie Maxwell - Senior Associate Medical Director/ Imp Cymru. Clinical Lead Lynne Grundy- Associate Director of R&I. (Arpan Guha - Deputy Executive Medical Director)
investigators: Melissa Baker/ Steve Goodman /Nurse support

3. Time frame

3.1 Data collection to be completed by 15th August

3.2 Report draft to be completed by 24th August.

3.3 Factual accuracy check by 28th August

3.4 Report complete by 4th September

4 Objectives of Review

The objectives of the review are to identify the factors that contributed to healthcare acquired COVID infections with a view to inform appropriate mitigating actions and lessons learnt. Specifically, it will identify:

4.1 Why there was a delay in recognising the volume of HAIs within the Health Board.
4.2 What actions were in place to mitigate HAIs for both patients and staff
4.3 Whether those actions were implemented effectively
4.4 Whether there is any evidence of patient harm as a result of HAIs
4.5 What lessons learnt were identified from post infection reviews and previous outbreak investigations, whether these were communicated and implemented
4.6 Recommendations arising from findings of the review to inform future practice to safeguard patients, public and staff.

5. Remit

The HAI Review will establish:

5.1 how HAIs among patients and staff in both acute and community setting are believed to have occurred and over what timeline

5.2 the process for monitoring and reporting Covid19 HAIs from the start of the pandemic, including the timeliness and transparency of any information and the extent of its sharing

5.3 actions taken to prevent HAIs from start of pandemic including the monitoring and effectiveness of those processes and the extent to which those actions were coordinated and owned

5.4 whether the actions taken were sufficient and if not why (including any clarity of role, capability and capacity considerations

5.5 the extent to which and the process used for post infection reviews including consideration of whether it was healthcare acquired and how the results were reported and to whom

5.6 the process of the post infection reviews as a learning tool and implementation of actions arising

5.7 the information/data available to the HB and the process for analysing and reporting on that data to inform potential outbreaks or clusters

6. Accountability, Responsibility and Authority

6.1 The lead reviewer/investigator is accountable to the Executive Team and will ensure appropriate escalation arrangements are in place to alert the Director of Nursing of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.

6.2 The lead reviewer will keep the Chair of QSE Committee informed of progress and emerging recommendations.

6.3 the final (and any interim) report and recommendations will be presented to the QSE Committee and the Board

7. Reporting

The lead investigator shall:

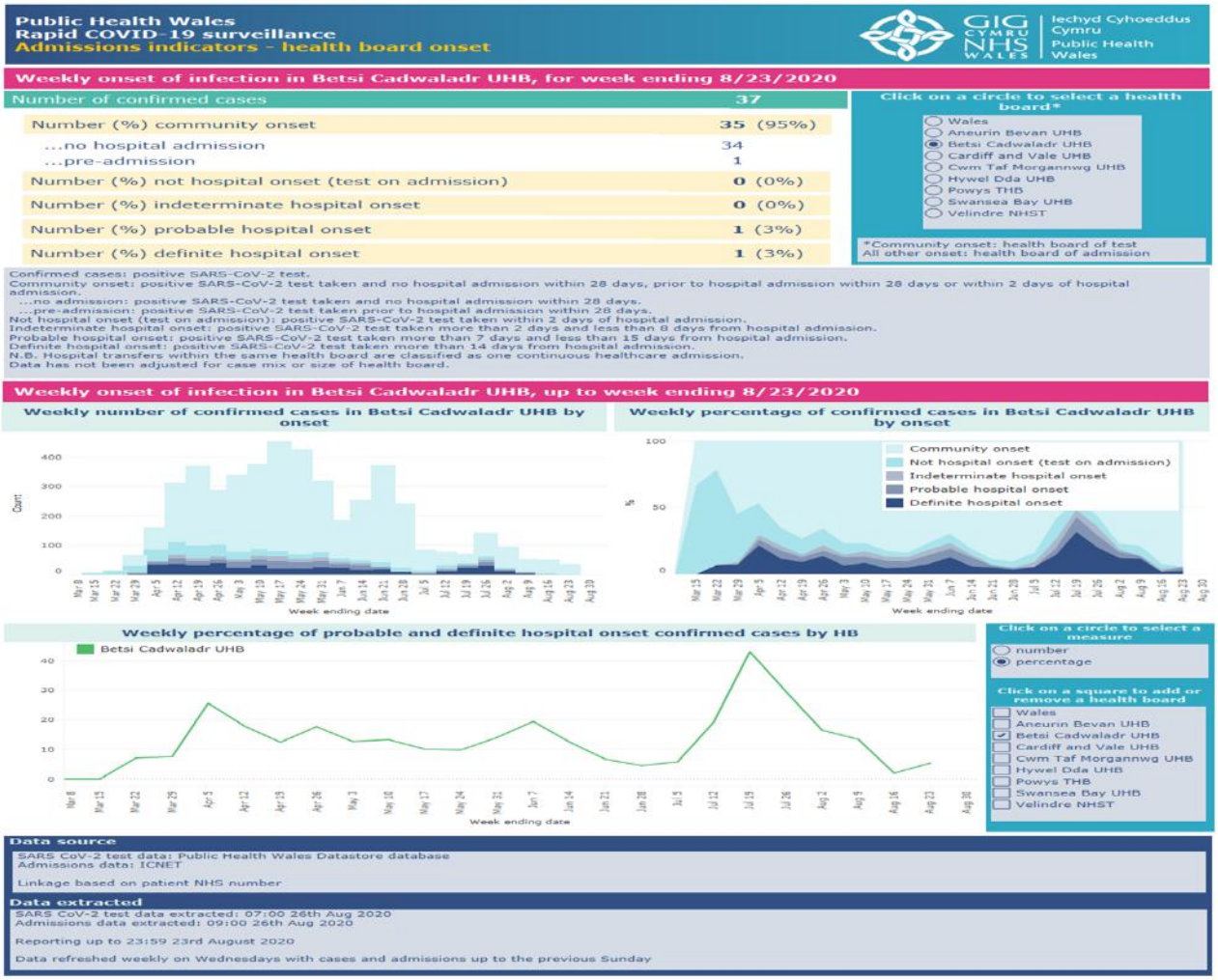
7.1 Provide a progress report by 14th August to Director of Nursing/ Chair of QSE Committee. Deliver a final review document with recommendations by 4th September

7 2 Ensure appropriate escalation arrangements are in place to alert the Director of Nursing of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.

Dr Melanie Maxwell

29/07/2020

Appendix 2


Public Health Wales
Rapid COVID-19 surveillance
Admissions indicators - health board onset
GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales
Weekly onset of infection in Betsi Cadwaladr UHB, for week ending 8/23/2020
Number of confirmed cases 37
Number (%) community onset 35 (95%)
...no hospital admission 34
...pre-admission 1
Number (%) not hospital onset (test on admission) 0 (0%)
Number (%) indeterminate hospital onset 0 (0%)
Number (%) probable hospital onset 1 (3%)
Number (%) definite hospital onset 1 (3%)
Click on a circle to select a health board*
Wales
Aneurin Bevan UHB
Betsi Cadwaladr UHB
Cardiff and Vale UHB
Cwm Taf Morgannwg UHB
Hywel Dda UHB
Powys THB
Swansea Bay UHB
Velindre NHST
*Community onset: health board of test
All other onset: health board of admission
Confirmed cases: positive SARS-CoV-2 test.
Community onset: positive SARS-CoV-2 test taken and no hospital admission within 28 days, prior to hospital admission within 28 days or within 2 days of hospital admission.
...no admission: positive SARS-CoV-2 test taken and no hospital admission within 28 days.
...pre-admission: positive SARS-CoV-2 test taken prior to hospital admission within 28 days.
Not hospital onset (test on admission): positive SARS-CoV-2 test taken within 2 days of hospital admission.
Indeterminate hospital onset: positive SARS-CoV-2 test taken more than 2 days and less than 8 days from hospital admission.
Probable hospital onset: positive SARS-CoV-2 test taken more than 7 days and less than 15 days from hospital admission.
Definite hospital onset: positive SARS-CoV-2 test taken more than 14 days from hospital admission.
N.B. Hospital transfers within the same health board are classified as one continuous healthcare admission.
Data has not been adjusted for case mix or size of health board.
Weekly onset of infection in Betsi Cadwaladr UHB, up to week ending 8/23/2020
Weekly number of confirmed cases in Betsi Cadwaladr UHB by onset
Count
Week ending date
Weekly percentage of confirmed cases in Betsi Cadwaladr UHB by onset
%
Community onset
Not hospital onset (test on admission)
Indeterminate hospital onset
Probable hospital onset
Definite hospital onset
Week ending date
Weekly percentage of probable and definite hospital onset confirmed cases by HB
Betsi Cadwaladr UHB
Week ending date
Click on a circle to select a measure
number
percentage
Click on a square to add or remove a health board
Wales
Aneurin Bevan UHB
Betsi Cadwaladr UHB
Cardiff and Vale UHB
Cwm Taf Morgannwg UHB
Hywel Dda UHB
Powys THB
Swansea Bay UHB
Velindre NHST
Data source
SARS CoV-2 test data: Public Health Wales Datastore database
Admissions data: ICNET
Linkage based on patient NHS number
Data extracted
SARS CoV-2 test data extracted: 07:00 26th Aug 2020
Admissions data extracted: 09:00 26th Aug 2020
Reporting up to 23:59 23rd August 2020
Data refreshed weekly on Wednesdays with cases and admissions up to the previous Sunday

Public Health Wales
Rapid COVID-19 surveillance
Admissions indicators – hospital onset

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Weekly hospital onset of infection in Ysbyty Glan Clwyd, for week ending 8/23/2020

Number of hospital onset confirmed cases	1
Number (%) indeterminate hospital onset	0 (0%)
Number (%) probable hospital onset	0 (0%)
Number (%) definite hospital onset	1 (100%)

Week ending: includes specified date and previous 6 days.
Hospital onset confirmed cases: positive SARS-CoV-2 test taken more than 2 days from hospital admission.
Indeterminate hospital onset: positive SARS-CoV-2 test taken more than 2 days and less than 8 days from hospital admission.
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Select a health board from the drop down

Select health board
Betsi Cadwaladr UHB

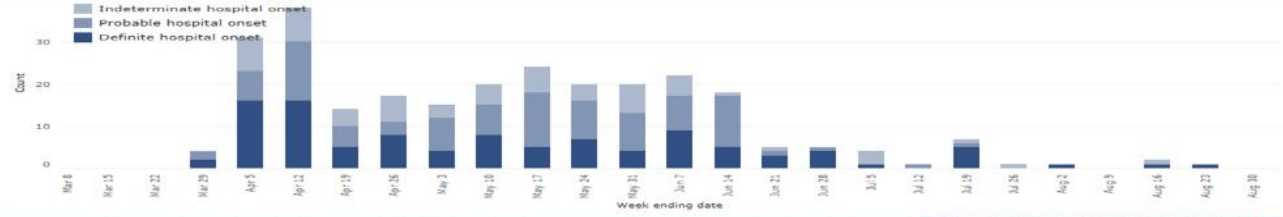
Click on a circle to select a hospital

Select hospital
- ○ Wrexham Maelor Hospital
- ◉ Ysbyty Glan Clwyd
- ○ Ysbyty Gwynedd
- ○ Betsi Cadwaladr UHB other location

*Health board of admission

Weekly hospital onset of infection in Ysbyty Glan Clwyd, up to week ending 8/23/2020

Weekly number of hospital onset confirmed cases in Ysbyty Glan Clwyd by onset



Weekly number of probable and definite hospital onset confirmed cases by hospital

Click on a square to add or remove a hospital

- ☐ Bronglais General Hospital
- ☐ Llandough Hospital
- ☐ Morriston Hospital
- ☐ Neath Port Talbot Hospital
- ☐ Nevill Hall Hospital
- ☐ Prince Charles Hospital
- ☐ Prince Philip Hospital
- ☐ Princess of Wales Hospital
- ☐ Royal Gwent Hospital
- ☐ Singleton Hospital
- ☐ The Royal Glamorgan Hospital
- ☐ University Hospital Of Wales
- ☐ Velindre Cancer Centre
- ☐ Withybush General Hospital
- ☑ Wrexham Maelor Hospital
- ☑ Ysbyty Glan Clwyd
- ☐ Ysbyty Glangwili
- ☑ Ysbyty Gwynedd
- ☐ Aneurin Bevan UHB other location
- ☐ Betsi Cadwaladr UHB other location
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- ☐ Hywel Dda UHB other location
- ☐ Powys THB other location
- ☐ Swansea Bay UHB other location

Data source

SARS CoV-2 test data: Public Health Wales Datastore database
Admissions data: ICNET

Linkage based on patient NHS number

Data extracted

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Number (%) indeterminate hospital onset	0 (0%)
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Number (%) definite hospital onset	1 (3%)

Click on a circle to select a health board*

- ○ Wales
- ○ Aneurin Bevan UHB
- ◉ Betsi Cadwaladr UHB
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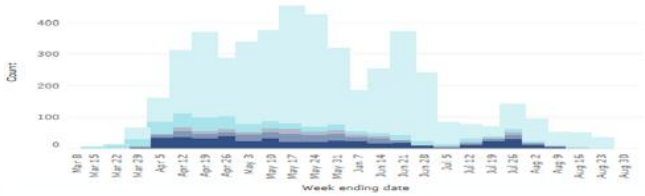
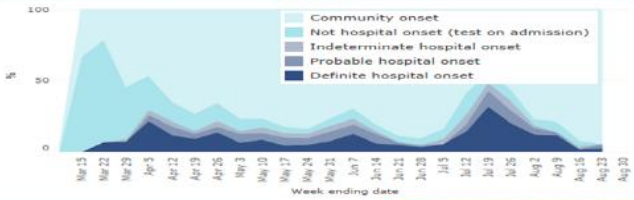
Weekly onset of infection in Betsi Cadwaladr UHB, up to week ending 8/23/2020

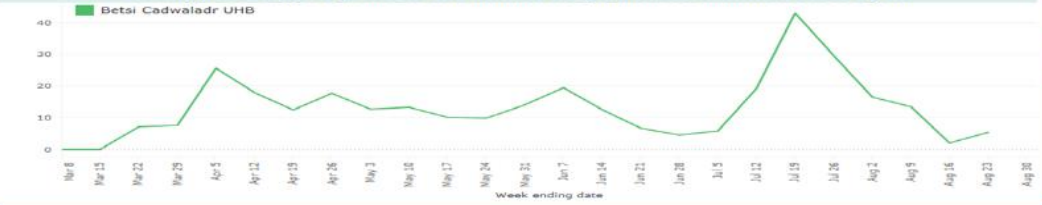
Weekly number of confirmed cases in Betsi Cadwaladr UHB by onset



Weekly percentage of confirmed cases in Betsi Cadwaladr UHB by onset



Weekly percentage of probable and definite hospital onset confirmed cases by HB



Click on a circle to select a measure

- ○ number
- ◉ percentage

Click on a square to add or remove a health board

- ☐ Wales
- ☐ Aneurin Bevan UHB
- ☑ Betsi Cadwaladr UHB
- ☐ Cardiff and Vale UHB
- ☐ Cwm Taf Morgannwg UHB
- ☐ Hywel Dda UHB
- ☐ Powys THB
- ☐ Swansea Bay UHB
- ☐ Velindre NHST

Data source

SARS CoV-2 test data: Public Health Wales Datastore database
Admissions data: ICNET

Linkage based on patient NHS number

Data extracted

SARS CoV-2 test data extracted: 07:00 26th Aug 2020
Admissions data extracted: 09:00 26th Aug 2020

Reporting up to 23:59 23rd August 2020

Data refreshed weekly on Wednesdays with cases and admissions up to the previous Sunday

Appendix 3

Supporting Documents

WREXHAM MAELOR HOSPITAL Contingency Plan in the event of COVID-19 (for up to 10 patients) 6.3.2020

Make it Safe YGC 21 April 2020

Make it Safe YGC 17th June 2020

WMH Covid summary to date lessons learnt (undated)

Datix Ref INC232422

Email communications between WMH consultants and HMT/executives May – July 2020

Incident and complaint reporting during COVID-19 outbreak Version 3.0 14 May 2020

NU19 Patient Transfer Procedure (July 2018)

A Principles Framework to assist the NHS in Wales to return urgent and planned services in hospital settings during COVID-19 NHS Wales June 2020

Covid-19 guidance for bed-spacing in healthcare settings 26 June 2020

Bed spacing survey June 2020

Email dated 1/8/20 summary of WMH datix reports 21-26 July (9 datix)

Timeline Wrexham outbreak from 6th July 3 August 2020

Standard Operating Procedure for the Management of single cases, clusters/outbreaks of COVID-19 v6 August 2020

Board Workshop Learning Outcomes and Actions from COVID-19 Post Infection Reviews Nosocomial Coronavirus Paper August 2020

Brief update on BCU tableau Covid Dashboards August 2020

Communications email and attachments August 2020

References and Web links

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/epidemiological-definitions-of-outbreaks-and-clusters-in-particular-settings

NHSEI CNO Letter (Ref No 001559) 19 May 2020 Interim data collection – hospital-onset COVID-19.

A Principles Framework to assist the NHS in Wales to return urgent and planned services in hospital settings during COVID-19. Welsh Government. 02nd June 2020

https://rytu6srvtabl001.cymru.nhs.uk/views/COVID-19hospitaladmissionindicators/Onsetdashboard-HB?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no

PHW Rapid COVID -19 Surveillance
https://rytu6srvtabl001.cymru.nhs.uk/views/COVID-19hospitaladmissionindicators/Onsetdashboard-HB?iframeSizedToWindow=true&%3Aembed=y&%3AshowAppBanner=false&%3Adisplay_count=no&%3AshowVizHome=no

http://aviationknowledge.wikidot.com/aviation:shell-model

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 3rd November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	COVID-19 Delivery Group - Proposed workstreams
Cyfarwyddwr Cyfrifol: Responsible Director:	Debra Hickman- Acting Executive Director of Nursing
Awdur yr Adroddiad Report Author:	Graham Alexander – Outbreak Support
Craffu blaenorol: Prior Scrutiny:	COVID-19 Delivery Group
Atodiadau Appendices:	1. High level agreed work programme

Argymhelliad / Recommendation:

The Committee is asked to note the report.

Please tick as appropriate

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

Sefyllfa / Situation:

This report is intended to demonstrate how we are seeking to share lessons learnt and distil best practice to reduce /minimise further avoidable nosocomial (hospital associated) infection. Furthermore to assist the COVID Unit in general preparedness for the 2nd wave of the pandemic.

Cefndir / Background:

The Health Board has sustained to date two significant hospital associated outbreaks (Wrexham & Central Hospitals) which have required Outbreak Control Teams (OCT's) with specific governance arrangements underpinning these. As a consequence of these outbreaks (Central hospitals is still ongoing) the COVID Delivery Group under the Chairmanship of the Acting Executive Nurse Director has been formed to achieve the following:

- Effectively embed systems and processes developed as a result of learning to reduce/minimise further avoidable nosocomial (hospital associated) infection.
- Lead the review of literature and intelligence together with linking with relevant organisations/stakeholders to share learning and best practice, ensuring the dynamic review and improvement of systems is in place.
- The review and operational implementation of local outbreak control plans to ensure it meets the safety requirements of our service and ensure Health Board wide dissemination.

Asesiad / Assessment & Analysis

Strategy Implications
This work is designed to ensure that we adopt evidence based practice in managing such outbreaks and that all actions are propionate and responsive to any findings of learning/evidence from COVID outbreaks. This will then ensure consistency with our IPC strategies.

Options considered
The COVID Delivery Group considered a number of approaches to deliver their remit but then agreed to adopt a focused work programme approach based on 6 themes as follows with a designated Executive Lead and Project Director:

-Governance of policies (outbreak related) : Professor Arpan Guha, Dr Melanie Maxwell
-Incident Reporting: Sue Green, Peter Bohan
-Quality & Safety: Debra Hickman, Amanda Miskell
-Data Quality & Reporting: Dr Chris Stockport, Richard Walker
-Communications (outbreak approach): Sue Green, Katie Sargent
-Environmental: Mark Wilkinson, Rod Taylor

Attached at appendix 1 is some additional detail of the overarching work programme with further current discussions taking place with the respective Project Directors on clear deliverables and completion dates. The Assistant Director – COVID Coordination Unit is also now part of the Delivery Group to ensure synchronisation with the new work taking place on preparedness for the 2nd wave of the pandemic.

Financial Implications
The COVID Delivery Group would refer to the Executive or any other COVID Forum should this work programme generate any capital or revenue investment decisions.

Risk Analysis
This work programme is designed to reduce clinical risk for the HB as per information set out in the background section.

Legal and Compliance
N/A

Impact Assessment
Any new policies or procedures recommended within particular work streams will require the mandatory impact assessments which would form part of the individual work programmes**.**
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Summary of Completed Actions - Wrexham Outbreak.

Action Ref.	Action Theme	Action Title (Original Log)	Action Description
1	**Quality and Safety**	Patient Transfer	Urgent RCA on the movement of the Glyndwr patient.
8	**Quality and Safety**	Swabbing	Swabbing and clarifying nose/throat or throat based on assay in use by lab or lighthouse.
10	**Quality and Safety**	Additional Bed Capacity	Need to de-clutter the wards. There are beds that are not socially distanced. We need to socially distance beds, which will reduce the capacity. Therefore, we need to find additonal capacity. To be reviewed by the HMTs. Can we re walk this so we are confident? A review of this work lead by hospital management team. GH needs an updated risk assessment on this
11	**Quality and Safety**	Impact Assessment	1 - The impact of cancelling electives if this is not under control. What will this be? 2 - The impact if we have to treat and transfer for ED. Access and egress is limited and we need to be locking the site down as much as possible. Staff side input also. Gel and masks for staff not just public. Confident they are meeting the pathway that had been set out at the beginning of the outbreak. No more entrances open that we should not have open.
12	**Quality and Safety**	Corridor Trolleys	To be reviewed by the HMTs. Reference action 10 above. A review of this work lead by hospital management team. GH needs an updated risk assessment on this.
27	**Quality and Safety**	Re-Testing of Staff	Staff who have been tested positive in last 6 weeks to be re-tested. R Masters to confirm to Occupational Health if re-test required. To ensure that staff/managers are aware of the re-test process for those tested positive in last 6 weeks. R Masters to confirm what staff test/process is to be carried out.
32	**Quality and Safety**	PIRs	Report on PIRs the Lessons learned
29	**Quality and Safety**	Cleaning Standards	GL Requested - Facilities to confirm that the required cleaning staffing/resource is in place to meet the National Standards of Cleaning across all areas of the hospital.
50	**Quality and Safety**	Ward Openings	Site to share the documentation on the decision making surround the reopening of a Ward.
54	**Quality and Safety**	RCA on Staff Moves	To undertake an RCA on staff movements from Covid - Covid and Non Covid - Covid. We need to understand what actions are in place to prevent this happening. We need to understand if they have been moved at the start of their shift. We need to give assurance on the detail.
55	**Quality and Safety**	RCA Decisoon Process	Who made what decision to move patients and the risk base? What level is this decision being made? We need this clear in the RCA. Actions to mitigate over the weekend, RCA and immediate lessons we can support you with. We need assurance on this before a full RCA update on 17/08.
58	**Quality and Safety**	Merging of two wards, patient movements and assurance	To get get written assurance form the consultants that they are comfortable with patient movement. This will give us a surge ward – PANTOMINE WARD.
61	**Quality and Safety**	PIRs & RCAs	Would like to see the analysis coming out of these, to ensure we are learning lessons on site and HB. RCAs I would like to see these themes coming out of here. Preferably on the same day as the PIRs.
68	**Quality and Safety**	Staff Posiitve on from ENT **(Part of Sitrep Agenda Item)**	To bring back the actions already taken with the staff positive from ENT, dates and times of all the shifts. should the staff member have been tested previously? Have they worked elsewhere other than BCU?
73	**Quality and Safety**	Ward Reopening (On agenda)	Summary of decision to reopen ENT and Mosrris to be shared with OCT
74	**Quality and Safety**	Communications **(On agenda)**	Reiterate hand hygiene with internal communications and consider messaging re ward movements.
63	**Quality and Safety**	Bed Spacing **(On Agenda Monday)**	Where we are and the risk assessment associated. Identify the wards where we have moved beds. Update on 17/08.
2	**Quality and Safety**	Patient LOS **(On Agenda)**	Urgent review of the LOS data and undertake a RCA on this.

3	**Policies and Procedures**	Communications	Communications briefing for all the staff, to re inforce the messages and that these messages are BCU policy. Individual patient letters agreed on the call yesterday, with PHW template. AL – the final version went to print 28/07/20. Need to send AL a copy of the final version. To get this out on site with immediate effect. The need for visible daily updates for the affected site. For all staff to access and include outbreak specifics.
5	**Policies and Procedures**	Mortality Review **(On Agenda)**	Have asked for the mortality review. ToR from TM by the end of the week to bring back to this group. We need granular detail regarding the deaths to be collated and shared accordingly.
7	**Policies and Procedures**	Staff & Testing Kits	Encouraging staff to use BCU testing kits, not other processes. We need to establish daily communication with PHW on the daily data. We are linking in with ESR.
9	**Policies and Procedures**	WAST	Engaging in communication with WAST. DH will pick up with MW to feedback to the action log.
13	**Policies and Procedures**	Home Working	Maximising home working for more on site, ensuring all admin staff are home working and not on site if they are not needed to be. The message is to work remotely if you can.
15	**Policies and Procedures**	Communication Meetings	To set up daily communication meetings.
16	**Policies and Procedures**	Evington Staff Testing	M Wain to confirm if any staff have previously tested positive on Evington. Assurance also required that staff positives have been added to datix.
20	**Policies and Procedures**	Cohorting Positive Patients	N Craine highlighted that IPC had recently set out guidance on cohorting of positive patients in same bay as negative symptomatic patients on the same ward and this had been discussed with Public Health Wales. **Cohort wards for exposed patients required as soon as possible. Advice should be sought from Estates & Facilities colleagues to ensure appropriate cleaning safely in place.** A Ledgerton/D Bhattacharjee to develop Standard Operating Procedure.
21	**Policies and Procedures**	Communication	T Mahambrey/D Bhattacharjee to convene group today to produce document that gives clear direction and to carry out execution of communication, this should be carried out at speed. **G Harris requires confirmation, by end of play today, that communication has been issued. Assurance also required that Medical colleagues are comfortable with this.**
22	**Policies and Procedures**	Standard Operating Procedure	A Ledgerton/D Bhattacharjee to develop Standard Operating Procedure, reference action 20.
23	**Policies and Procedures**	Wearing Masks on Wards	D Hickman to discuss wearing of masks across wards with S Stanaway and will pick up with wards across Site – need to actively encourage and to reinforce with team. Very visible presence required on site to support until embedded.
17	**Policies and Procedures**	Volunteer Staff	L Osgood to have discussion re Volunteer staff.
25	**Policies and Procedures**	Border Issues	R Masters is to discuss how to address gap/ border issues with G Harris later today and will also discuss the Countess of Chester. Need to escalate the information to the countess.
37	**Policies and Procedures**	SOP for patient cohorting	We need to approve and become a HB policy with supportive national guidance. This is a multifaceted piece of work. As a Health Board we never suggest cohorting positive cases with negative cases.
42	**Policies and Procedures**	Whole YMW Site Staff Testing Meeting **(On Agenda)** Workforce Timeline & Plan	We need to agree the way forward to whole hospital testing. How are we going to do this and the impact of this? We need a strategy on a way forward on implementing screening across the workforce in the Maelor. We need to be explicit about what we are doing and not doing. Clear Plan and timetable to come back 07/08/20 regarding staff testing. Need to prevent the HUB being over whelmed. There needs to be coordination here and a meeting pulled together by the HB. Clear communication on what we are doing and why we are doing it. To create messaging on what staff need to do regarding testing. Clarification on the right process to follow.
47	**Policies and Procedures**	TTP of Staff	When staff test positive the local contact tracing team will contact and advise. We need to know if this happening in the hospital regarding other staff colleagues. This is being followed up with OH and the TTP team for clarification.
48	**Policies and Procedures**	HOPE Tool Kit	Eleri Davies to send link and we can look to incorporate this into our process.

49	**Policies and Procedures**	Staff Movement Rules	To set up a meeting to discuss what rules for staff movements are in place, who made these rules and why. We need to know the number of moves we are doing, rational and risks that led to the decision.
43	**Policies and Procedures**	Definition of Case	We need an agreed definition on what is an Outbreak case, active case and recovery case. We need to be transparent on the way we are reporting. Explicit on how we are changing this and why. Dates to be included.
76	**Policies and Procedures**	Staff Testing	Advice OCT on the consequences of staff retests done within 42 days. Flow chart developed and being consulted on with CTU and Booking Centres.
77	**Policies and Procedures**	Staff Testing	Tushar Mahambrey to coordinate a working group to meet with PHW/TTP to agree potential staff exclusion criteria or clear actions for staff who have previously tested positive
71	**Policies and Procedures**	Staff Movements **(Delivery Group)**	Development of Management of Outbreak Staff Flows SOP.
4	**Environmental**	Estates and Additional Capacity	To look at the feasibility of this single bay and the cubicle on Erddig, just outside bay 7. AH to pick up with the nursing team on site. Adam/Andrew. The plan is to open the additional capacity by ASAP.
24	**Environmental**	Negative Pressure Rooms	R Taylor to contact colleagues in Liverpool Hospital, who have created negative pressure rooms. To be guided by Authorised Engineer who is working with many Health boards.
45	**Environmental**	Environmental Guidance	Go back on the environmental guidance to review the bed spaces.
53	**Environmental**	Isolation Facilities	Update regarding the options to enhance isolation facilities. Need a date from RT to bring and present to this group.
6	**Data and Reporting**	Staff Format - Communications	We need a daily update on staff, where they were and what actions were taken. To include Occupational Health.
14	**Data and Reporting**	Health & Safety **(On the Agenda & SITREP)**	RIDOR reporting - need to have the reports completed ASAP To report RIDDOR we will need Datix and 72 hour reviews; happy to report when have information understand being worked on.
18	**Data and Reporting**	IRIS	A Miskell to provide update from IRIS.
19	**Data and Reporting**	Community & Acute Reporting	M Wain to provide situation report for Community and Acute, going forward; confirmation required of: 1 - What wards are closed and where beds have been removed due to social distancing. 2 - How many deaths are being related to/the number of COVID positive patients exposed and died; numbers in Critical Care to be included.
26	**Data and Reporting**	Case definition for patients and staff	M Wain/C McKerr/A Ledgerton to discuss case definition for patients and staff.
28	**Data and Reporting**	Weekly Audit Data	At the request of GL. Weekly outbreak data to be presented to the outbreak control team.
30	**Data and Reporting**	Staff/Patient Movements	How many staff and patients have moved in the shift? Rational of this. Presentation on 04.08.20.
31	**Data and Reporting**	Review of Datix	Consistent review of the data on Datix to be reported.
33	**Data and Reporting**	Template for Patient Movements	We need a standard template drafting in order to record patient movements form PHW.
34	**Data and Reporting**	Review	Review of the information shared by Dr Gillian Richardson
35	**Data and Reporting**	Granular Detail of Deaths	We need granular detail regarding the deaths to be collated and shared.

36	**Data and Reporting**	Timeline	We need a timeline of events and interventions from the initial outbreak.
38	**Data and Reporting**	Death Reporting	The need to establish how the deaths are being reported by PHW and the HB
39	**Data and Reporting**	Communications on Death Reporting	Deaths in relation to this outbreak will be reported through the HB. YMW deaths we report as YMW deaths as to HB deaths. Moving from BCU to more local deaths, owned by the HB.
40	**Data and Reporting**	Staff Communications	The need for visible daily updates for the affected site. For all staff to access and include outbreak specifics.
41	**Data and Reporting**	Epidemiology and Mapping Data	Helpful to over lay the timeline data with this. Epidemiology and the mapping data. To arrange a meeting with Eleri Davies, Andrea L, Amanda M, Behrooz, Maureen W, Steve GR, Sam Newitt, Robin Howe, Peter Bohan
44	**Data and Reporting**	Monitoring Form	The monitoring form the GR has shared with us, how are we to implement thiis? This wil need support from the control centre.
46	**Data and Reporting**	Staff Testing Groups	We need to break down the data into staff groups and the areas the staff are associated with. We can then see activity related to the outbreak, or the hospital in general.
51	**Data and Reporting**	SITREP	Site to amend the narrative column in the SITREP presentation, to be more precise in the description.
52	**Data and Reporting**	Site Communications	Individual patient letters agreed on the call yesterday, with PHW template. AL – the final version went to print 28/07/20. Need to send AL a copy of the final version. To get this out on site with immediate effect. The need for visible daily updates for the affected site. For all staff to access and include outbreak specifics. LINK TO ACTION 3 - Provide us with assurance of letters that had been sent out and who they have been sent to. To ensure all patients that have been impacted have been informed. SOP of how we are informing patients. If any questions to raise for the patient and family.
56	**Data and Reporting**	Mortuary Daily Reporting	To link SS's new process to our list, on which are HCAI infections and which are not. To get a definitive list and include in the daily SITREP.
57	**Data and Reporting**	Surveillance Form **(On Agenda)**	WG would appreciate receiving a report on the completion of the surveillance form and measures being taken to improve compliance.
59	**Data and Reporting**	SITREP Front Sheet	GH would like to see a front sheet, since the outbreak, these are the numbers, HCAI, Community etc. That consolidated actions ar still being monitored etc.
60	**Data and Reporting**	Publishing of Deaths	We need to be clear on patients passing away as part of the outbreak,with HCAI . Validation of the data to be done to ensure that what we publish is correct. Correlation of locally held patient lists (RW reported source) with Line List to establish one definitive data source. Ensure that Line List is source for reporting of outbreak related deaths. To gather every Covid-19 test since 6th July, number of tests on staff and patients to date, and the numbers of positive cases generated. GA and RWalker will assist. Reference area too. Diffrenciate A&E tests also as part of the analysis. To be available for Wednesday Communications**A Miskell** How many test, total positive tests and to separate staff and patients. Cumulative total of cases to be included. Will include definitive data supplied for us to do this. **Comms**
62	**Data and Reporting**	Line List **(On Agenda)**	AM & SS to take control of the Line List, for a HB approach not just site. To gather trends and analysis.
64	**Data and Reporting**	Death Reporting	Follow up with Mold Clinician to confirm death Covid related, including completion of surveillance form, and inclusion on Line List.

66	**Data and Reporting**	Positive Patient Reporting	Correlation of locally held patient lists (RW reported source) with Line List to establish one definitive data source.
67	**Data and Reporting**	Death Reporting **(On Agenda)**	Ensure that Line List is source for reporting of outbreak related deaths.
69	**Data and Reporting**	Cumulative Figures **(On Agenda)**	To gather every Covid-19 test since 6th July, number of tests on staff and patients to date, and the numbers of positive cases generated. GA and RWalker will assist. Reference area too. Diffrenciate A&E tests also as part of the analysis. To be available for Wednesday Communications.
70	**Data and Reporting**	Comms Cumulative Number **(On Agenda)**	How many test, total positive tests and to separate staff and patients. Cumulative total of cases to be included. Will include definitive data supplied for us to do this.
72	**Data and Reporting**	Line List Reporting	GA to link in with AM/CM to add readmissions with multiple positive tests to Line List, confirming reporting.
75	**Data and Reporting**	Actions Summary	Summary of completed action to GH for update to the Delivery Group.
78	**Data and Reporting**	Staff Testing	YWM consultant meeting - creating a set of FAQ to respond to some of their queries
79	**Data and Reporting**	Postive Case Reporting **(Delivery Group)**	IPC to confirm definition of when reported positive patients are deemed to be negative, if they are still in HB fsacilities; i.e how long do they need to be nagtive after last positive test to be no longer reported as outbreak related patients.
82	**Data and Reporting**	Communications	Outcome report to be shared with Care homes
83	**Data and Reporting**	Delivery Group **(On Agenda)**	Terms of Reference for Delivery Group to be shared with OCT
86			
85			
80	**Open - Transfer to Delivery Group**	Trigger Tool **(Delivery Group)**	Early warning trigger mechanism that should be built into the data management (i.e. an automated notification function which activates when one of the case definitions criteria is met), to be incorported into the new Recovery Reporting process.
81	**Open - Transfer to Delivery Group**	Staff Movements **(On Agenda for YGC and Delivery Group)**	YG abd YGC Staff Movements summary
84	**Open - Transfer to Delivery Group**	Debrief Process **(Delivery Group)**	Debrief Session/Process to be picked up by the Delivery Group; to include PHW colleagues.
85	**Open - Transfer to Delivery Group**	Mortality Review Process **(Delivery Group)**	Mortality Review Process to be completed.
87			
88	**Policies and Processes**	Governance of Policies	Update existing IPC policies that are out of date; links to wider work on governance of policies
89	**Policies and Processes**	Communication	Share and implement HCAI / IPC policies across BCU
90	**Policies and Processes**	Incident reporting	Reinforce the use of incident reporting to support early identfication of staff HCAI/outbreak
91	**Policies and Processes**	Completion of PIRs/ MiS	The reports are not produced in a timely way in line with policy. Enable the requirement to do this (so we can share learning)

92	**Data and Reporting**	Data intelligence cell	Dedicated intelligence unit with anlytical support ; this links to a wider piece of work within Informatics
93	**Data and Reporting**	Data Quality (triggers)	Determine additional resources to support timely data input - enabling triggers
94	**Quality & Safety**	IPCT resource	Business case to increase capacity within the IPCTeam to support pandemic
95	**Quality & Safety**	Organisational learning	Agree and implement a framework to systematically learn across sites and depatments; this is not just related to outbreaks
96	**Quality & Safety**	Training Needs Analysis	Review IPC training to enbsure fit for purpose and delivered to appropraite groups - links to agency workers adan training assurance. This was specifically donning and doffing as an example- some staff untrained.
97	**Quality & Safety**	Local Investigation	Clinically led review of communications during the Wrexham Outbreak focussing on communication
98	**Policies and Processes**	Document Management System	There is no single data source to identify when guidance was updated/ staff were told/actions were taken to sup[port investigations that requre time lines.

Executive Sponsor	**AG**	**SG**	**DH**	**CS**	**SG**	**MW**
Project Director	**MM**	**PB**	**AM**	**RW**	**KS**	**RT**
Theme	**Governance of Policies (Outbreak Related)**	**Incident Reporting**	**Quality and Safety**	**Data Quality and Reporting**	**Communications (Outbreak Approach)**	**Environmental**
1	Standardised set of Policies and Procedures to be established to support the management of an outbreaks. To include the new SOPS/Policies adopted at Wrexham, below. - Off the shelf minimum approach - similar to major incident doc in on call info? **What do we include?**	**Review of current incident reporting methodology,** update as needed, outcome being 'up to date' full set. Split between BAU and Outbreak? (*Datix system to be used, reinforce. How does RIDDOR fit in? Do we need to include for clarity, do we need separate system? Guidance refresh and reinforce message.)*	PIR reports to be standardised with proforma approach? Clear guidance as to what (as a minimum) generates need for one?	**Single data source, with all policies, including updates.**	**Standard communications policy to cover outbreaks and SI's?** Specific issue of comms to Medical staff raised, needs to be visible part of policy, including direct feedback at exisiting forums.	**Isolation Facilities** - Review of current side rooms and negative pressure facilities.
2	**All new SOPs and Policies that were developed as part of Wrexham outbreak to be rolled out across HB as initial step.** Patient transfers, staff movements, screening compliance and changes to dept policies, reopening of ward checklist, patient cohorting,TTP others?	**Assure that 'up to date' incident reporting policies are embbede/reinforced across whole HB.** Assuranace that all key staff have visibility, part of annual mandatory training.	Standard regular Audit Reporting - PPE, Hand Hygiene, Screening of all Admissions, Staff Movement and Patient Transfers. Do some of these audit results need to part of BAU reporting and some outbreak only?	**BAU reporting, clear plus additional requirements if outbreak is declared. BAU reporting to be monitored received by which internal group?**	Communication to all staff of key changes and updates and their **individual responsibility.**	**Guidance** to review bed spaces - assurance that consistent across HB.
3	**Agreed Policy update process, who what, when?** Timescales and agreement/change process. Specifically IPC policies to be assessed as minimum.	**Clear responsibility for reporting, escalation and review and managing lessons learned**. Need to include timescales. Escalation process separate to outline triggers consideration of outbreak or SI being declared.	Cleaning audit information? Does it form part of BAU, link into the management of all HAIs plus additional protocols for outbreaks?	**Trigger Reporting finalised, roll out across HB.** To include Exec visibility of reporting, specific management responsibility (Operational) including agreed escalaltion process, and embedding into the existing HB governance structure	Do we do roadshow, learning type sessions? **Alternative communications methods.**	
4	**Production of a SOP that defines both BAU and outbreak for data/reporting battle rhythmn, including escalation structure**. Need to include use of key info, Trigger Tool, etc. Do we need separate management infrastructure to manage outbreaks, OCT approach?		**H&S** - Embed and assure donning and doffing guidance/training for all staff requiring Level 1 and Level 2 PPE. Include checks for temporary workers	**Separate/additional reporting to be put in place once outbreak declared** eg positive case monitoring, screening compliance or frequency of BAU reporting etc.		
5	**Assurance process that all policies are embedded across the HB, evidence the roll out.** Process to agree variations to standard if required? Formal sign up and accountability framework.			**Review of key departmental resource, or roles and responsibilities. Need to standardise departmental /role/responsibilities**, eg IPC. Apparent that IPC pick up most of key actions/decisions. What is role and responsibility of H&S and site management teams? Does it change in outbreak, do IPC get primacy for specific		
6	**H&S** - Checks for alternative occupations of workers, and assurances of adequate workplace precautions - ?SOP for temp staffing, including volunteers.			**H&S** - Consider standard investigation protocol for staff cases - data sources, data requirement/quality, membership/responsibilities, timescales, documentation, escalation, criteria for close-out. Pooling and sharing of relevant data (IPT, Workforce, Governance, H&S) - consider mechanism and resource requirement		
	Mortality Reviews? WAST specific communications? Home Working? PPE usage SOP? Communication with other ajoining NHS organisations? HOPE toolkit? Case definitions?		Swabbing? De cluttering/oocial distancing on w Impact assessment - elective cance LOS data - Wrexham specific?	Case Definitions? IRIS, where does it fit? Weekly Audit data? Granular death reporting? Timelines of outbreak? Epidemiology reporting and input? Sitrep format? WG Surveliance Form? Line List reporting?		

Outbreak Related Work Program Summary - Delivery Group

Executive Sponsor	AG	SG	DH	CS	SG	MW
Project Director	MM	PB	AM	RW	KS	RT
Theme	**Governance of Policies (Outbreak Related)**	**Incident Reporting**	**Quality and Safety**	**Data Quality and Reporting**	**Communications (Outbreak Approach)**	**Environmental**
1	Standardised set of Policies and Procedures to be established to support the management of an outbreaks.	Review of current incident reporting methodology, BAU and outbreak distinction needed?	PIR reports to be standardised with proforma approach.	Single data source, with all policies, including updates.	Standard communications policy to cover outbreaks and SI's e.g. Medical Staffing forums.	Isolation Facilities - Review of current side rooms and negative pressure facilities.
2	All new SOPs and Policies that were developed as part of Wrexham outbreak to be rolled out across HB as initial step.	Assure that 'up to date' incident reporting policies are embbede/reinforced across whole HB.	Standard regular Audit Reporting - PPE, Hand Hygiene, Screening of all Admissions, Staff Movement and Patient Transfers.	BAU reporting, clear plus additional requirements if outbreak is declared.	Communication to all staff of key changes and updates and their individual responsibility.	Guidance to review bed spaces - assurance that consistent across HB.
3	Agreed Policy update process, ensuring always up to date.	Clear responsibility for reporting, escalation and review and managing lessons learned.	Cleaning audit information.	Trigger Reporting finalised, roll out across HB.	Communications to external NHS bodies	
4	Production of a SOP that defines both BAU and the additional requirements relating to an outbreak, data/reporting battle rhythmn, including escalation structure.		Embed and assure donning and doffing guidance/training.	Separate/additional reporting to be put in place once outbreak declared.		
5	Assurance process that all policies are embedded across the HB, evidence the roll out.			Review of key departmental resource, or roles and responsibilities.		
6	Specific Policies/Procedures and SOPs identified, part of 1&2? - Temp staffing - Mortality Reviews - PPE usage - Home working policy			Consider standard investigation protocol for staff positive cases.		
7			To be included above: - Swabbing - De cluttering/soocial distancing on wards - Impact assessment - elective cancellation, Treat and Transfer ED - LOS review of data - Wrexham specific	To be included in above: - Case Definitions - IRIS, where does it fit? - Weekly Audit data - Granular death reporting - Epidemiology reporting/input - WG Surveliance Form		

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 3rd November 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Patient Safety Report – Q2 2020/21
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Debra Hickman, Acting Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Matthew Joyes, Acting Associate Director of Quality Assurance and Assistant Director of Patient Safety and Experience Kath Clarke, Head of Patient Safety Shan Kennedy, Redress and Claims Lead Manager Debbie Kumwenda, Inquests Lead Manager
Craffu blaenorol: **Prior Scrutiny:**	Review by the responsible Directors and Executive Director
Atodiadau **Appendices:**	1. Q2 report 2. Incident Process Review Update 3. Action plan update

Argymhelliad / Recommendation:

The Committee is asked to:

1. Note the report.
2. Note the focus on improving learning, reducing incidents resulting in avoidable harm and the evolving improvement of assurance in this area recognising significant work remains.
3. Receive this report and provide feedback on its evolving content and layout.

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

Sefyllfa / Situation:

The Quality, Safety and Experience Committee is the delegated Health Board committee with responsibility for seeking assurance on patient safety. This report provides the committee with information and analysis on significant patient safety issues arising during the quarter under review, alongside longer-term trend data, and information on the safety improvements underway.

Cefndir / Background:

This new format report is designed to offer improved information and analysis in relation to patient safety, in order to improve the assurance received by the committee. The period under review is primarily July 2020 to September 2020 (inclusive); however, longer-term data for the previous 27 months (allowing month on month comparison) has been included in the graphs to provide a better longitudinal view and to enable the use of statistical process control (SPC) charts.

Asesiad / Assessment & Analysis

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

Appendix 1

Patient Safety Report
Q2 2020/21

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

1. INTRODUCTION

1.1 Patient safety 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 and a culture of safety is fostered that involves health care professionals, partner organisations, patients and their carers/families.

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

1.3 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.

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

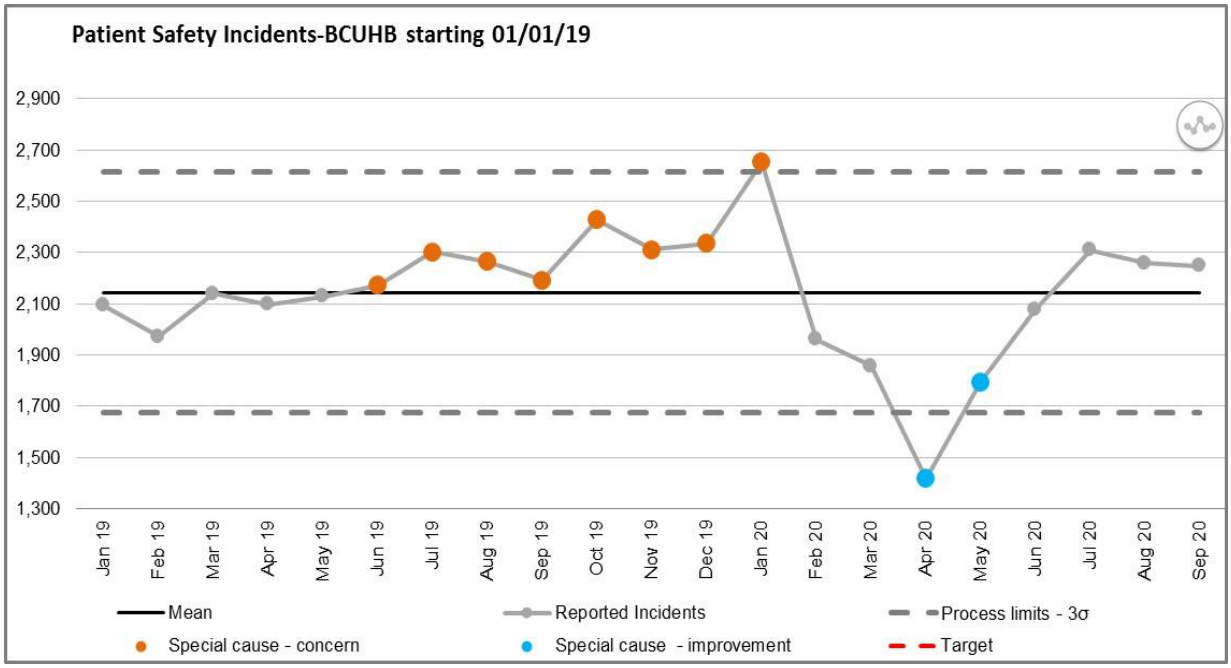
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

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

2. PATIENT SAFETY INCIDENTS

2.1 Patient safety incidents are any unintended or unexpected incidents, which could have, or did, lead to harm for one or more patients receiving healthcare. Incidents are reported on Datix, the integrated risk and safety management system used by the Health Board.

2.2 The graph below demonstrates the number of patient safety incidents reported during Quarter 2. In total, 6,817 patient safety incidents were reported in this period. The number of incidents reported has shown an increase for this Quarter. As hospital activity begins to return to a more usual level following the COVID -19 pandemic, the reporting of patient safety incidents have now started to increase. In addition, the reporting of COVID-19 patient related incidents account for 349 incidents compared to 549 last quarter – these range from the inappropriate transfer or discharge of patients to a number of COVID-19 cluster outbreaks.



2.3 Investigation toolkits to support an all Wales Approach to COVID-19 reviews of staff who have contracted the virus, and for patients with nosocomial infection, are in development. The work is led by Welsh Risk Pool and the Head of Patient Experience (HoPE) network. The use of the toolkits is expected to be supported by Welsh Government. We are currently waiting for the investigation toolkit to be approved however the tool kits are available to use if services wish.

2.4 The Patient Safety and Experience Department is undertaking a comprehensive review of the incident process (including serious incidents) and this is being conducted in co-production with divisions and other stakeholders. This work was delayed until the beginning of August 2020 because of the COVID-19 pandemic. To enable engagement with Divisions a questionnaire was developed and sent to Directors of Nursing, Governance Leads and key stakeholders. The questionnaires were analysed and the results are feeding into the ongoing review. An organisation-wide patient safety culture survey is also underway using an accredited international tool. An update paper is included in appendix 2.

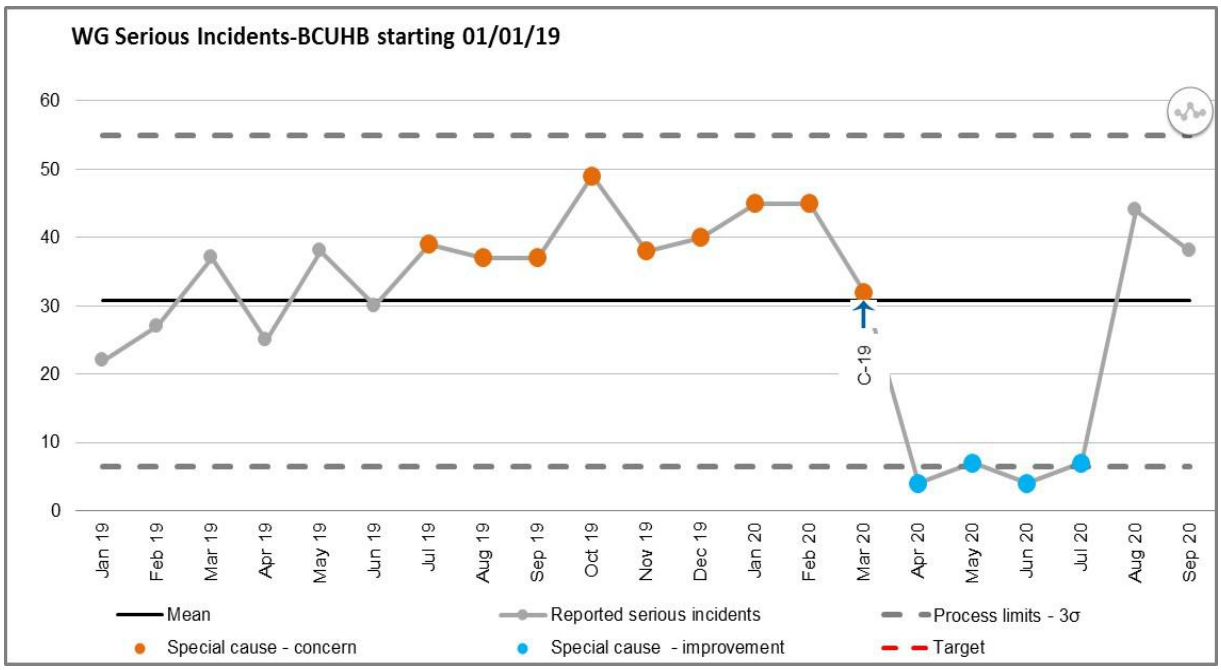
3. WELSH GOVERNMENT REPORTABLE SERIOUS INCIDENTS

3.1 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

3.2 Welsh Government provide a list of serious incidents that require formal notification if reported. This list is not exhaustive and notification of any incident resulting in serious harm must always be considered as Welsh Government Reportable.

3.3 During the Covid-19 outbreak, Welsh Government reduced their list of reportable serious incidents, including healthcare acquired pressure ulcers (avoidable) and falls with harm, consequently resulting in a sharp decrease in the number reported during Quarter 1 (see graph below). Reporting has now returned to the previous (pre-Covid-19) process as of August 2020 and a clear increase in reporting can be seen, (see Graph below). This decrease is in line with other Health Boards during the Covid-19 first wave with information shared via the HoPE Network to support this assertion.



3.4 The bi-monthly Serious Incident Report provides a regular update of newly reported incidents to the Committee. The most common categories of reported serious incidents (SI) for the quarter include:

- **Self harm in primary care, or not during 24-hour care** (n=12). Of the 12 reported,11 have been reported under Mental Health Community Services, making them the highest reporter of SI to Welsh Government. Of these 12 incidents, eight are recorded as 'Unexpected death whilst under the care of a health professional (n=8). All eight of these have been reported by the Mental Health and Learning Disability Division (community teams), who are required to report all unexpected deaths of patients open to services, regardless of whether the death was contributed to by healthcare services (as per the national Serious Incident Framework).

- **Patient falls resulting in severe harm or death** (n=12)**.** During the time period, falls with harm have been recorded by unit as follows: Ysbyty Penrhos Stanley (2), Wrexham Maelor Hospital (2), Eryri Hospital (2), Ysbyty Gwynedd (3), Ysbyty Tywyn Memorial Hospital (1), Ysbyty Glan Clwyd Hospital (1), Learning Disability Community Services (1)

- **Avoidable grade 3/4 pressure ulcers, unstageable or deep tissue injury** (n=6). Of the 6 incidents reported during Q2, three of these were related to extended stay or episode of care.

It is important to note, serious incident reporting was noticeably reduced during the quarter as a result of the COVID-19 pandemic reporting changes and activity changes.

3.5 At the end of Quarter 2, 73 serious incidents remain open with Welsh Government of which 24 are overdue (down from 31 in the last report). Of these, the predominance of overdue incidents relate to Central Area (6), Corporate (5) and East Area (6). All divisions have seen and continue to see a reduction in overdue incidents. A small number of incidents are overdue by twelve months (6) and these relate to matters subject to police investigation. A number (6) are overdue by 6-12 months and a slightly larger number (7) are overdue by 3-6 months. There has been significant reduction over the last 12 months.

4. PATIENT SAFETY STRATEGY

4.1 A Patient Safety Strategy for BCUHB is in development. A proposal was submitted to the Quality and Safety Group outlining how engagement with key stakeholders, patients and staff can be done under the current COVID-19 restrictions. A patient safety culture questionnaire was piloted within the Heddfan Unit during August 2020 and was launched BCUHB-wide in September. The results will inform the strategy. In addition, interviews with key stake-holders are also taking place. The plan is to develop the new strategy over quarter 3 and seek approval during quarter 4 ahead of a launch in April 2021.

5. NEVER EVENTS

5.1 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.

5.2 During Quarter 2, two Never Events were reported as follows

Division	Ward/Team	Type of Event	Description	Harm
Ysbyty Glan Clwyd	ITU	Retained foreign object post-operation	CT scan of lower abdomen revealed wire in Inferior Vena Cava. Subsequent Chest X-Ray showed this extending back into thorax.	Negligible
Wrexham Maelor Hospital	Eye Clinic	Wrong site surgery	Procedure carried out on incorrect eye	Major

In total, four Never Events have been reported so far in 2020 – three fall into the "wrong site surgery" bracket and the lack of or failure to use a LocSSIPs is a theme. The approach to LocSSIPs and NatSSIPs is to be redesigned as part of the priorities for the Patient Safety Team with work commencing in January 2021, at the latest. In addition, the Secondary Care Medical Director has been tasked with leading improvement work in this area. The remaining relate to "retained foreign object post operation" and "wrong route administration of medication".

Last year, a never event was reported by Ysbyty Glan Clwyd when a patient's gall bladder was removed in error. A comprehensive investigation was undertaken and an action plan developed based on the findings. The action plan update can be seen in appendix 3 – it is important to note evidence has not been tested for this action plan and this will be progressed depending upon the findings of the external review. Only two actions remain to be completed:

- **Consider facilitating a human factors review of the incident for further learning and building of relationships.** Recruitment is underway of clinical staff into a human factors faculty.
- **Vascular network to ensure theatre teams, on all sites, are made aware of the vascular support that is available and how to access.** YGC has completed this action but awaiting confirmation from YG and WMH.

In addition, an external independent expert has been commissioned to review the incident, the investigation and its findings. A report is expected later this year.

6. INQUESTS

6.1 During September 2020 inquest hearings have been recommenced following restrictions placed because of the COVID-19 pandemic. The North East and Central Wales Senior Coroner is currently only listing 'Read only' inquests – those that require no witnesses and where evidence may be read under Rule 23. It is unlikely that any inquests with witnesses summonsed will be heard until 2021.

6.2 The Health Board has received notification that the Coroner has opened 65 new inquests during Q2 involving the Health Board. Although a review of inquest data

from Datix appears to show a drop in inquests opened across the Health Board, since March 2020 there has been a more rigorous review of inquests logged, and duplication avoided. Prior to this there was frequent duplication of cases logged between Secondary Care and Mental Health, as well as across Areas. The MHLD Division continue to operate their own inquest coordination activity.

6.3 29 inquests were concluded during Q2:

- Of these 28 were heard under Rule 23 with the North Wales Coroner
- One inquest was heard by the South Manchester Coroner in Stockport. The BCUHB witnesses all gave evidence via video link, with the Health Board legal representative present in court. This was the first time that BCU witnesses had given evidence in these circumstances. There were a number of learning points associated with this inquest, and these were reviewed during a debrief session following the inquest (see 6.5).

6.4 Inquest conclusions:

Unfortunately due to some IT changes and restricted working arrangements within the Coroner's Office at present, the inquest conclusions for this period have not yet been forwarded to the Health Board.

6.5 Inquest learning

Learning from inquests is fed directly back to services, and where appropriate into organisation-wide leads or groups. Key learning points taken from the inquest debrief session listed in 6.3 were

- Priority of Inquests when booking rooms for virtual inquests
- Appropriate technology being available in the rooms to enable correct level of communication with inquest court
- Development of a check-list to be used for all statements associated with falls in particular to ensure comprehensive level of information gathered at outset.

6.6 The Patient Safety and Experience Department's planned comprehensive review of the inquest process, to be conducted in co-production with divisions and other stakeholders, is due to be completed by December 2020. A stakeholder questionnaire has been developed and is due to be issued to staff members across the organisation during October 2020. The BCU Inquest team is involved in the All Wales Inquest process review, but unfortunately, the meeting planned for September 2020 had to be postponed at short notice due to the impacts of rising Covid-19 levels in communities across South Wales.

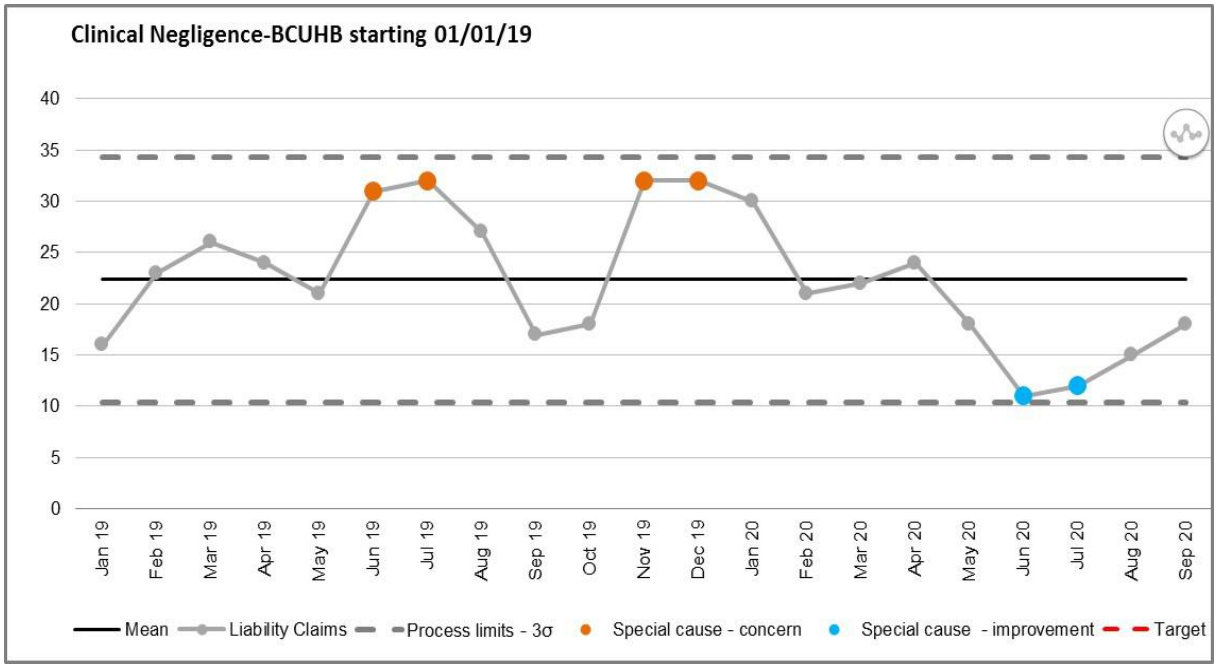
6.7 The Inquest Board Round continues to be held virtually via Skype, held in collaboration with representatives from clinical, managerial and governance teams. The meeting purpose is to track progress and escalate any issues or delays in order to support an efficient process and enable effective communication of responses/timescales to the Coroner. Overall feedback on this process is positive

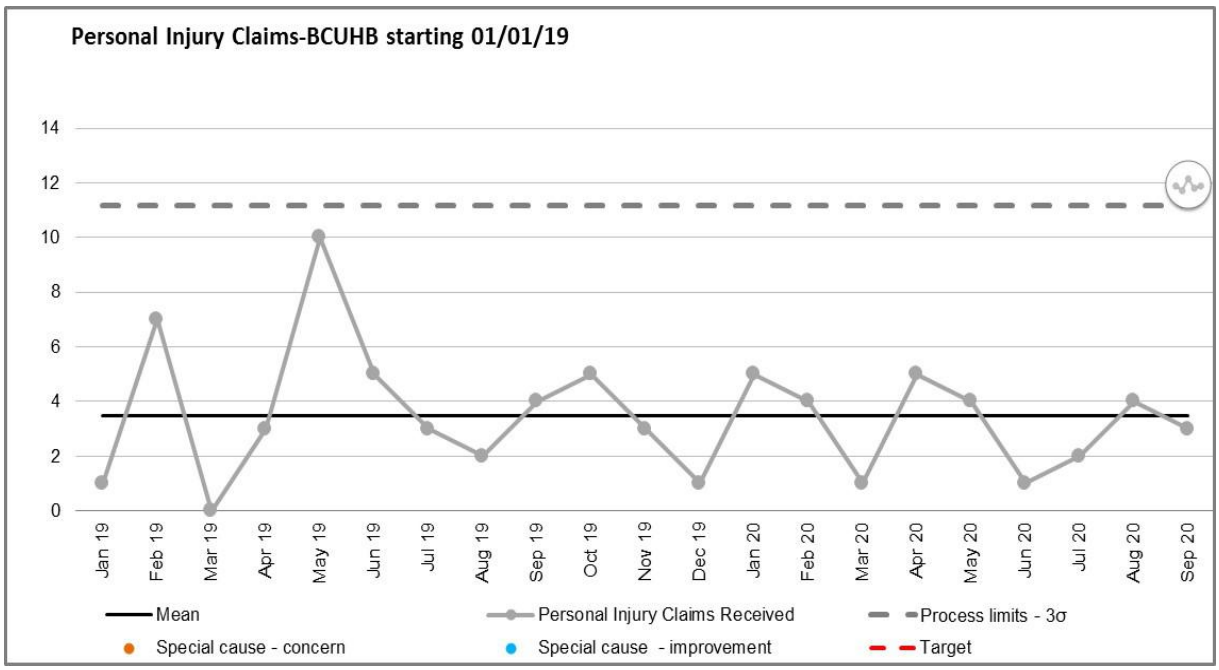
however implementation across different localities has been inconsistent. The process has been to hold separate Inquest Board Rounds for each locality, but these will merge to form a BCUHB Combined Inquest Board Round, with timed slots for different services. This is on track to be in place by December 2020 and will improve the overall coordination of inquests.

7. LITIGATION

7.1 During Quarter 2, 54 claims or potential claims were received against the Health Board. Of these, 45 related to clinical negligence and 9 related to personal injury.

7.2 We have now seen an increase in claims generally during Q2. When looking back at Q1 and comparing, Q1 was the start of the Covid-19 pandemic and it was anticipated that we would see a further rise in claims as business begins to return to a new normal. This increase is therefore as expected.





7.3 During Q2, 53 claims were closed. Of these, 33 related to clinical negligence and 20 related to personal injury. The total costs for these closed claims amounted to £12,102,096.95 before reimbursement from the Welsh Risk Pool. The most significant claims related to:

i. Delay in diagnosis and treatment of subarachnoid haemorrhage. Failure to consider subarachnoid haemorrhage and investigations to exclude this in accordance with the Royal College of Emergency Medicine Guidelines 2009. Claimant should have undergone a CT scan (£2,720,716.26)

Learning:

Case presented at Mortality and Morbidity meeting August 2013. Doctor reflected on the case with personal supervisor and also presented the case at the M&M meeting.

Ensured RCEM and NICE guidance available on ED website for consultation by junior doctors.

Compared with 2013 and 2014, the threshold to refer for CT scan for patients who present with “headache” to the Emergency Department is far lower today. There are now second CT scanners at the main acute hospital sites, and general radiographers are now trained to undertake CT head scans as part of their routine training.

ii. Failure to undertake screening tests in GP Out of Hours following attendance with a foot injury of an undiagnosed diabetic. Patient subsequently lost to follow up by Ophthalmology and both claims merged (£1,031,334.30).

Learning:

Medical Advisor for West to include case in newsletter to ensure all clinicians aware that in rare circumstances to think of contributing factors to the presenting complaint such as diabetes in infected wounds.

Papers relating to eye health care presented to Boards throughout Wales outlining proposals for the future model to ensure improved eye care for patients

Eye Care Measure an All Wales initiative introduced

iii. Nerve damage sustained during left nephrectomy in September 2009 leading to paraplegia. There were delays calling for medical opinion and in recognising the claimant's hypovolemia. (£3,226,061.93).

Learning:

Individual management plans now developed for practitioners where issues have been identified. Nursing staff accompany a member of Acute Intervention Team (AIT) and objectives set. Scenario based training is in place developed by the AIT. All staff in high risk areas, i.e. critical care/acute cardiac units, have an advanced life support (ALS) or immediate life support (ILS) qualification.

The Health Board developed the RRAILs (rapid response to the acutely ill) guidance and the acute intervention team are now in place 24/7 on all acute sites.

iv. Failure to diagnose and treat an infection in the mother resulting in the baby's death. Issues with conducting fetal biometry noted. Majority were carried out to acceptable standard, but an opportunity was over looked and it transpired that there should have been a concern regarding the growth on that date. Issues also observed regarding use of the CTG trace stickers.

Learning:

Implementation of the Perinatal Institute GAP Training Programme in 2017 detailing the management of symphysial fundal height (SFH) measurements. Annual e-learning package including this area for all midwifery and medical staff.

In 2019, the Health Board implemented the Fetal Surveillance Standards in accordance with national recommendations. All staff must undergo six hours face to face training in CTG assessment and fetal monitoring.

Incident shared with Obstetric Ultrasound lead to ensure learning across the board.

v. Failure to diagnose and treat a condition called hyperekplexia (also known as startle syndrome) between the years of 1992 and 2007. During this time, the claimant had previously been diagnosed and treated for epilepsy and cerebral palsy (£873,746).

Learning:

This matter goes back nearly 30 years and there have been advances in the diagnosis of hyperekplexia since then.

Hyperekplexia will be considered as one possible reason when an infant has seizures. A family history is an important part of the diagnosis because of the usual genetic linkage. The major features of this condition have been shared since the claim with clinical staff.

vi. Delay in proceeding to emergency caesarean section. Claimant suffered bradycardia leading to a brain injury. There were significant failures to recognise and act upon evidence of fetal distress on at least three occasions, in spite of evidence of pathological CTG traces pre-delivery (£5,751,238.91).

Learning:

Introduction of a daily multidisciplinary review of all cases within the previous 24 hours on labour ward.

Introduction of the "Fresh Eyes" approach in the interpretation of the EFM whereby a senior review is undertaken every hour in established labour.

Introduction and full implementation of the RCOG/RCM e-Learning for Healthcare EFM package for all relevant staff within maternity services and the ongoing annual competency requirement as stipulated by WG.

Introduction of the Antenatal and Intrapartum CTG assessment stickers and use of prompt cards to aid timely intervention if CTG becomes abnormal.

7.4 The following themes have been identified during Quarter 2 for 2020/21 for clinical negligence:

1. Implementation of care
2. Diagnosis – Including delay in diagnosis
3. Treatment or procedure

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

The following themes have been identified during Q2 for personal injury:

A rise in the numbers of claims relating to the following:

1. Abuse/violence to staff
2. Slips/trips

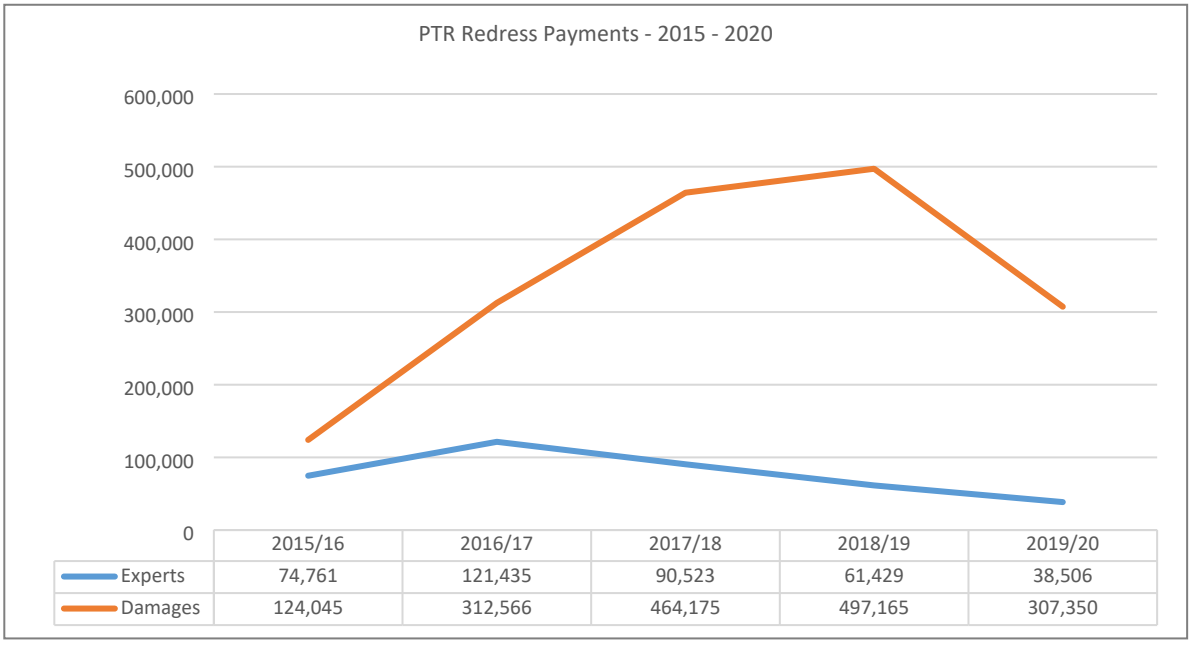
Other categories remain steady and we continue to see claims being brought for the breaches of Data Protection.

7.5 All settled claims require completion of a Learning from Events Report. This records the findings of investigation and any actions taken and is jointly developed by the claims manager and relevant clinical lead. This report must be submitted to the Welsh Risk Pool in order to reclaim costs.

7.6 The Welsh Risk Pool (WRP) arrangements require that individual NHS bodies meet the first £25,000 of any claim or loss. Thereafter the NHS bodies can submit a reimbursement request to the WRP for consideration and approval. The WRP administers the risk pooling arrangements and meets the cost of financial losses over £25,000. All Health Boards and Trusts across Wales have been advised by the Welsh Risk Pool that the annual revenue allocation from the Welsh Government is not sufficient to meet the value of forecast in year expenditure and that it is likely additional contributions will be required. BCUHB's share of the increase will be 17.07% and the current forecast predicts an additional cost of £2.56m in addition to the contribution already made, creating a significant impact on the overall financial position. The Finance Division are aware and it will be included as a potential risk until things are finalised later on in the year. National discussions are underway, however this figure succinctly reflects the increasing costs arising from liability claims across the NHS and within the Health Board.

7.7 When an investigation of a complaint or incident determines that there is, or may be, a qualifying liability, the Health Board must make an offer of redress to the patient.

Redress can include financial compensation up to the £25,000 limit allowed under the Regulations; providing a full explanation; a written apology; and providing a report on the action which has been, or will be taken to prevent similar cases arising.



	2015/16	2016/17	2017/18	2018/19	2019/20
Experts	74,761	121,435	90,523	61,429	38,506
Damages	124,045	312,566	464,175	497,165	307,350

7.8 The Regulations state that where a person is seeking Redress, the findings of the investigation must be provided within 12 months of first receipt of the concern.

During Q2 2020-21, 14 Redress cases were concluded as follows:

- offers of financial compensation as redress were accepted totalling £99,500
- 2 written apologies
- 4 proceeded to become a clinical negligence claim (including one case where the Health Board's investigation had concluded there was no qualifying liability;

one where an offer had been made but rejected, one had been advised to pursue a claim due to likely value exceeding the PTR limit, and the other was removed from redress before an offer was made.

Only 30 of these were concluded within 12 months of being received by the Health Board. However, four cases were offered the maximum allowed under Redress which is reflective of the complexity of the investigation required, and which in turn can cause delays in the process, for example when external independent opinions are required.

7.9 Redress offers accepted during this quarter were about the following issues:

- Following an incident being reported about antenatal care, the investigation concluded but for the failure to arrange an induction of labour, baby would not have been stillborn.
- Breakdown in communication between clinicians and poor documentation of planned management for patient's pregnancy.
- Elective caesarean section proceeded to massive obstetric haemorrhage.
- As a result of a chemotherapy medication error, the patient became acutely unwell and required hospital admission.
- Sensitive personal information had not been sent to the patient's correct address.
- Failure in communication pre-operatively in relation to treatment options resulted in patient receiving the incorrect surgical procedure.
- Surgery to remove bowel cancer was not performed to an acceptable standard.
- Failures in nursing care with regards to nutrition assessment, weight monitoring and risk of falls assessments.
- Delay in applying splint to fractured limb.
- Failure to identify fracture and commence appropriate treatment.

7.10 To ensure that learning and improvements are actioned at the earliest possible stage, the Welsh Risk Pool requires the Health Board to submit a Learning from Events Report (LFER) within 60 working days of a qualifying liability being determined within a complaint or incident investigation – this process includes the actions that the Health Board have put in place. The LFER will be considered by the WRP Committee who will approve reimbursement to the Health Board for the costs entailed in each redress case, once satisfied with the evidence of learning provided.

7.11 The Patient Safety and Experience Department is planning a comprehensive review of the claims and redress process and this will be conducted in co-production with divisions and other stakeholders including Legal and Risk Services from the NHS

Wales Shared Services Partnership. Due to COVID-19, this work is now planned to commence in 2021.

8 SAFETY ALERTS

8.1 The Health Board currently has six active alerts and is currently non-complaint against four alerts.

Reference	Issue Date	Deadline Date	Status	Narrative
PSN034/September 2016 Supporting the introduction of the National Safety Standards for Invasive Procedures	29/09/2016	28/09/2017	Overdue	Work to be led by the Secondary Care Medical Director in relation to the use of NatSSIPS and LocSSIPS. This is detailed further above and in the SI Report.
PSA010 /April 2020 Interruption of high flow nasal oxygen during transfer	10/04/2020	10/04/2020	Overdue	Patient Safety Team cascaded alert and are actively chasing evidence of compliance. East and West Acute sites currently outstanding.
PSN051/28 February 2020 Depleted batteries in intraosseous injectors	12/08/2020	28/08/2020	Overdue	Patient Safety Team cascaded alert and are actively chasing evidence of compliance.
PSN054-Aug2020 Risk of death from unintended administration of sodium nitrite	28/08/2020	12/11/2020	In progress	Patient Safety Team cascaded alert and are actively chasing evidence of compliance.
PSN053 /February 2020 Risk of harm to babies and children from coin/button batteries in hearing	05/11/2020	10/11/2020	In progress	An evidence review panel is arranged for 09 November 2020.

aids and other hearing devices.				
PSN030/April 2016 The safe storage of medicines: Cupboards	-	-	Not Compliant	WG Update Sept 2020: The original Notice is being revised and a final version is currently being considered for issue soon.

8.2 The Patient Safety and Experience Department are carrying out a comprehensive review of the safety alerts process and this will be conducted in co-production with divisions and other stakeholders. This work has now commenced with a new process flowchart being developed and cascaded to the safety solutions leads for review and comments. Interim measures being put in place for December 2020 with a full review and improvement plan in place for March 2021.

8.3 To support this review, an internal audit is also underway to identify issues with the current process and inform future improvements.

9 ONCE FOR WALES CONCERNS MANAGEMENT SYSTEM (OFWCMS)

9.1 There is currently no national project plan or key milestones with dates from the RLDatix Team and WRP which is impacting on the ability of the organisation to develop an implementation plan for BCUHB. The risk is shared by Health Boards across Wales and has been raised in the HoPE Network.

9.2 There are representatives on the national work streams which have recently recommenced following the initial COVID-19 challenges.

9.3 The Patient Safety and Experience Department has established a system group, which is led by the Department's Lead Manager for Transformation and Improvement.

10 CONCLUSION AND RECOMMENDATIONS

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

10.2 The QSE Committee is asked to note the report.

10.3 The QSE Committee is asked to note the focus on improving learning, reducing incidents resulting in avoidable harm and the evolving improvement of assurance in this area recognising significant work remains.

10.4 The QSE Committee is asked to receive this report and provide feedback on its evolving content and layout.

APPENDIX 2

Incident Process Review Update
October 14th 2020
Dr Kath Clarke, Head of Patient Safety

Purpose of the review:

The current incident process was designed in 2014 and over the intervening years, changes have been made to various parts of the process. For example, a *Rapid Review* process was introduced which was then replaced by a *Make it Safe* process in March 2020. Templates have changed to accommodate these changes and the current serious incident report template is no longer fit for purpose. This has meant that reports do not look professional and are no longer of a similar standard as staff attempt to make the best of what they have.

In addition, meeting the Welsh Government's performance target of closing all serious incidents within 60 days is only achieved in approximately 47% of cases.

Concerns also exist regarding assurance of learning across the organisation.

Reviewing the process to rectify the issues already identified whilst taking into account any barriers to timely closure became a key priority for the Patient Safety and experience Department.

Staff engagement:

The incident process review was set to commence in March 2020. Due to onset of the COVID-19 pandemic the planned engagement sessions with staff, via workshops, had to be cancelled. The review was delayed until the Health Board was able to return to a more normal working pattern.

The review recommenced early August 2020. Engagement with staff was completed via a questionnaire which was sent to Directors of Nursing, governance leads and key stakeholders with a request to share widely across their teams. Collective responses were submitted from governance teams with some additional individual responses from ward sisters and consultants. Analysis of the returned questionnaires was completed mid-September and the findings from this have been used to inform a redesign of the current process.

Findings:

In brief, the findings are outlined below:

- Staff liked the "Make it Safe" process but want clarity about the detail required within the documentation.
- Staff supported the introduction of a redress panel where breach of duty and qualifying liability would be determined by those with the relevant clinical and legal expertise.

- Staff identified that sharing lessons learned required improvement
- Staff, without exception, stated that speaking with patients and/or families at the time of an incident rests with the clinical teams.

It was noted, however, that no one suggested changing the current process and focused on keeping what worked rather than radically changing or improvements.

Review:

To date, two workshops have been held. The purpose of which was to map the process, consider barriers to timely closure of incidents and to improve assurance at Health Board level. The findings from the questionnaire were also considered.

A high level draft incident process has been agreed and the detail is currently being developed. The review is currently on target to be completed by the end of the year for launch in early January 2021.

Further information will be shared with the Committee as the plans developed – however, the early thinking is as follows:

- Introduction of a daily, corporate-led oversight and decision making panel for potential serious incidents;
- Make it Safe Reviews to be focused on two parts: immediate make it safe actions and 72 hour actions from the service with new forms being built into Datix;
- Corporate commissioning of serious incident reviews;
- Introduction of a corporate-led serious incident approval panel;
- Tracking of serious incident actions through Datix;
- Introduction of a separate redress panel – removing the decision on qualifying liability out of the investigation and learning process;
- Development of a central list of investigators underpinned by a skills passport consisting of key investigation skills beyond root cause analysis;
- New templates and documentation underpinned by a wider range of methodologies;
- Early adoption of the duty of candour – involvement of patients and relatives in the investigation process;
- Professionalising the role of investigating officer, removing the role of chair and review meeting, allowing a greater range of methodologies to be used appropriate to the circumstances and introducing a new senior reviewer role to support investigating officers;
- Development of a lessons learned library including written, audio and video formats for sharing of learning.

APPENDIX 3

Scrutiny	Emma Hosking, Hospital Medical Director	**National Drives**	Risk and Safety Management Fundamentals of Care. NMC Code of Conduct
Action Plan Lead(s)	Roger Haslett, Clinical Director, Surgery Angela Jones, Theatre Manager Mared Owen, Consultant Pathologist Helen Hughes, Head of Quality and Governance, Radiology		
Strategic theme / Priority Addressed	Making it safe, better, sound, work, happen.		
Updated	12/10/20		

PROBLEM: Referral of another consultant was outside of normal process

Findings	Actions	Leads	By	RAG	Comments/update
The surgery was indicated within the context of the patient's life, i.e. the patient's inability to manage her baby and ongoing pain, the decision to expedite was reasonable. Although the referral was outside of normal process, it was not an unreasonable response from the Urologist.	Clarification is required for specific BCUHB guidance to assist with such referrals as a 'favour to a colleague'	RH	5/06/20		The process for referral should follow the standard process as for any other referral i.e. via the GP.
	All Consultant email to be sent out with clarification of the correct process.	EJH	15/07/20		

PROBLEM: No documentation in the patient's notes from speciality surgeons who attended					
Findings	**Action**	**Leads**	**By**	**RAG**	**Comments/updates**
There is no documentation in the records from either the vascular or the general surgeon nor is there a record of the discussions that took place. Surgeons who join operations must write their findings/actions in the notes contemporaneously.	Surgical Clinical Director to discuss with surgeons involved the necessity to complete adequate operative notes.	RH	16/06/20		
	Clinical leads/vascular clinical director to raise professional responsibility of necessity to complete adequate operative notes at Clinical Governance Meeting	RM/KE/SS	16/06/20		
	Prompt on debrief document to be added	AJ	30/07/20		Debrief document updated – to be circulated and in use by November 1st 2020
PROBLEM: No incident reported on datix regarding the complications of surgery and activation of the massive haemorrhage protocol.					
Findings	**Actions**	**Leads**	**By**	**RAG**	**Comments/update**
Unexpected blood loss or perioperative complications not always reported on datix. The reporting often defaults to theatre staff and not the operating surgeon or anaesthetist.	Surgical Clinical Director to discuss with surgeons involved their responsibility for reporting of incidents on datix	RH	16/06/20		
	Clinical Leads/ Vascular Clinical Director to raise professional responsibility for reporting of incidents at Clinical Governance Meeting	RM/KE/SS	16/06/20		

	Prompt on debrief to discuss any unexpected events and the need to report on datix for investigation and learning.	AJ	30/07/20		Debrief document updated – to be circulated and in use by November 1st 2020. Lessons learnt formally shared from Datix Incidents at safety brief and governance meetings.
PROBLEM: Discrepancy between surgeons about patient's anatomy					
Findings	**Actions**	**Leads**	**By**	**RAG**	**Comments/update**
General surgeon's queries were not listened to and recollection of events of those present differed in their focus.	Clinical Director to contact the Executive patient safety team to consider arranging a human factors external agency to facilitate a review of the scenario for learning and building of relationships.	RH	May 2020		RH has contacted MJ and is awaiting a reply.
	Once agreed, meeting to be facilitated with those involved.	RH	TBC		RH contacted MJ. Human factors faculty being recruited.
PROBLEM: Post-operative debrief not undertaken to a satisfactory standard.					
Findings	**Actions**	**Leads**	**By**	**RAG**	**Comments/update**
Despite the perioperative complications, these were not documented on the debrief. It was agreed that the document was not fit for purpose.	Debrief document to be reviewed to include discussion and reporting of any unexpected events and the need for speciality medical staff to write in the medical notes.	AJ	30/07/20		Debrief document updated – to be circulated and in use by November 1st 2020.
	Theatre staff, anaesthetists and surgeons to undergo education of the debrief process.	AJ/AF/RH	30/07/20		Awareness raised with all Theatre staff and is ongoing with new starters, and refresh training on Audit days. Datix training took place on 16/6/20 & 06/08/20 for Theatre staff.

	Quality audit of the debrief process to be undertaken and feedback given on any improvements required.	AJ	30/09/20		Monthly Audits take place – any Lessons Learnt are shared and Rapid Reviews take place if needed
PROBLEM: Suspicion about the nature of the specimen not followed through					
Findings	**Actions**	**Leads**	**By**	**RAG**	**Comments/update**
Pathology registrar examining a now formalin fixed and distorted specimen thought it looked 'odd'. Escalated to consultant pathologist but in the context of the clinical information received no further enquiry made and continued as routine specimen.	Review of the process within histopathology when there are concerns as to the nature of a specimen, to include documentation of actions taken	MO	30/07/20		Discussed in pathology and the specimen would be appropriately escalated and staff notes as to the outcome of further comments added within the body of the pathology report.

PROBLEM: No incident reported by pathology when it was identified that the specimen was not a kidney.					
Findings	**Actions**	**Leads**	**By**	**RAG**	**Comments/update**
Once the specimen was examined in pathology and identified substantially consisting of gallbladder, cystic duct and a large lymph node, this was reported to the Consultant. However, no incident was reported that the specimen did not match the	Pathologists to be informed of the requirement to report as an incident any specimen that does not match what is stated on the label.	MO	30/07/20		Discussed in pathology. In the incidence where the handled specimen is a resection of a visceral organ and a different organ is received than that which is stated on the request form then this will be DATIX'd.

label of the specimen received.					
PROBLEM: No incident reported by radiology when it was noted that the kidney was still in situ.					
Findings	**Actions**	**Leads**	**By**	**RAG**	**Comments/update**
Clinical indication on the request stated recent right nephrectomy. The findings identified the right kidney remained in situ and although discussed with Consultant surgeon, was not reported as an incident.	Radiologists to be informed of the requirement to report as an incident any findings that do not match the clinical indication.	HH	30/07/20		Incident discussed in Radiology meetings
PROBLEM: Actions required within 24 hours of discharge from ITU not undertaken.					
Findings	**Actions**	**Leads**	**By**	**RAG**	**Comments/update**
On discharge of the patient from ICU to the Ward, actions required within 24 hours of ICU discharge included liver function tests as it was noted that the ALT (837) and bilirubin (43) were raised. This action was never undertaken and liver function not rechecked prior to discharge home.	Doctors to be reminded at next clinical governance meeting of the necessity to complete actions requested by ITU discharging consultant.	RM/KE/SS	16/06/20		

PROBLEM: Due to complexity of the operation, there should have been a Consultant review prior to discharge.					
Findings	**Actions**	**Leads**	**By**	**RAG**	**Comments/update**
Consultant had reviewed the patient on 25/11/2019 but not again prior to discharge. It is documented that pain control was still an issue at discharge on 28/11/2019 but there was open access to the ward if required.	Clinical Director to discus with Consultant the need for appropriate review of post operative patients prior to discharge.	RH	16/06/20		
PROBLEM: No firm plan across BCUHB to deal with unexpected intraoperative vascular bleeding.					
Findings	**Actions**	**Leads**	**By**	**RAG**	**Comments/update**
When vascular assistance was required this was supported by a Consultant who was preparing for his own emergency case. Expertise for these	Vascular network to ensure theatre teams, on all sites, are made aware of the vascular support that is available and how to access.	SS/JG	31/07/20		YGC aware of vascular support on site but need confirmation from YG and WMH. Raised with vascular network manager

incidences in a timely manner across BCUHB is very difficult particularly where there is no vascular service on site.				

Action Plan completed By:	**Action Plan Leads and Titles:**
Roger Haslett, Clinical Director	Roger Haslett, Clinical Director, Surgery RH
Tracey Radcliffe, Governance Lead Nurse	Angela Jones, Theatre Manager AJ
	Kingsley Ekwueme, Clinical Lead Urology KE
	Richard Morgan, Clinical Lead Surgery, RM
	Soroush Sohrabi, Clinical Director Vascular Surgery SS
	Mared Owen, Consultant Pathologist MO
	Helen Hughes Ekwueme, Head of Quality and Governance, Radiology HH
	Kate Clark, Secondary Care medical Director KC

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 3rd November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Serious Incident Report – August and September 2020
Cyfarwyddwr Cyfrifol: Responsible Director:	Debra Hickman, Acting Executive Director of Nursing and Midwifery
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 the responsible Director and Executive Director
Atodiadau Appendices:	1. Serious Incident Report – August and September 2020

Argymhelliad / Recommendation:

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

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

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.

Appendix 1

Serious Incident Report
August and September 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 From Monday 23 March 2020 to 13 August 2020, as part of interim COVID-19 contingency measures, only the following incidents were formally reporting to the Welsh Government under the serious incident framework (following a temporary revision to 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 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.

1.4 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 within 24 hours of the incident. 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, Welsh Government will automatically close the incident after 3 days and no further correspondence with them 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 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.

1.5 In September 2020, the NHS Wales Delivery Unit took on the responsibility for oversight of serious incidents on behalf of Welsh Government in anticipation of the NHS Wales Executive being formed. The Corporate Patient Safety and Experience Department has met with the NHS Wales Delivery Unit and will continue its strong working relationship with them.

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

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

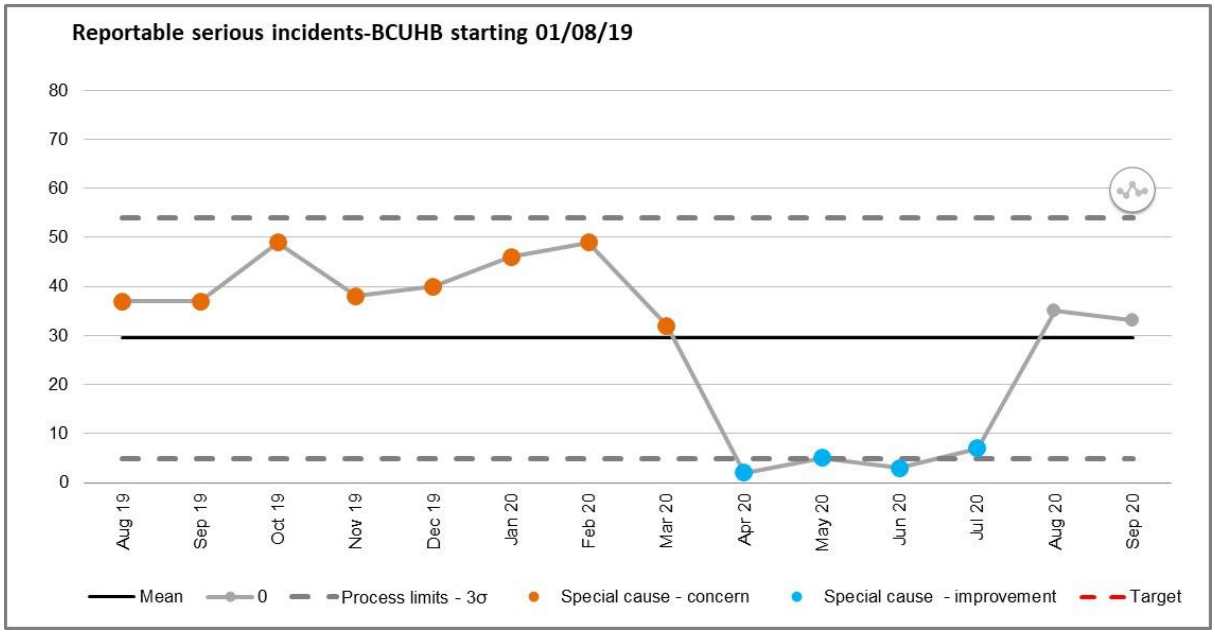
- A run of seven or more values showing continuous increase or decrease is a trend – this is indicated by coloured dots.
- A target (if applicable) is indicated by a red dotted line.

1.8 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, 68 serious incidents were reported and 11 sensitive issue notifications were submitted.



2.2 At the time of writing, 73 serious incidents remain open with Welsh Government of which 24 are overdue (down from 36 in the last report). Of these, the predominance of overdue incidents relate to Central Area (6), Corporate (5) and East Area (6). All divisions have seen and continue to see a reduction in overdue incidents. A small number of incidents are overdue by twelve months (6) and these relate to matters subject to police investigation. A number (6) are overdue by 6-12 months and a slightly larger number (7) are overdue by 3-6 months. There has been significant reduction over the last 12 months.

2.3 Overall closure rate within timeframe for the year is around 48%, which has dropped from previously high levels of compliance (remaining behind the national target of 75%).

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:

Mental Health and Learning Disability Division

- Patient on 1:1 observations attempted self-injury by tying earphones around their neck.
- Death by suicide of a patient open to CMHT.
- 11 unexpected deaths of patients open to community services including substance misuse services (cause unknown).

No immediate themes or hot spots have been identified from these 11 unexpected deaths. Investigations or mortality reviews are ongoing – a number are already confirmed as natural causes. It is important to note, in-line with the national Serious Incident Policy, all unexpected mental health deaths are reported as a serious incident within 24 hours of being made aware of the death regardless of circumstances.

Secondary Care Division

- COVID-19 outbreak at YGC.
- 18 avoidable pressure ulcers.
- 6 falls resulting in severe harm.

Whilst an increasing number of falls and HAPUs are noted, due to the impact of COVID-19 on reporting and activity, it is difficult to draw any immediate conclusions at this time. It has been identified that YGC had not been submitting SI Notification Forms as required. Following rapid investigation, it was identified that since April 2019, 17 notifications were not submitted and of these 4 All-Wales Review Tools were not competed or uploaded to the Datix system. A full investigation is underway led by the Associate Director of Quality Assurance who has held discussions with Welsh Government, Healthcare Inspectorate Wales and the NHS Wales Delivery Unit to provide assurance. The report will be completed by early November 2020. Immediate strengthening of pressure ulcer scrutiny on the site has taken place.

Area Divisions

- 7 avoidable pressure ulcers across community and community hospital services.

No immediate themes or hot spots have been identified from these 7 incidents; investigations remain underway.

4. NEVER EVENTS

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

- YGC - Occurred in ICU where insertion of a mid-line has inadvertently led to a wire being retained. This was only recognised later that day following a CT scan. This particular midline insertion pack contains a second wire, one of the wires is already inside the line itself. It is unclear from the instructions why this is in the pack. In this incident the clinician has not read the instructions, assumed seeing the second wire (the only one visible without close inspection), the technique for insertion was the same as for lines they had previously used, and used a standard approach. The wire has since been removed by interventional radiology and the patient has not come to any long term harm beyond discomfort from the additional procedure. The clinician who performed the midline procedure and ICU consultant informed the patient of the incident, explained what had happened and apologised. The incident has been reported to Welsh Government as a Serious Incident/Never Event and the Medicines and Healthcare Products Regulatory Agency (MHRA) as a Yellow Card safety incident given the unclear nature of the packaging.

4.2 All internal investigations into Never Events are complete. An external expert review into a Never Event in urology remains underway and we await the final report; the incident therefore remains open. The independent expert undertaking this review requested and was provided additional information in October 2020 to help finalise their report.

4.3 In total, four Never Events have been reported so far in 2020/21 (compared to six in the full year of 2019/20).

5. LEARNING FROM SI REVIEWS

5.1 The serious incident process was amended in response to Welsh Government changes to PTR and the current COVID 19 pandemic. The rapid review was 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. This process has been continued post the return to normal reporting.

5.2 A number of recurring issues have been identified in relation to surgical incidents and Never Events as outlined above. The failure to have or use a LocSSIPs is a theme. The Quality and Safety Group prior to its transition into the new Patient Safety and Quality Group has requested a detailed assurance plan from the Secondary Care Division to address these concerns. This was expected in October 2020 but due to changes in key personnel has been delayed; the issue has been escalated to the Secondary Care Medical Director.

5.3 In response to the increasing number of falls and HAPUs, the Acting Executive Director of Nursing and Midwifery has re-commenced the strategic falls and HAPU groups. Additionally, the Associate Director of Quality Assurance has requested progress updates on the work and outcomes of both quality improvement collaborative projects.

5.4 Since the start of the financial year, seven Never Events have been closed within the Health Board with the following key learning/themes identified:

- Lack of Local Safety Standards for Invasive Procedures (LocSSIP);
- Failure to follow correct procedure or check;
- Gaps in the availability of effective human factors training.

As mentioned above, an improvement plan is awaited regarding the first two points. Work has also been underway in Secondary Care to improve PICC line safety and there are plans to take this forward regarding mid line safety. A working group is also now underway to take forward human factors training and two cohorts of clinical staff have recently been trained.

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

5 CONCLUSION AND RECOMMENDATIONS

5.3 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 longer term trend data is included to allow for period on period comparison in the last year. Thematic analysis is included in the quarterly Patient Safety Report.

5.4 The QSE Committee is asked to receive the report for assurance.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 3rd November 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Patient & Carer Experience Report – Q2 2020/21
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Debra Hickman, Acting Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Matthew Joyes, Acting Associate Director of Quality Assurance and Assistant Director of Patient Safety and Experience Carolyn Owen, Head of Patient & Carer Experience Jane Owen, Patient Experience and Carer Engagement Lead Yvonne Williams, Complaints Lead (Quality and Learning) Sian Youssef, Complaints Lead (Operational)
Craffu blaenorol: **Prior Scrutiny:**	Review by the responsible directors
Atodiadau **Appendices:**	1. Complaints Process Review Update 2. Annual Report PSOW Letter 3. Accessible Healthcare Six Monthly Report 4. Patient Experience Delivery Framework Six Monthly Report

Argymhelliad / Recommendation:

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

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

Sefyllfa / Situation:

The Quality, Safety and Experience Committee is the delegated Health Board committee with responsibility for seeking assurance on patient and carer experience. This report provides the committee with information and analysis on significant patient and carer experience issues arising during the quarter under review, alongside longer-term trend data, and information on the improvements underway.

Cefndir / Background:

This new format report is designed to offer improved information and analysis in relation to patient and carer experience, in order to improve the assurance received by the committee. The period under review is primarily July 2020 to September 2020 (inclusive); however, longer-term data for the previous 27 months (allowing period on period comparison over two years) has been included in the graphs to provide a better longitudinal view and to enable the use of statistical process control (SPC) charts.

Asesiad / Assessment & Analysis

Assessment and analysis is included within the report including a breakdown of complaints, details of the most common type of reported patient and carer experience feedback and a high-level summary of identified learning.

Patient & Carer Experience Report Q2 2020/21

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

1. INTRODUCTION

1.1 Patient and carer experience is what receiving care feels like for the patient, their family and carers. It is a key element of quality, alongside providing safe care and clinically effective care.

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

1.3 The Health Board has responsibilities for improving patient and experience under the following key statutory responsibilities and policy frameworks;

- NHS Delivery Framework 2019/2020 (NHS Wales, April 2019);
- Listening and Learning from Feedback – A Framework for Assuring Service User Experience (Welsh Government, 2015);
- Healthcare Standards for Wales (Welsh Government, 2015)
- Wellbeing of Future Generations (Wales) Act 2014;
- Social Services and Wellbeing (Wales) Act 2014;
- Parliamentary Review of Health & Social Care in Wales (Welsh Assembly, 2018)

1.4 The Health Board is committed to engaging with the public and to listen and learn as part of the process of driving continuous improvement in everything we do. The current Strategy 2019-2022 sets out a number of initiatives designed to provide the Board with a holistic view of how our services are experienced by those who use them. Feedback in all its forms is critical to the design of our many and varied services, and indeed how our staff deliver them. Only by understanding how people experience our services can we further develop and improve what we do. The Patient Safety and Patient and Carer Experience Strategies 2021-2024 will replace the above in April 2021, in line with the Health and Social Care Quality and Engagement Wales Act published in June 2020, to support continuous quality improvement.

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

- A data point falling outside a process limit (upper or lower) indicates something unexpected has happened as 99% of data should fall within the process limits – the process limits are indicted by dotted grey lines.
- Two out of three data points falling near a process limit (upper or lower) represents a possible change that should not result from natural variation in the system – the process limits are indicted by dotted grey lines.

- A run of seven or more values above or below the average (mean) line represents a shift that should not result from natural variation in the system – this is indicated by coloured dots.
- A run of seven or more values showing continuous increase or decrease is a trend – this is indicated by coloured dots.
- A target (if applicable) is indicated by a red dotted line.

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

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

2. COMPLAINTS

2.1 The Health Board (BCUHB) recognises that patient and carer experience and feedback via comments and complaints can be a valuable source of information in maintaining and improving standards of care. It is a key indicator of quality, the aim is to learn from these and use them positively to improve patient and carer safety and the quality of care delivered.

2.2 The Patient and Carer Experience Team aims to provide an effective process that ensures the voice of the patient, carer and member of the public is heard. Following the listening exercises completed earlier in 2020, it is clear the current process is in need of improvement and work is underway to make changes as detailed later in the report. Ongoing evaluation of the changes being made will be undertaken by gaining direct feedback from people involved in the process (such as through surveys and stories). Through timely review, consideration and action of performance against standards for management of complaints and concerns, an increased awareness and understanding can highlight areas for attention and to improve. This report reflects our approach and why listening and learning makes such a difference.

2.3 Complaint handling in NHS Wales is governed nationally by a set of rules: The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. These regulations known as 'Putting Things Right' (PTR), set out arrangements by which each Welsh health organisation manages their complaints process.

2.4 Complaints are currently reported as 'on the spots' (OTS) or those managed through PTR (previously known as formal complaints). Complaints raised at the point of service delivery, and resolved satisfactorily within an agreed timeframe are referred to as OTS/

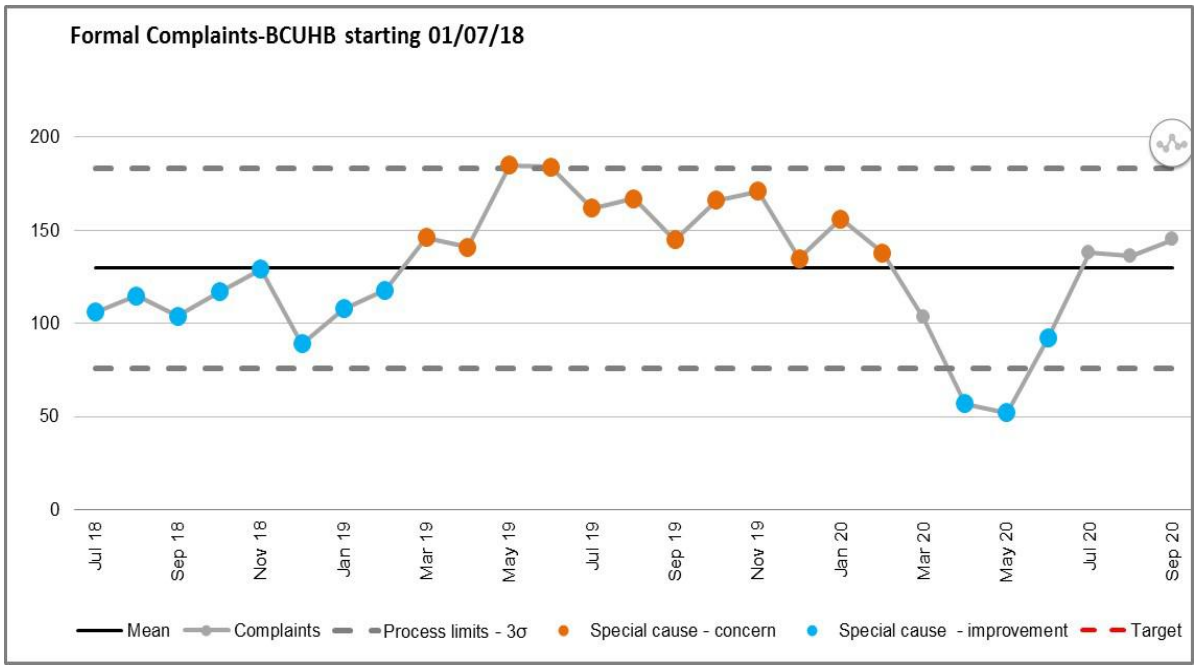
'Early Resolution'. These complaints are dealt with outside of the PTR process for complaints, providing they can be resolved within 2 working days of receipt.

2.5 The type of complaint and subsequent approach for management is determined at the point in which they are received into the Health Board (facilitated through the triage or review process). The Patient and Carer Experience Team (Complaints), in accordance with PTR regulations and Health Board policy and procedure, acknowledges the complaint.

2.6 The Patient Safety and Experience Department is at the time of this report, undertaking a comprehensive review of the complaints process. This review has been conducted in co-production with other stakeholders, including Community Health Council (CHC) and Public Services Ombudsman for Wales (PSOW). This work commenced in February 2020 and the ongoing work will include a review of the redress process. Due to the COVID-19 pandemic, this work was paused in March and has recently re-commenced.

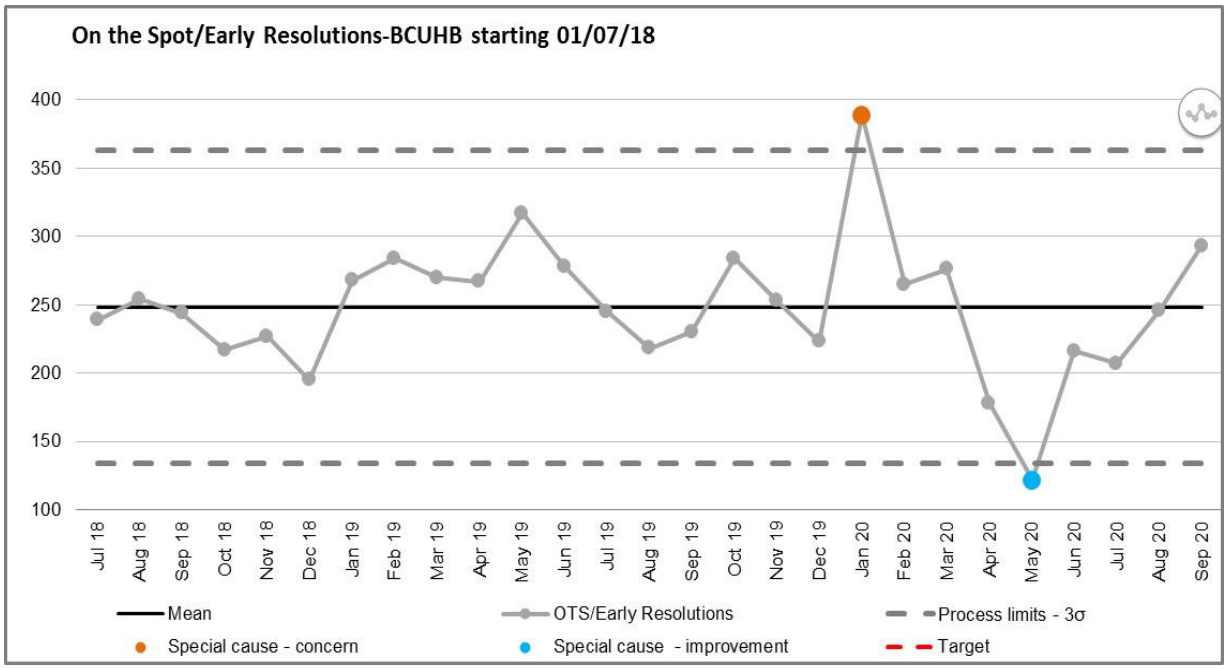
2.7 An independent expert review of the BCUHB complaint-handling proposal was commissioned following review of the complaints process. The new policy, procedures and guidance is currently in the process of proceeding through the approval process. The proposed procedural approach for complaints is included with this report (Appendix 1).

2.8 Quarter 2 2020/2021 saw a continued upward trend in the number of complaints received. In total, 419 complaints (managed under PTR) were received for the period:



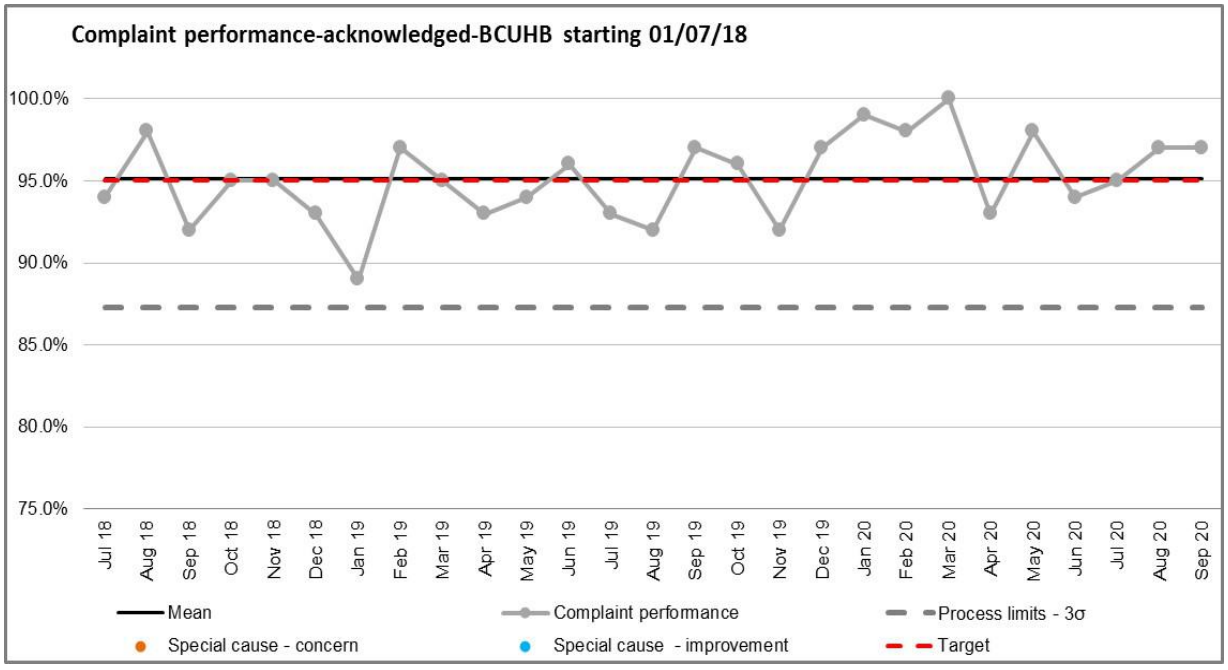
2.9 A further 746 OTS/Early Resolution cases were received for the same period, 89 of which were unresolved and transferred to be managed under PTR. This followed a significant drop in Quarter 1, which was associated with the initial wave of the COVID-19 pandemic. The increase shows the number of complaints managed under PTR

returning to previous levels, whilst the OTS/Early Resolution rise is slower to reach pre-COVID numbers

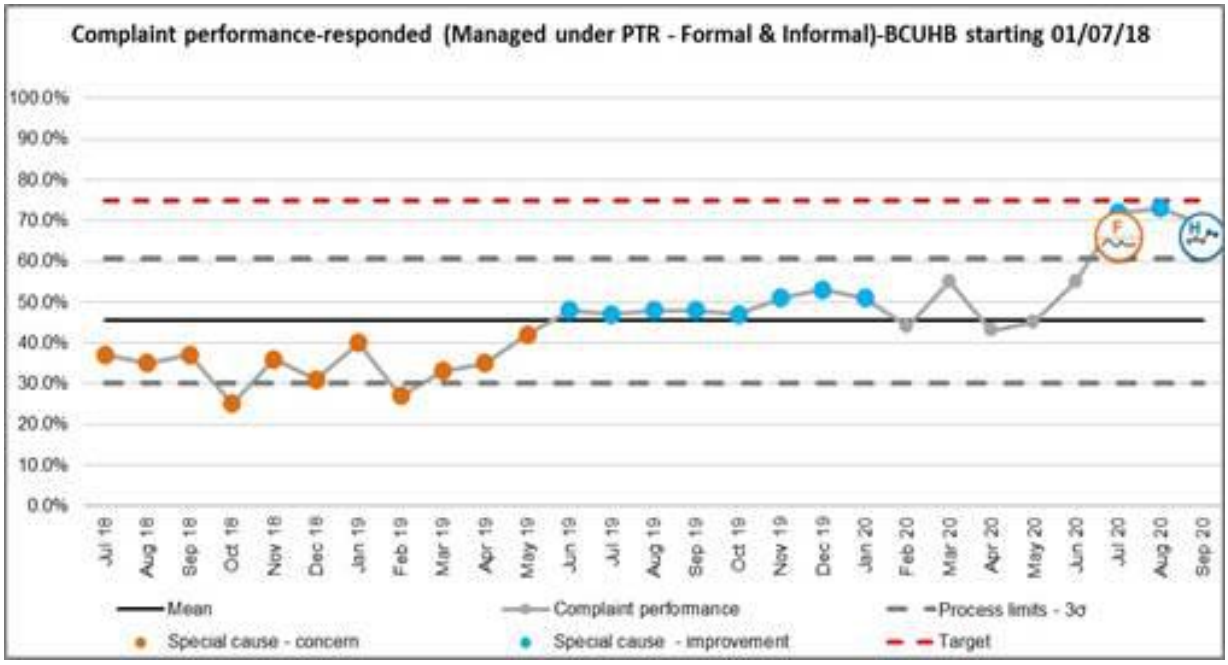


3. COMPLAINTS PERFORMANCE

3.1 During Quarter 2 2020/2021, an average 96% of complaints were acknowledged within 2 working days (against a target of 95%). Further work is required to ensure all complaints are acknowledged within the 2-day timescales.



3.2 The graph below demonstrates that on average, 71% of complaints closed within 30 working days against an all Wales target of 75%. Some improvement in the response rate is noted, however, further work is required to facilitate further improvement. The proposed new complaints process will reinforce the process and timescales required to meet performance standards for the management of complaints.



3.3 At the time of writing, 1st October 2020, 240 complaints were open of which 101 complaints were overdue 30 days (42%). Reasons for delay in achieving the 30-day target include awaiting consent, investigation more complex or involved than originally anticipated, delays in receipt of information requested.

3.4 51 of the overdue complaints related to Secondary Care (21 West, 11 Central, and 19 East). Other divisions with a number of overdue complaints includes Central Area (23), East Area (8), Women's, and Maternity (9).

3.5 The impact from delays in receiving consent (in order to comply with GDPR) prior to commencing an investigation has previously been identified as a contributory factor for performance being below target. This has been explored as part of the complaints process review and updated guidance will indicate investigations should commence immediately with the absence of consent only delaying any sharing of information.

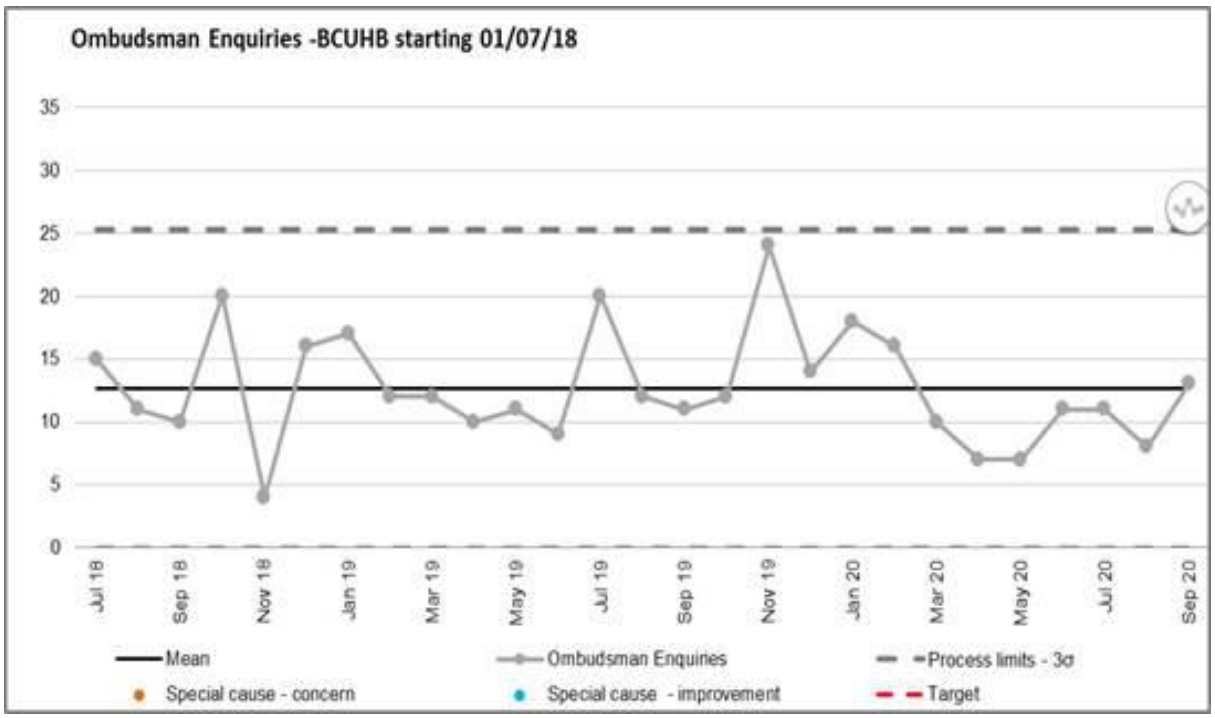
4. OMBUDSMAN

4.1 The Public Services Ombudsman of Wales (PSOW) has legal powers to look into complaints about public services and independent care providers in Wales.

4.2 During the quarter under review, 32 Ombudsman enquiries were received (compared to 25 in the prior comparable period).

4.3 The annual Ombudsman letter is enclosed at Appendix 2. A response letter is in development.

4.4 Quarterly meetings are now re-commencing with the Ombudsman local liaison officer.



4.5 The Ombudsman's office contacted the Health Board during August 2020 stating that following the COVID-19 pandemic their office was reverting to their usual way of working and that they would no longer be making contact with relevant bodies before starting an investigation, issuing a draft decision or a final report. The decision was taken on the basis that the pandemic appeared to be easing across the majority of Wales.

4.6 In June 2020, the Ombudsman notified the Health Board that they were now able to fully investigate new complaints. By the end of June 2020, the backlog of investigation start letters (9) had been received.

4.7 During the quarter under review the Health Board have received notification that a further 10 new complaints are being investigated by the Ombudsman. There are no immediate themes or hot spots identified although from initial review although it is of note a number relate to possible COVID-19 issues such as discharge arrangements.

5. COMMUNITY HEALTH COUNCIL

5.1 As is the case with regulators, North Wales Community Health Council (NWCHC) suspended their review programme and routine inspections during the COVID-19 pandemic.

5.2 Actions following site visits earlier in the year continue to be progressed to completion, with two areas for action outstanding due to staff changes.

5.3 During Quarter 2 2020/2021, 19 enquiries were received through the dedicated email address. Key themes from the enquiries received, relate to communication and access to services, particularly Dentistry.

6. PATIENT FEEDBACK

6.1 Patient and carer feedback supports the health board to understand the feelings and views of patients, carers and service users, and provides a learning platform for service improvements. To ensure all areas are compliant with capturing 20% experience feedback, which is in compliance with the Patient and Carer Experience Strategy 2019-2020, the Patient and Carer Experience Team continue to support all services ensuring every opportunity is taken to capture feedback from a minimum 1 in 5 patients and carers. All areas must ensure a minimum of 20% return rate in their patient and carer feedback in order to assist with promoting positive change. The aim is to improve quarter on quarter and year on year feedback rates.

6.2 The View Point System contract ended in March 2020. In the interim period, the Patient and Carer Experience Team have continued to gather feedback through various means, including paper questionnaires, comments cards, increased media visibility, and a bilingual PALS phone line and inbox. We are also in the final stages of adding a fully accessible questionnaire to the intranet. There has been a recent announcement that a provider for a 'Once for Wales real-time feedback system' has been agreed. BCUHB continue to have discussions with Welsh Risk Pool prior to launch. Although, due to Covid-19, the ability to disseminate and return the feedback has been challenging, procedures are in place to engage with Wards and Departments to re-establish relationships.

6.3 All feedback, both positive and negative is valued. Perhaps as importantly as the feedback itself, is what happens after and how this is followed up and shared with services. The value of feedback is unquestionable, in that it can guide, and drive service delivery improvement, and conversely boost staff morale. However, whilst undeniably, the need for service user feedback remains paramount, the ongoing COVID-19 restrictions remain challenging to this being carried out. The Health Board has had to think creatively, an example of this being the launch of virtual Care2Share throughout all areas of BCUHB from mid-October. This process will involve services gaining written consent from service users to allow contact by a member of the Patient and Carer Experience Team following discharge or attendance at clinics etc. This will allow the Health Board to gather feedback, comments, patient and carer stories, which we believe will provide a rich source of information, which in turn will be fed back to service leads, to highlight both good practice, and service delivery problems.

6.4 One such example of positive feedback is the 'Friday Feel-good Comment of the Week' which is selected by the Patient and Carer Experience Team. A newly launched certificate is presented to the individual/department, and then publicised on the Health Board's social media pages. The ability to utilise patient and carer feedback to increase staff motivation, well-being and job satisfaction is an extremely important consideration for BCUHB.

An example of a Feel Good Friday received in Quarter 2:

'This is a long overdue thank you to everyone at Ysbyty Gwynedd for the outstanding care that my mother received-she could not have had better care. Welsh speaking

made her feel especially at ease. We continue to live through extraordinarily difficult times. Please know that your skills, your care and all the little kindnesses matter more than words can express. Thank you all.'

6.5 There are always areas in care, where improvements can be made, in relation to patient and carer feedback during the quarter under review, the following comments has been received:

No of Positive & Negative Sub-Themes				
	BCUHB Central	BCUHB East	BCUHB West	Total
Positive	**56**	**31**	**13**	**100**
Basic Nursing Care - Positive	43	15	1	59
Quality of Care - Positive	5	1	8	14
Staff Attitude and Approach - Positive	2	3	4	9
Assisting Service Users - Positive	3	3		6
Coordination of Care – Positive		4		4
Understanding and Involvement in Care - Positive	1	1		2
PALS Information (FAQ) - Positive	1	1		2
Communication - Positive	1	1		2
Third Party Signposting - Positive		1		1
Communicating Sensory Loss - Positive		1		1
Negative	**1**	**26**		**27**
Communication - Negative		12		12
General Facilities - Negative		3		3
Assisting Service Users - Negative		2		2
Basic Nursing Care - Negative		2		2
Infection Control - Negative		2		2
Coordination of Care – Negative		2		2
Wayfinding - Negative	1			1
Staff Attitude and Approach - Negative		1		1
Communicating Sensory Loss - Negative		1		1
Nutrition - Negative		1		1
Total	**57**	**57**	**13**	**127**

6.6 The Patient Advice and Liaison Service (PALS) across BCUHB actively listen, learn and act on feedback from patient, carers, visitors and staff. A variety of methods are used by PALS officers to listen, support and help, including early resolutions via arbitration, liaison and 'you said we did.' All themes, trends, and learning are shared to the hospital/area management teams via weekly reports, and local Quality and Safety Groups. Moving forward the Patient and Carer Experience Leads will be seeking assurance via a more formal tool that actions have been taken to improve the service issues raised, a possible tool being the Datix system.

6.7 PALS feedback has been collected within the last quarter, and passed on to the relevant services so that changes can be made.

No of Positive & Negative Sub-Themes				
	BCUHB Central	BCUHB East	BCUHB West	Total
Positive	**20**	**37**	**38**	**95**
Assisting Service Users - Positive	6	20	18	44
Communication - Positive	3	4	7	14
Understanding and Involvement in Care - Positive	4		5	9
PALS Information (FAQ) - Positive	4	2	2	8
Coordination of Care – Positive		5	1	6
Third Party Signposting - Positive	1	1	3	5
Basic Nursing Care - Positive	1	2		3
Quality of Care - Positive	1		1	2
Wayfinding - Positive		1		1
Infection Control - Positive		1		1
Staff Attitude and Approach - Positive		1		1
Parking - Positive			1	1
Negative	**171**	**170**	**111**	**452**
Communication - Negative	57	61	57	175
Coordination of Care – Negative	34	26	11	71
Waiting Times - Negative	20	9	14	43
Understanding and Involvement in Care - Negative	29	5	8	42
Assisting Service Users - Negative	7	18	2	27
Infection Control - Negative	8	17	1	26
Quality of Care - Negative	4	6	11	21
General Facilities - Negative	1	12	5	18
Basic Nursing Care - Negative	6	6	2	14
Staff Attitude and Approach - Negative	2	7		9
Communicating Sensory Loss - Negative	2	1		3
Parking - Negative		1		1
Nutrition - Negative		1		1
Third Party Signposting - Negative	1			1
	2	2	4	8
(blank)	2	2	4	8
Total	**193**	**209**	**153**	**555**

7. PATIENT STORIES

7.1 Stories told by individuals from their own perspective in a health care setting can provide an opportunity to understand their lived experience of the care received. This is a powerful method of collecting patient and carer feedback and can identify opportunities for service improvement. The improvement work underway so strengthen patient and carer stories is progressing well, with voice recorders being purchased, and a member of the PALS team receiving extensive training to record, and edit such audio material. This will be cascaded to the rest of the team. There are also ongoing discussions with a local production company, with training being requisitioned to capture video stories, and the equipment we will require to do so.

7.2 The Patient and Carer Experience Team are also co-working with other teams from an All Wales Perspective to refine and improve how patient stories are managed.

8. PATIENT & CARERS EXPERIENCE BEREAVEMENT AND LIAISON SUPPORT

8.1 During the continuing COVID-19 pandemic the volume of families that Bereavement Officers will be supporting will increase. To support this service, the Patient and Carer Experience Team, in partnership with the existing services, developed a ‘bereavement and liaison support service,’ its aim being to listen, offer advice and support, liaise with

staff and when appropriate contact other organisations to facilitate additional assistance.

8.2 Links have been established within BCUHB along with a mapping document, outlining the roles and responsibilities for Pathology, Bereavement Team, Chaplaincy and volunteers. This will form an extensive support pathway for bereaved families.

8.3 Referral forms have been developed for the Chaplaincy and volunteer services within the Health Board and are now in place.

8.4 Partnerships are continuing to form with third sector agencies such as local carer organisations and bereavement support charities; the partnerships formed will enable us to signpost effectively to the relevant agency to provide additional continued support for our service users.

8.5 A 'Here to Help With Your Bereavement' booklet has been revised to include information surrounding COVID-19 and is now available to read online and is accessible in British Sign Language. Thanks to funding through Awyr Las, hard copy bookets are also available.

8.6 Following a successful funding application to Awyr Las, the Patient and Carer Experience Team are currently scoping reflective gardens across all three acute sites. There are plans to link in with local community groups to provide art work, and environmental ideas. Exact development and launch dates are being considered at the present time, taking into account the evolving pandemic.

8.7 The Head of Patient and Carer Experience is now co-chair of the North Wales Bereavement Quality Group; this will enhance the cohesion of the services which we as a whole offer the bereaved.

8.8 It is vital that training and support is offered to those who are supporting the bereaved. Training has been sourced, the chosen provider being the Samaritans. This organisation will provide virtual training (recognising travel restrictions and social distancing requirements), with the first session planned for the end of October 2020.

8.9 The role of the new extended bereavement service is continuing to develop, and evolve in conjunction with service needs, including an increased on line presence. During the second quarter, there were 426 page views, demonstrating the power of virtual assistance.

9. LETTERS TO LOVED ONES

9.1 During the COVID-19, visitors to hospitals have been restricted; Letters to Loved Ones has been developed to maintain communication between loved ones and patients.

9.2 A message can be sent via email or passed over the phone that message will then be delivered to the patient on the wards. This remains a popular service, with the restrictions on visiting remaining in place in various forms. Over the last quarter there have been 576 page views.

9.3 Letters to Loved Ones received over Q2 2020/2021:

- Centre 49
- East 90
- West 39

The following feedback was received:

'Many thanks for your reply. Especially in these times, this is a terrific service and very much appreciated.'

10. CARERS STRATEGY

10.1 The leadership of carer experience and involvement now sits with the Patient Safety and Experience Department, with alignment to the Regional Partnership Board and its operational carer groups. The Patient and Carer Experience Team fully recognise the challenges that carers can face, these being exacerbated by COVID-19. In response, the Carers element of the new Patient and Carer Experience Stragey is being developed, along with an action plan. The new Strategy is planned for launch in April 2021.

10.2 The improvement work for Carers continues at pace, with extensive links being forged between the existing carers agencies, and the Patient and Carer Experience Leads; membership being gained on many carers groups, including both statutory agencies and specialist services such as dementia care.

10.3 The next phase of our Carers action plan is to implement Patient and Carer Experience Champions pan BCUHB. This is currently at the planning stage, with a resource centre being constructed on SharePoint which the champions will be given access to. This will include a repository of contacts, a guide to the role of PALS, dealing with concerns, carers groups and support, amongst others. The subsequent stage will be liaison with heads of service, to explain the proposal, then finally the recruitment of champions and their training. Being mindful of the COVID-19 pandemic, launch is planned for quarter four 2020/21.

11. CO-PRODUCTION

12.1 The Patient and Carer Experience Team are in the process of facilitating, and supporting the co-production of a service user led group for Dermatology Services in the West. This is truly exciting work, with the terms of reference being set by the services users themselves, to guide what they hope to "get out of it". It is anticipated that this group will become self-governing, and lend steer to quality improvements. The team are also in discussions with other specialities including adolescent mental health

to facilitate and guide further co-production work. Strengthening patient and carer involvement, through co-design and co-production, will be a key part of the updated Patient and Carer Experience Strategy mention above.

12. WORKING WITH MENTAL HEALTH SERVICES

13.1 The last two months, have seen the development of renewed partnerships between the corporate team and Mental Health and Learning Disability Services. The Patient and Carer Experience Team now have regular monthly meetings with CANIAD, where work streams are shared, and co-working encouraged. An invitation has also been offered and accepted for the Patient and Carer Engagement Lead to sit on the Mental Health and Learning Disability Division Quality, Safety and Experience Committee and CANIAD are now represented on the Health Board-wide Patient and Carer Experience Group. This strengthened joint working, whilst at an early stage, will improve the coordination of activity.

13. ACCESSIBLE HEALTHCARE

13.1 The Patient and Carer Experience Team are currently awaiting returns form the annual Accessible Health Care Audit, which has been distributed to all areas. At the moment the return is low, with reminders being sent out. The next phase of the action plan for this work stream is to carry out spot check audits in randomised areas, to ascertain if the accessible health care folders are being made available and utilised when needed. This will ne done by December 2020. There is a specific need for this, as there have been a number of complaints from sensory impaired service users, who have noted that staff were unaware of how to support. This will link into the role of the Patient Experience and Carer Champions, to safeguard against a recurrence of this.

13.2 The latest six monthly report is included at Appendix 3.

14. VASCULAR NETWORK

14.1 Within the Q2-2019/2020 the Patient Safety and Experience Department have in collaboration with the vascular service improvement network, undertaken a focussed review of patient and carer feedback post the reconfiguration and centralisation services at Ysbty Glan Clwyd.

14.2 The analysis of service user feedback built on a retrospective review of service user feedback for the period 2018/2019 derived from complaints, incidents, real time feedback, care2shares and patient and carer comments, to include within Q2-2019/2020 real time review of feedback from vascular outpatients within YG and YGC and inpatients at YGC (Ward 3).

14.3 The review of feedback was derived from a specifically designed variant on the standard real/near time patient and carers experience instrument (PREMS questionnaire). Which included three additional items relating to patient and carers usual place of residents – identified via the first three digits of their postcode, and items relating to feedback on length of time waiting for treatment and perceptions of the distance travelled.

14.4 Key insights/learning from the survey include;

- Overall participants recorded a very high level of overall satisfaction of 9.09/10, and this was consistent across both DGHs.

- Responses to items 2, 4 & 6 (below) indicated that 100% of participants who responded to these items reported that these characteristics were either Always or Usually a feature of their care;

    - *Q2. Do you feel you were listened to?*
    - *Q4. Did you get assistance when needed?*
    - *Q6. Did staff take the time to understand what matters to you as a person and take account of this when planning and delivering care?*

- Responses to item 1 – *Did staff introduce themselves to you?* Suggested that this may be a slightly stronger feature of the experience of care in YGC compared to YG, but nonetheless is a strong feature of care within Both DGHs.

- Responses to Item 3 – *Do you feel you were given all the information you needed?* Suggested that this is a slightly stronger feature of the experience of care in YG compared to YGC, but nonetheless is a strong feature of care within Both DGHs.

- Response to item 5 – *Were you involved as much as you wanted to be in your Care?* Suggested that at YGC this was featured less strongly in the participant's experience of care than at YG.

- Responses to item 7 - *Could you speak in Welsh to staff, if you wanted to?* Whilst this is much more likely to be a feature of patient and carer experience in the West, care has to be exercised in interpreting this data, as responses to this item tend to be an indirect measure of the usage of the Welsh Language in the West and Centre operating regions respectively.

- Responses to items 8 – *How long did you have to wait?* Indicate that the waiting a 'short time' for treatment is more strongly experienced feature of the service in YG compared with YGC. However, there are only n=5 out of n=48 responses to this item where waiting either 'longer than needed' or 'a long time' was reported as a feature of the care received.

- Responses to item 9 – *Do you feel that the distance you have to travel for treatment is?* Indicate that for the vast majority of participants travelling 'about the right' distance for treatment is reported as a key feature of the care received. The responses to this item may suggest this is a slightly less strongly reported feature of care by patients and carers from YG compared with YGC.

The findings reported at 14.4 above, coupled with the secondary analysis of patient and carers experience data for the financial year 2019/2020 enable the following

tentative conclusions to be made in relation to patient and carers feedback following the reconfiguration of vascular services:

Whilst a recent report by the North Wales Community Health Council (NWCHC) (April 2020) cited numerous examples of care being less favourably received by patients and carers post reconfiguration and centralisation of services at YGC, across all the PREMs measures within this survey, there are generally no difference in the quality of care experienced at YGC compared to YG. Moreover, across all PREMS measures care was experienced in very favourable and positive light.

Whilst this survey provides a real-time snapshot of one point in the care pathway, within the context of providing care during the COVID-19 pandemic, the care reported by our patients and carers was of a very high quality and different to the picture provide by the NWCHC report, which was retrospective and within the context of the whole pathway. The differences in method are important and make direct comparisons problematic. Notwithstanding these caveats the data from the survey paints a picture of a service where our staff are committed to 'going the extra mile' to provide a service experience which is universally reported in a positive light across all of the NHS Wales PREMS measures.

Thematic analysis from item *11. What was good about your experience?* (see below) coupled with retrospective analysis from complaints and incidents for the period 2018/2019 tend to reinforce this argument and indicate that patients and carers are far more likely to report their experiences in a positive compare to a negative light.

Positive Themes	Frequency
Staff Attitude & Approach	10
Involvement/Information	5
Quality of Care	5
Access	3
Organisation of Care	2
Otherwise +ve	1

Otherwise +ve	1
None Specified	8

Negative Themes	Frequency
Delay	4
Environment	1
Food & Nutrition	1
Organisation of Care	1

Otherwise +ve	1
None Specified	8

These conclusions were reported to the Vascular Service Improvement Task and Finish Group (of which the Community Health Council are part of) in line with agreed project plan and the following recommendations agreed;

- To continue to survey and report on patient and carers experience of vascular clinics and other service points (e.g. Ward 3 YGC).

- To undertake some retrospective review of patient and carer experience via care2share, patient and carer stories, and NHS Inpatient Satisfaction

Questionnaire etc., within vascular service points, in order to provide a better picture of the how the 'whole vascular pathway' is experienced.

- Report the feedback to Vascular Improvement Network and Patient & Carer Experience Group and relevant managers and staff, as the basis for quality/ organisational assurance, learning and service development.

- Continue to work in partnership with the Community Health Council to ensure all patient and carer feedback is heard and acted upon – the CHC have indicated they will repeat their listening exercise once the service improvements are complete providing an externally facilitated source of information.

20. LEARNING FROM PATIENT & CARER EXPERIENCE

20.1 The Health Board's Patient, Carer Service User Experience Improvement Strategy 2019-2022 reflects national framework commitments to harness patient and carer experience information, for quality improvement work. This feedback also being shared across the Health Board, via QSE Committees for assurance.

20.2 To help address this, the Listening and Learning Group was launched in October 2019 to facilitate the sharing of patient and carer experience information and improvement with each division reporting into the group. This has since been renamed the Patient and Carer Experience Group, with new terms of reference reflecting the revised agenda.

20.3 Based on patient and carer experience methods of reporting, service areas were requested to identify the emerging key themes that encompassed positive feedback and also those areas that patients and carers felt needed improvement. The service areas were asked to provide details of the changes proposed to enable that improvement to be implemented. Due to the COVID-19 pandemic the ability to collect the information became difficult with busy schedules and higher demand on services.

20.4 The latest Delivery Framework report is included at Appendix 4.

20 CONCLUSION AND RECOMMENDATIONS

20.1 This report aims to provide the Quality, Safety and Experience Committee with information and analysis regarding significant patient and carer experience issues arising during the quarter under review, alongside information on the improvements underway. The aim being to provide the committee with assurance on the Health Board's work to improve patient and carer experience.

APPENDIX 1

Complaint Process Review Update
October 16th 2020
Carolyn Owen, Head of Patient and Carer Experience

Why we did the review

The aim of the BCUHB complaints process review is to produce a new complaints policy, procedure, guidance and process for managing complaints. The scope of this process begins at the first contact stage and is completed when there is evidence of resolution and demonstrable learning and action.

Welsh Government (WG) performance reports, external and internal reviews have indicated that BCUHB has scope to improve the complaints handling processes. This theme has been the subject of a series of recent development events involving key stakeholders in dialogue with the Patient Safety and Experience Department. The key focus being on identifying what works well and what needs to be improved.

How we did it and who we spoke with

A complaints project structure was developed and followed involving key clinical leads.

The Patient and Carer Experience Team consulted widely on the exploration and engagement for the complaint procedure. Exploration and engagement events involved; Community Health Council, Ombudsman, three regional event workshops.

External expertise has been commissioned under the broad terms of reference for the work undertaken; development of innovative proposals for improvements to BCUHB existing complaint handling model compliant with relevant Welsh legislation, delivering recognised policy objectives and best practice concerning the receipt, investigation and response to patient and carer complaints.

Benchmarking on an UK wide research landscape for NHS complaint handling has been reviewed to ensure the 'new' BCUHB complaint procedure is fully consistent with best practice and the Welsh complaints system in order to ensure that any proposals complied and aligned with relevant regulations and guidance. They also reflect current UK wide recognised best practice in the handling of public service complaints. This included a benchmarking exercise with Northumberland Healthcare NHS Foundation Trust – a recognised exceptional leading organisation for patient experience.

An engagement event was held with the Community Health Council (CHC) to find out what matters most to patients, carers and families with the complaint process.

A series of facilitated events involving key stakeholders, including a day in dialogue with the Patient Safety & Experience Department as a whole. The key focus for this day was to identify what works and what needs to be improved.

The development events were structured around three key questions in a rapid improvement event methodology:

1. What is the ideal complaints process?
2. What would be seen as an ineffective process?
3. What needs to change?

In parallel with this process, a skills audit has recently been undertaken within the Patient Safety and Experience Department, which provided all team members with an opportunity to self-report their skills, knowledge and understanding against 14 domains of practice

What we found currently works well

PALS

Slight improvements in 'holding letters'

Digital meeting recordings and note taking

What we found currently needs improvement

The development events and broader engagement responses to the current process identified the following barriers to effective performance in complaint management:

- Defensive culture with a lack of transparency
- Complicated navigation complaints process
- Poor communication, lack of patient focus, feeling 'ignored', not listened to
- Lack of clear point of contact for communication
- Inconsistencies across all regions, different teams lead to different interpretations
- Robust investigation
- Poor quality reporting
- Inadequate final responses
- Failing to implement learning
- Improve outcome for patients
- Feedback and resolution for learning
- Expectations not met
- Poor staff attitudes in patients' meetings
- Timely response time
- Response letters depersonalised and PTR is stark
- Action and improvement plans incomplete
- Strong relations with clinical staff
- Meaningful templates
- Reduce process steps

Proposals for the future

The following provides the framework for implementing a programme of reform to the BCUHB's complaint handling arrangements.

The following principles will be used which arose from the engagement activity:

- Fairness

- Timely, effective, consistent
- Accountable
- Delivers continuous improvement

By definition, each work stream has a detailed plan and strategy to ensure the effective implementation of proposals relevant to that particular area of activity. As outlined below, the four work streams sitting within the overarching reform programme are as follows:

- First contact
- Early resolution
- Investigative quality
- Final responses

The framework will be achieved by changing aspects of the patient and carer journey through the complaint process and by revisiting certain fundamentals (such as what actually constitutes a complaint).

First Contact

"There is a difference between serious complaints, concerns and enquiries"

Keith Evans, 'Using the Gift of Complaints' – June 2014

The term 'First Contact' is used in this paper to define the point at which a patient, carer, or someone on their behalf, brings a matter requiring a response to the attention of a member of staff or agent of the health board. It is at this critical moment that the potential for escalation into a formalised complaint often occurs, principally because of the default tendency for staff in the NHS to be led by the individual's articulation of the matter in question, rather than a forensic focus on the actual issue(s) at hand. Put simply, not everything is a complaint just because it is described or presented in those terms. PTR defines a complaint as an 'expression of dissatisfaction', a situation in which the person in question has clearly identified a matter about which they are specifically unhappy.

Time spent with a patient or carer addressing their concerns is time saved responding to an investigation at a later point

In the context of the NHS complaints procedure, it is not uncommon for matters that are not complaints (by any of the definitions above) to enter the process. Examples of this include:

- Questions about care and treatment
- Subjective personal opinions on policy or services
- Requests for information (personal or organisational)
- Suggestions for improvement to services
- Comments concerning service delivery and patient, carer experience

For example, this may occur as a consequence of a misunderstanding, or representation, or by attributing the status of a complaint to the communication as a result of the language

and tone used by the person in question. However, what matters are the content of the representation and the desired outcome sought.

Not everything is a complaint because it is described or presented in that way. It is the substance of a patient's concerns that should inform decisions about how best to respond to the matter raised.

This is an important point. Unless a representation made by a patient or carer clearly meets the definition of a complaint, it should not enter the procedure and the 'rules' of the procedure will not apply. The issue raised by the person in question still requires a response, however the provision of this response sits outside the complaints process as part of the Board's 'business as usual' activities (e.g. a doctor providing a concerned patient or carer with a thorough explanation regarding their care and treatment). The following table illustrates this concept:

Issue Raised	Example	Guidance
Complaint	*"I had an appointment booked for 2pm on 14 June and when I arrived your receptionist told me all surgery for that day had been cancelled. I am very unhappy about his as I am self-employed and lost a day's money as result"*	• This is clearly a complaint as **dissatisfaction** is expressed • It concerns a matter of **fact** (an appointment for the day and time in question) • An **investigation** of this issue is possible • (access to relevant evidence) • Dependant on the findings and conclusions of the investigation, it will be possible to either **uphold** or **not uphold** the complaint
Question	*"I wasn't given an epidural. Nobody explained why it was refused. I've read somewhere that I should have been given a choice. Is this right?"*	• The patient or carer is **unclear** about epidural policy and practice issues • The **facts** are absent • The patient or carer wants **information** • Once the information is provided, the patient or carer will be in a position to **decide** whether or not to make a complaint • **You cannot investigate a question**! Unlike a complaint, it does not assert a position on a factual matter
Opinion	*"I think you should train your staff properly. You should take a long hard look in the mirror. I will never use your hospital again!"*	• Here the patient or carer shares their **personal view** • No **facts** are provided • **You cannot investigate an opinion.**

Effective triaging of general concerns will be done under the new framework. This will lead to a reduced volume of complaints. This will mean that there will be a reduction in time and resources devoted to complaints handling, and more to early problem solving or investigative consideration. Patients will receive a better outcome. This supports the opportunity for a speedy solution to what are invariably simple and readily resolvable matters.

The right solution at the right time will be a guiding principle in our engagement with patients and carers

In instances where a patient or carer present with a list of questions about their care and treatment, the relevant healthcare professionals with the aid and assistance of PALS should facilitate the answers. This can take the form of face to face meetings, phone calls, emails and written correspondence etc, which are all mainstream activities not exclusive to the complaints process. In other words, the conversation with the patient or carer in whatever form it takes is a core business activity and no different to booking an appointment, undertaking surgery, or providing post- operative care. It is part of the day job, not a complaint related activity.

Some patients or carers may have multiple questions and once addressed it is likely that a far smaller group of matters remain that are clearly expressed as complaints. The new framework will reduce the occurrence of letters containing twenty or more questions being treated as complaints from the outset. This new approach result in scale and clarity, i.e. smaller numbers of complaint are more manageable and require less specialist resources, and absolute certainty about the matters being inquired into avoids investigative drift and unfocused responses.

This approach will be similarly applied to other 'non-complaint' concerns such as responding to subjective personal opinions, requests for information and suggestions for improvement to services. A more robust approach to the filtering of general concerns at 'First Contact' ensures that the complaints procedure is only used for the purposes intended with consequent benefits to both patients'/carers and the health board. It is important to note, that this approach is not about 'gating access' to the complaints procedure, but rather ensuring that general concerns are dealt with speedily as part of the core business of the health board and that finite investigative resources are appropriately directed.

In summary, these improvements to the management of 'First Contact', will provide patients and carers with a more immediate response to their representations. All general concerns falling outside the scope of the complaints process, will benefit the performance of the complaints procedure. This includes clarity of access to the process, increased investigative capacity and reduced activity volumes. The improvements to 'First Contact' is seen as an essential part of this complaints reform framework.

First Contact is a form of triage in which the substance of the general concern is carefully considered and the person directed to the most appropriate person, place or process for a response

<u>Early Resolution</u>

'PALS Plus', is a specific part of the complaints process to front facing staff who are empowered to proactively use their skills and expertise to resolve matters that would otherwise escalate into formal complaints, (i.e. a problem solving, mediation, conciliation and conflict resolution). It will be a proactive approach to support verbal 'concerns', either in person, or by telephone, to be resolve to the person's satisfaction. This will be done no later than the next working day on which the concern was notified. This is line with the PTR

Regulations (2011), to encourage early resolution. This reduces the number of complaints requiring investigative action.

'PALS Plus' is an enhanced model of patient and carer engagement in which locally sited PALS functions have greater delegated responsibility in dealing with patient and carers information requests and informal complaint handling. The kind of activities that will fall within this enhanced profile include the following:

- General Customer Service
- Outreach & Patient, Carer Engagement
- Patient and Carer Information, Advice, Guidance & Support
- Responding to General Patient or Carer Concerns
- Facilitating Answers to Patient or Carer Questions
- Real Time Problem Solving
- Coordinating Local Mediation & Conciliation
- Enabling Local Early Resolution of Complaints
- Signposting to the Complaints Hub
- Promoting a Positive Local Complaints Culture

'PALS Plus' enhanced purpose and objectives clearly delineate the activities to be undertaken by the complaints function, these include:

- Complaints Process Information, Advice, Guidance & Support
- Complaints Policy & Procedure Management
- Complaint Handling Best Practice Training & Development
- Triage of Patient Complaint Referrals
- Receipt & Acknowledgement of Patient Complaints
- Caseworker Engagement with Complainants
- Commissioning & Management of Investigations
- Management of Investigator & Experts Pool
- Investigation Report Quality Assurance
- Production of Draft Adjudication (Decision) Letters
- Monitoring of Outcomes & Actions Implementation
- PSOW Liaison
- Performance Data, Reports etc

The two functions work collaboratively to ensure a seamless experience that is patient and carer focussed.

Investigative Quality

The investigation report template (particularly for more complex complaints) in which findings, conclusions and recommendations are drawn from a body of available evidence will result in a stand-alone document concerned exclusively with matters of fact. This will assist greatly in circumstances where a complainant subsequently pursues a legal claim and the question of evidential proof becomes more nuanced (i.e. 'narrative' letters response containing investigative material aligned with subjective opinion can be subject to dispute where matters of interpretation and meaning are concerned). The following table provides the example of an investigation report template:

Section	Description
Front Cover	This should indicate the status of the document (investigation report) and other relevant key information
Contents Page	List of sections complete with content numbering and page numbers
Terms of Reference	**'A record of an investigation conducted under The NHS Concerns, Complaints and Redress Arrangements Wales Regulations 2011 SI 704 (W.108)'**. This section should also address any specific matters 'out of scope'
Defined Complaints	A list of the individual 'heads of complaint'
Desired Outcomes	The complainant's expectations concerning an outcome
Methodology	Investigative process, i.e. a list of the staff and other relevant persons interviewed, and a list of relevant evidence accessed (policies, procedures, best practice guidance, data, records etc.)
Findings & Conclusions	A record of the findings and conclusions relating to each individual head of complaint in a numbered sequence. **This will include a clear judgment on whether the complaints are upheld or not.**
Recommendations	The investigator's proposals for remedying any identified failings
Annex 1 (Chronology)	A chronological list of key events relevant to the complaints investigated
Annex 2 (Evidence)	A repository for any documents of value that evidentially confirm a conclusion on a complaint

Training will be supported to develop a cohort of trained investigators who will represent a significant commitment to addressing the challenge.

Final Responses

There are three stages in the management of a complaint; 1) receipt of the referral and the defining of the complaint and desired outcomes, 2) the investigation, and 3) the response.

The third stage is the adjudication, and the concept of adjudication has relevance for the following reasons. The investigator is an impartial and objective fact finder to determine

whether a complaint is upheld or not on the basis of the evidence available. Once completed, the investigation report is submitted to the 'responsible officer' who, as final decision maker, performs the role of adjudicator. The separation of these roles reflects the need for the avoidance of conflicts of interest. The role and responsibility for the adjudication (decision) letters that clearly communicate investigative outcomes is with the site divisional Directors of Nursing and Midwifery.

It is the adjudicator responsibility to communicate BCUHB final decision on the complaint in the light of the investigator's findings, conclusions and recommendations. This enables the adjudicator to act as the final arbiter, thereby conveying ownership for the complaint where any consequent action is concerned. The letter will be brief, focussed and concise as the substantive content is contained in the investigation report. This removes the extended narrative correspondence.

The letter will headline terms for the decision, any action to be taken, and the complainant's further rights. The complainant can be referred to the investigation report where necessary for the detail concerning the judgement on their complaint. The letter will detail apologies, convey empathy and acknowledge opinions. Letters can be personal and appropriately conversational. 'Soft' detail will not appear in the investigation.

In line with the recommendations of the Evans Report, a standard adjudication template will be developed that provides a consistent format. This document is complementary to the 'stand-alone' investigation template, and together they represent the 'Final Response'.

<u>Next steps to implementation</u>

Work streams will be developed to support the above framework, including the following key changes:

- A fundamental shift in approach – to focus on resolution and restitution.
- The policy, procedures and processes will be one document.
- A triage tool (First Contact) with associated guidance and advice will be developed.
- Improved involvement of patients and carers in setting the terms, followed by improved proactive engagement.
- Development of a central list of investigators underpinned by training for relevant staff using a skills passport – this will include an integrated training offer with programmes provided by the new PSOW Complaints Standards Authority.
- Development and introduction of relevant tools and templates to support and facilitate a robust investigation model using a range of methodologies.
- Introduction of the PALS Plus model.
- New quality assurance systems for investigation reports to adhere methodology adherence and preparation of reports complaint with policy and process.
- Tracking of improvement actions through Datix.
- Removing the decision on qualifying liability out of the investigation and learning process – new, separate redress panel.
- Alignment of MS/MP complaints within the same overall framework.
- Development of a lessons learned library including written, audio and video formats for sharing learning.

APPENDIX 2

Ombwdsmon Ombudsman
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU
PUBLIC SERVICES OMBUDSMAN FOR WALES

Our ref: NB

Ask for: Communications

01656 641150

Date: 7 September 2020

Communications
@ombudsman-wales.org.uk

Mr Mark Polin OBE QPM
Chair of the Board
Betsi Cadwaladr University Health Board

By Email Only
mandy.williams7@wales.nhs.uk

Dear Mr Polin

Annual Letter 2019/20

I am pleased to provide you with my Annual letter (2019/20) for Betsi Cadwaladr University Health Board.

I write this at an unprecedented time for public services in Wales and those that use them. Most of the data contained in this correspondence relates to the period before the rapid escalation in Covid-19 spread and before restriction on economic and social activity had been introduced. However, I am only too aware of the impact the pandemic continues to have on us all.

As you will note, Betsi Cadwaladr University Health Board has continued to receive the highest number of complaints. However, the percentage of interventions was in line with the average for Health Boards.

I was pleased to note that the Health Board has developed a programme of improvement to manage complaints in real-time and that it has also developed a programme aimed at improving the quality of its response letters. In addition, Health Board staff met with my Complaints Standards colleagues and expressed a desire to receive complaint handling training at the earliest available opportunity.

The Health Board continues to work with my Improvement Officer and has engaged in regular quarterly meetings. In addition, the Health Board has maintained regular contact with the Improvement Officer during the Covid-19 pandemic, which facilitated effective amendments to working arrangements during these testing times. The Improvement Officer will continue to work with the Health Board to help identify areas where we can provide support.

Public Services Ombudsman For Wales | Ombwdsmon Gwasanaethau Cyhoeddus Cymru, 1 Ffordd yr Hen Gae, Pencoed CF35 5LJ
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I am delighted to report that during the past financial year, we had to intervene in (uphold, settle or resolve early) a smaller proportion of complaints about public bodies in Wales: 20% compared to 24% last year.

With regard to new complaints about public bodies, 1020 or 45% related to NHS bodies — an increase of 1.3% compared to 2018/19.

Complaints about NHS bodies related predominantly to health (88%). However, as in previous years, a significant proportion of these complaints related to complaint handling (8%). We will continue to work with NHS bodies on reducing the number of these complaints, including as part of our new Complaints Standards role.

Work has already started as part of our Complaints Standards role for Wales, so far predominantly with Local Authorities. .We have seen great benefits already from this work, including the standardisation of complaints data recording. We look forward to working more closely with you in the coming months to help embed the new 'Once For Wales' system and, for the first time in Wales, provide complaints handling training to Health Boards, free of charge.

Action for the Health Board to take:

- Present my Annual Letter to the Board to assist Board Members in their scrutiny of the Board's performance.
- Continue to work to reduce the number of cases which require intervention by my office.
- Work with my Improvement Officer and my Complaints Standards colleagues to improve complaint handling practices and standardise complaints data recording.
- Inform me of the outcome of the Health Board's considerations and proposed actions on the above matters by **30 November**.

This correspondence is copied to the Chief Executive of your Health Board and to your Contact Officer. Finally, a copy of all Annual Letters will be published on my website.

Yours sincerely

Nick Bennett
Ombudsman

CC: Simon Dean, Interim Chief Executive
Denise Williams, Contact Officer

Factsheet

A. Complaints Received

Health Board	Complaints Received	Complaints received per 1000 people
Aneurin Bevan University Health Board	140	0.24
Betsi Cadwaladr University Health Board	227	0.33
Cardiff and Vale University Health Board	100	0.20
Cwm Taf Morgannwg University Health Board	80	0.18
Hywel Dda University Health Board	92	0.24
Powys Teaching Health Board	23	0.17
Swansea Bay University Health Board	91	0.23
	753	0.24

B. Complaints Received by Subject with percentage Share

Betsi Cadwaladr University Health Board	Complaints Received	
Adult Social Service - Services for vulnerable adults (eg with learning difficulties, or with mental health issues)	3	1.32%
Complaint Handling- Health	29	12.78%
Health - Appointments/admissions/discharge and transfer procedures	7	3.08%
Health - Clinical treatment in hospital	128	56.39%
Health - Clinical treatment outside hospital	24	10.57%
Health - Continuing care	11	4.85%
Health - De-Registration	1	0.44%
Health - Funding	2	0.88%
Health - Medical records/standards of record-keeping	1	0.44%
Health - Medication> Prescription dispensing	1	0.44%
Health - Non-medical services	5	2.20%
Health - Other	9	3.96%
Health - Patient list issues	3	1.32%
NHS Independent Provider - Care Homes	1	0.44%
Various Other - Poor/No communication or failure to provide information	1	0.44%
Various Other - Rudeness/inconsiderate behaviour/staff attitude	1	0.44%

C. Complaint Outcomes (* denotes intervention)

Complaints Closed	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution/ voluntary settlement*	Discontinued	Other Reports- Not Upheld	Other Reports Upheld - in whole or in part*	Public Interest Report *	Grand Total
Betsi Cadwaladr UHB	6	31	101	42	1	11	24	1	217
Percentage Share	2.76%	14.29%	46.54%	19.35%	0.46%	5.07%	11.06%	0.46%	

D. Number of cases with PSOW intervention

	No. of Interventions	No. of Complaints Closed	% Of Interventions
Aneurin Bevan University Health Board	55	165	33%
Betsi Cadwaladr University Health Board	67	217	31%
Cardiff and Vale University Health Board	29	104	28%
Cwm Taf Morgannwg University Health Board	9	59	15%
Hywel Dda University Health Board	29	92	32%
Powys Teaching Health Board	7	13	54%
Powys Teaching Health Board - All Wales Continuing Health Care cases	4	13	31%
Swansea Bay University Health Board	7	62	11%
Former Health Boards			
Abertawe Bro Morgannwg University Health Board	26	36	72%
Cwm Taf University Health Board	9	21	43%
Grand Total	**242**	**782**	31%

Appendix

Explanatory Notes

Section A compares the number of complaints against the Health Board which were received by my office during 2019/20, and the number of complaints per 1,000 residents (population).

Section B provides a breakdown of the number of complaints about the Health Board which were received by my office during 2019/20 with the percentage share.

Section C compares the complaint outcomes for the Health Board during 2019/20, with the percentage share.

Section D provides the numbers and percentages of cases received by the PSOW in which an intervention has occurred. This includes all upheld complaints, early resolutions and voluntary settlements.

Feedback

We welcome your feedback on the enclosed information, including suggestions for any information to be enclosed in future annual summaries. Any feedback or queries should be sent via email to communications@ombudsman-wales.org.uk

APPENDIX 3

Accessible Communication and Information

NHS Organisation	Betsi Cadwaladr University Health Board
Date of Report	Sept 2020
Report Prepared By	Peter Morris.

The All Wales Standard for Accessible Communication and Information for People with Sensory Loss sets out the standards of service delivery that people with sensory loss should expect when they access healthcare. These standards apply to all adults, young people and children. The Accessible Information Standard requirements sit alongside the 'Standards' as an enabler to implementing them.

Reporting Schedule: Progress against the organisation's action plan for the current operational year is to be reported bi-annually. This form is to be submitted on 31 October and 31 April.

Complete form to be returned to: hss.performance@gov.wales

Does the organisation have an action plan in place to implement the All Wales Standard for Accessible Communication & Information for People with Sensory Loss?

Update on the Actions to Implement the All Wales Standards for Accessible Communication & Information for People with Sensory Loss:

Needs Assessments	Key Actions Achieved April-Sept 2020	Risks to Delivery	Corrective Actions & By When
All public & patient areas should be assessed to identify the needs of people with sensory loss	As in previous reporting periods continued development of the self-evaluation tool, and Sensory Loss Toolkit, including primary care variant, which enables managers to evaluate compliance with the standards in relation to their service points, which include a section related to Environmental Signage and wayfinding and is supported by addition guidance.	During this period the BCUHB's C19 pandemic response has resulted in the suspension of the ward accreditation programme and direct visiting to most wards and clinical areas has not been possible. Given that the ward accreditation audit instrument contains items specifically relating to improved compliance with AHCS and progression from bronze to silver to gold standard of ward accreditation requires consistent	Organisational Compliance with AHCS achieved via the Organisational Quality & Safety Group and Patient & Carers Experience Groups, thus providing executive/board level oversight. Operationally a specific project managed work stream and action plan has been developed within the Patient Safety &

	The self-evaluation tool is utilised as an integral component of organisational governance and performance management in relation to compliance the AHCS. A revised action plan has been developed which takes account of BCUHB's C19 pandemic response plan and places a greater focus on the use of web-based materials, collaborative communication technologies and the Patient Advice Liaison & Support Service (PALS) to support the needs of our patients, service users and staff. BCUHB has utilised Patient Stories, Care2Share discovery interviewing and real time patient/service user feedback system during this period and within the constraints of the HB's C19 pandemic response. In addition to the inclusion of the NHS Wales standard PREMs, the survey instrument underpinning BCUHB's real time patient feedback system has been redesigned to ensure that we explicitly capture and segment the views of service users with a sensory loss.	improvement in relation to compliance with AHCS – along with other evidence of utilising feedback to improve services. This has understandably resulted in a lack of focus on the evaluating and improving compliance with the standards, which our revised action plan addresses – see op cit. Continued roll out of patient feedback questionnaire to managed practices, which enable segmentation of feedback sensory loss, as the basis for service improvement, has been negatively impacted by the C19 Pandemic response, however, this has been identified as a priority and is an integral component of the PALS work stream moving forward into Q3&Q4 2020/2021. However, it needs to be recognised that given the current level of sustained C19 transmission, then engagement with key stakeholders is for the most part likely to rely on remote, computer mediate communication, such as MS-Teams™, and a stronger focus on the development of intra and internet resources.	Experience Team with the aim of ensuring increased organisational awareness and compliance with the standards. The Deputy Head of Patient Experience and Complaints is the acting project manager and key deliverables relating to this domain for 2020/2021 include; • *Completion of BCUHB audit of Compliance Levels using baseline assessment and action planning by end of **Q3 2020/2021**.* (Each speciality and/or service point(s) to develop an action plan for improvement). • *Continued development of the capability to listen, learn and act on service user feedback in relation to service users with sensory loss.* *Specifically during **Q3 2020/2021**; utilise PALS Officers to undertake care2share discovery interviewing, patient stories and continue the roll out and utilisation of BCUHB's real/near time patient feedback system which for 2020/2021 enables improves*

			reporting by protected characteristics at ward/service point level. • *In collaboration with BCUHB managers and staff, service users and the COSS review the content of the Toolkit to ensure that it is commensurate with the standards, technological developments and the needs of our service users.* ***(By Q4-2020/2021)*** • Continued Utilisation of existing performance, quality assurance and governance arrangements to support (i) improved utilisation of the evaluation tool and resultant action planning and (ii) exception reporting to relevant organisational scrutiny groups where this is not occurring. ***(Quarterly performance reporting)***

Needs Assessments	Key Actions Achieved April-Sept 2020	Risks to Delivery	Corrective Actions & By When
All public information produced by organisation should be	The Sensory Loss Toolkit and associated self-evaluation audit instruments (see above) ensures that	Whilst BCUHB guidelines on the written patient information (Ver 0.4 Sept 2020) provides clear	Operationally a specific, project managed work stream and action plan has been developed

assessed for accessibility prior to publication.	the managers and staff are aware of their responsibility to produce information in accessible formats. Policy ISU02 – Written Information Patients reinforces this responsibility and provides best practice guidance. Within Q2-2020 these guidelines have been updated (Ver 0.4 – Sept 2020) to include specific guidelines in relation to the responsibility of departments/service points to provide information in variable formats, to ensure that the communication needs of patients and service users with sensory loss are met. Additionally, within these guidelines the role of corporate communications department has been strengthened to include support with provision of easy read versions where required. Specifically, the latest guidelines on the production of written information (i) formally re-establish a Readers Panel for peer review of written information and include representatives from the Centre for Sign Sight and Sound (COSSS) who provide our accessible health care support programme under the auspices of a rolling SLA, (ii) endorses the utilisation of EIDO patient information leaflets which are available in easy read and variable	organisational clarity in relation to ensuring that all public information produced by the organisation is assessed for accessibility prior to publication, and will over time improve the accessibility, given the range and diversity of existing patient information it is likely to take a number of reporting cycles for these aims to be totally realised. As in previous reporting periods requests for change to templates for appointment letters are under the auspices of WIS project management and whilst the Accessible Information Standards reinforce the need to ensure that public facing information is available in accessible format, this is very difficult to action at a local level. However the migration to the all Wales WPAS product, the continued development of the Telephone Preference System (TPS) for making and amending appointments, along with the development of patient portal for accessing communications, will over the next reporting periods and into 2021/2022 enable improved access to information and participation in health services for people with sensory loss.	within the Patient Safety & Experience for ensuring increased awareness and compliance with the guidelines inherent in ISU02 (Ver 0.4, Sept 2020). The Deputy Head of Patient Safety & Experience is the project manager for this work stream and key deliverables relating to this domain for 2020/2021 include; • *Reestablishment of the 'Readers Panel' and review of new requests for written information for patients according to criteria contained within guidelines including those relating to accessibility* ***by Q3 2020/2021*** • *Cataloguing of existing written information for patients ensuring compliance with guidelines on accessibility,* ***on-going Q3-Q4 2020/2021.*** • *Development of improved guidelines for the production of written information for patients including the need for accessibility, ensuring clear link to the requirements*

	font format provide a useful resource in relation to the provision of information in accessible format, for standard procedures and diagnosis and (iii) will enable the organisationally cataloguing of written information leaflets and thus their associated accessibility formats. During this period, in line with other HB in Wales BCUHB is migrating its current internet site to MURA content management system, which along with the latest browser technology will provide improved compliance with Web Accessibility Guidelines (QCAG) 2.1 AA and include an ability to change font side and support for a variety accessibility add-ins such as Adobe™ – Read Out Loud. Patient Experience Team members have been trained to set up and edit internet pages using MURA, and in relation to the requirements of the standards. Which has within this reporting period greatly enhance our ability to ensure essential information relating to Patient Safety & Experience is available in formats which improve compliance with AHCS.		*of the standards and existing training materials* ***by Oct 2020*** • *Development of on-line training materials relating to the production of written information for patients, ensuring clear link to the requirements of the standards* ***by Nov 2020***

	Within this period, the migration from Isoft's Patient Information System (PIMS) to the all Wales WPAS project was completed in the East and Central operating regions and within 2020/2021 will be completed in the West. This will provide increased control over the accessibility of appointment templates and provides the ability to record communication needs based on sensory loss as an integral component of the patient record.		

Standards of Service Delivery	**Key Actions Achieved April-Sept 2020**	**Risks to Delivery**	**Corrective Actions & By When**
Health Prevention (Promotion Screening, SSW, Flu Vaccination, Bump Baby & Beyond). Priority areas include:			
Raising staff awareness	As in previous reporting periods one of the key frameworks for raising awareness is the Sensory Loss Toolkit. The latest version of the Sensory Loss Toolkit contains (i) factsheets (1-4) relating to best practice for dealing with service users with sensory loss and (ii) endorses the use of the NHS Wales e-sensory loss module. This is reinforced by the baseline evaluation tool (see above). The toolkit includes a community and primary care variants.	As in previous reporting periods Sensory loss training is not mandatory within the NHS in Wales and this does pose a significant risk in relation to increasing staff awareness, especially given the pressure to complete other mandatory training. Additionally Access to (enrolment on) e-learning modules which are not an integral component of the ESR learning suite, is for some staff groups problematic due to lack of access to computers during work hours and the need to search for specific courses and add these	This remains a risk moving forward into 2020/2021 and ideally requires an all Wales control/solution such as mandating the e-sensory loss module. In the meantime sensory loss training and awareness will continue to be supported via (i) Sensory Loss Toolkit, (ii) Treat me Fairly Equality Training, (iii) Intranet based materials and (iv) e-sensory loss module (Participation rates to be reviewed throughout 2020/2021 and reporting on via Quality & Safety and Patient & Carers

	The New treat me fairly (equality training) module includes a more comprehensive reference to the AHCS based on factsheets 1-4 from Sensory loss toolkit. This programme has been rolled out in face-to-face format from Q3-2019/2020 onwards. Instructions on how to access the e-learning sensory loss module included on updated web-page and given at the end of face-to-face equality training. Additionally latest version of the Equality Impact Assessment training contains specific reference to the AHCS (factsheets 1-4 Sensory Loss Toolkit) The PALS work stream includes within this reporting period a specific focus on sensory loss awareness and improving organisational compliance with the standard.	enrolments to ESR at an individual learner level. The policy framework underpinning national compliance with the standards does not include specific reference to performance targets associated with training/staff awareness. Whilst BCUHB had planned and argued strongly for changes to the NHS Wales e-learning infrastructure to enable the local (BCUHB level) mandatory enrolment of the NHS Sensory Loss Module on a 3 year cycle as an alternative to 'Treat me Fairly' refresher. The lack of an all Wales Consensus has now caused BCUHB to abandon this approach. However, staff and managers are encouraged to undertake the NHS Wales e-sensory loss awareness module as an additional enrolment. .	Experience executive sub-groups – ***Quarterly Q3 & Q4 2020/2021)***. Redevelopment and migration to MURA of the inter and intranet sites in line with the sensory loss project plan to include updated guidance on searching for, and adding NHS e-learning modules to ESR, blended learning materials relating to the standards, interactive versions of the Toolkit and on-line version of the baseline evaluation – to be completed ***by Nov 2020*** Additionally section 3.2 of the sensory loss Toolkit contains similar guidance and provides an additional control where access to the e-learning module is not possible request that; *"3.2 Have frontline staff undertaken sensory loss e-learning module AND/OR have factsheets 1, 2, 2b, 3 & 4 been (i) discussed during a documented staff meeting, (ii) been copied and distributed to frontline staff and (iii) a signed record exists that staff have 'read understood and are able to act in accordance with these*

			guidelines." (Baseline Evaluation Tool, p.4) ***Evaluation to be completed across the organisation by Q3-2020/2021*** Given the restrictions imposed due to C19 response on face to face teaching and in In the absence of an ALL Wales approach to continue the utilisation of the e-sensory loss module as a recommended/optional (blue) enrolment, in conjunction with on-line version of the 'Treat Me Fairly' module will include reference to (i) responsibility of BCUHB staff to book BSL interpretation services and (ii) Fact Sheets 1-4 from the Toolkit. ***Ongoing throughout 2020/2021*** Continued monitoring of compliance rates in relation to (i) organisational compliance with AHCS via self-evaluation tool and (ii) operational monitoring of mandatory equality training. *Compliance rates and sensory loss awareness rates reported quarterly to Quality & Safety and Patient & Carers Experience executive sub-groups, in* ***Q3-2020/2021 and Q4-2020/2021***

			Develop the capacity and capability to utilise digital patient stories in order to raise staff awareness and promote the service development necessary to improve compliance with the standards. ***(Each regional patient experience team to curate a patient story relating to an aspect of sensory loss by Q4-2020/2021***)

Ensuring all public information is accessible for people with sensory loss	See 'Needs Assessment' above. Continued funding for the Accessible Health Care Scheme, completed SLA with Centre for Sign Sight & Sound for 2020/2021. Continued review activity data from the accessible health care scheme as the basis for organisational assurance and improving services.	See 'Needs Assessment' above. Despite the efforts described above in relation to ensuring that our patients and service users with sensory loss have access to information, which enables them to gain access to, and participate in health services on the same basis as other service users. Within this reporting period BCUHB continues to recognise the vulnerable nature of these service users, especially during periods of local restrictions due national and organisational response to the Public Health emergency caused by the C19 pandemic. Thus, the Accessible Health Care Scheme continues to provide;	See 'Needs Assessment' above. The critical nature of the Accessible Health Care Scheme and the SLA that supports this is recognised by BCUHB as a key control in ameliorating the potential risk that patients and service users with sensory loss may experience in accessing information and participating in health services. Therefore key deliverables for 2020/2021 and into 2021/2022 are; • Report to Quality & Safety and Patient & Carer Experience Groups, on the effectiveness and utilisation

		"the links Deaf and Hard of Hearing patients with Health Professionals like GPs, opticians, dentists and hospital departments. It supports Deaf and Hard of Hearing people to make, check, change or cancel an appointment, while also ensuring their communication needs are supported in the most appropriate way during the appointment" (COSS, Sept 2020).	of the service. ***Quarterly Q3-2020/2021 and Q4-2020/2021 by Deputy Head of Pt Experience.*** • Ensure that feedback from service users is used to develop the service, ***COSS Operational Manager and Deputy Head of Pt Experience – Quarterly Q3-2020/2021 and Q4-2020/2021*** • Secure continued funding for 2021/2022, ***by Q4-2020/2021 – Asst Director for Patient Safety &***

Standards of Service Delivery	Key Actions Achieved April-Sept 2020	Risks to Delivery	Corrective Actions & by When
Accessible appointment systems	Within this reporting period, the Wales Information Service (WIS), has ensure that systems are enabled in line with phase II of the Accessible Information Standard (AIS) to record communication needs and include these in e-referrals received by the Health Board. (Such an approach relies on fields relating to language, disability and communication needs being populated in a systematic and	The risks are similar to those of previous reporting periods, namely the utilisation of an IM&T infrastructure, which relies on communication needs related to sensory loss being recorded within primary care and then transferred via electronic referral to secondary care. At the time of writing BCUHB has still to complete the migration of the West operating area to the merged WPAS platform (see above).	Given the op cited risks, then the controls cited above in relation to the development of specific project management work-streams, the development of accessible patient information, the continued development of the PALS function, the introduction of carers champions, the development of the inter and intranet along with innovative frameworks for

	rigorous manner derived from universal reference values). Within this period continued communication with patient and service user groups, Centre for Sign Sight and Sound, Primary Care Governance Leads, and participation at community engagement events, amongst others; in order to increase awareness amongst patients, carers, service users, managers and staff of the importance of recording and responding to the communication needs of people with sensory loss. Within Q1-2020/2021; the Patient Safety and Experience Team have as an integral component of the ongoing development of our Carer's Strategy, developed operationally the role of 'Carers Champion', which whilst aimed at ensuring Carers rights, will also in conjunction with the PALS team provide added operational support for carers and patients with sensory loss. As in previous periods, Posters developed by the NHS Wales Centre for Equality and Human Rights in conjunction with the Snr Officers group, to be forwarded to all managed practices and to Cluster Development Managers/Officers	Within 2020/2021 the current system will remain characterised by a; • Reliance on service users to request that communication needs relating to sensory loss are communicated to health care providers (primary, community & secondary). • Lack of standardised generic reference values for recording communication needs within BCUHB where operating regions are not utilising the WPAS platform. • Currently the appointment system does not automatically create an alert reminding HCPs to book BSL interpreter, and this relies on local knowledge of the service user's needs being passed on to the service point. Although this risk is partially ameliorated via the AHCW scheme and the local knowledge These risks will remain relevant throughout 2020/2021, please see controls cited above and opposite.	harvesting patient and service user feedback and the continued funding and development of the Accessible Health Care Scheme are a key organisational imperative for 2020/2021 and into 2021/2022 *Additionally the migration of the West Operating Region on to the WPAS platform by the end of* ***Q4-2020/2021*** *will provide under the auspices of the WIS project proved;* • increased flexibility over appointment templates, • enable the standardisation of the coding and recording of communication needs, and the production of exception reports eg clinic preparation lists which flag in advance the need to book a WITS interpreter, • and increased integration with primary care information system, NHS Wales Health Portal(s) and other supporting systems.

	within BCUHB to encourage service users with sensory to request that their communication needs are recorded within primary care information systems. The use of type talk to facilitate access to centralised booking system. Working in conjunction with COSS Accessible Health Care Team (see above) booking staff are able to facilitate improved access to the appointment system for service users with sensory loss. Additionally text reminders are utilised for appointments. Continued funding for 2020/2021 by BCUHB of the Accessible Health Care Worker (AHCW) scheme to facilitate access to and participation in health care for service users with sensory loss. Accessible Health Care Scheme which in conjunction with the Centre for Sign Sight & Sound (COSS) and other voluntary organisations provides support for service users with sensory loss so that they are able to access information and services on the same basis as other service users. This has been an effective and innovative and effective.		

	Data for the period (October 2019 – March 2020) provided by the COSS indicates that the scheme supported the following activity; Month — Activity April 279 May 51 June 62 July 98 August 138 September 192 Total 820 Continued development of telephone preference service and patient portal to facilitate the dissemination of appoint letters, make and amend appoints etc., which will better enable service users to utilise their own access technologies to communicate with the health board as the basis for access to and progression within health care services. Appointment of additional 4.0 wte extra project officers to support the migration of the West operating region to the WPAS platform.		
Communication models	As in previous reporting periods within Q1-Q3 2020/2021 the WITS interpreter service continues to provide front line face to face BSL	Within Q1-Q3 2020/2021 the following key risks remain; Staff Awareness in relation to the responsibility of HCPs to book a	As above AHCW scheme partially controls for this risk and continued, recurrent funding for this scheme moving forward is imperative.

	interpretation and feedback on whole is positive. Digitally accessed interpretation services can now be supported via BCUHB internet based on Skype™ Technology, although these are not yet mainstreamed. The project plan for the development and piloting of Insight™ digitally accessed interpretation services within Q3-2020/2021 has been developed pending all Wales agreement. This is likely to become an integral feature of BCUHB's WITS contract. During Q1-Q2 2020/2021, BCUHB staff and managers are constantly reminded via, site Quality & Safety Group Meetings, Governance & Scrutiny Groups, via ward managers and matrons meetings, via e-mail, via posters, via the PALS service, and via Treat Me Fairly Equalities Training, of their have again been sent specific responsibility to book interpretation services where required. This message is reinforced via Factsheets 1-4 from the Sensory Loss Toolkit and additional intranet and internet based information.	WITS interpreter as required; this risk is sometimes compounded where communication needs are unknown to the HCP/Service Point (see note above). Feedback from Service Users indicates that the preference for a face-to-face interpretation service and such an approach is supported via the Accessible Health Care Scheme. Developing the capacity for a digital remote interpretation services as an integral component of the HB's SLA with WITS will provide an important control especially in relation to unscheduled/emergency care. However, the HB does need to be cognisant of the need to provide translation services in a dignified manner recognising that some service users where possible may wish to utilise their preferred interpreter.	Following on from the above the Accessible Health Care Communication card, is credit card available to all service users who wish to identify their communication needs. ***To be audited/re-audited via baseline evaluation tool by end of Q3-2020/2021.*** Continue to improve staff awareness via training and though quality assurance initiatives such as ward accreditation, utilisation of self-evaluation tool as previously stated. Additionally the development of PALS function and the role of the Carers Champion, coupled with the development and role of new guidelines on written information for patients (ISU02, Ver 0.4 Sept 2020) will enable the principles to be repeatedly reinforced as an integral component of the works streams associated with this domain. *Report progress quarterly to Quality & Safety and Patient & Carers executive sub-groups,* ***Q3 & Q4 2020/2021.***

			Continue to implement technological solutions where these are practically possible and commensurate with the identified needs of service users; including the purchase of additional skype™/Office 365 licences where necessary and hardware. *Implement as an integral component of the Insights™ digital translation pilot.* ***(A project plan for the latter to be agreed by end of Q3-2020/2021 pending all Wales support).*** Monitor incidents and complaints arising from communication with service users with identified sensory loss as the basis for improvement *Utilise PALS function to support communications between service users and the HB, and to reinforce evidence-based practice. Feedback in near/real time to ward/department managers, via standard PALS and Datix reporting frameworks, and include in lessons learned/changes made within quarterly reporting to Quality & Safety and Patient & Care*

			Experience executive sub – groups. ***Monthly*** *and* ***Q3 & Q4 2020/2021.***

Primary and Community Care. Priority areas include:			
Standards of Service Delivery	**Key Actions Achieved during April to September 2020**	**Risks to Delivery**	**Corrective Actions & by When**
Raising staff awareness	(See also Above). Continued review and update of the Community and Primary Care version of the Sensory Loss Toolkit – available on BCUHB intranet pages. (See above) Given the limitations imposed on face to face visiting due to organisational and national response to the C19 public health emergency. The PALS team have continued to engage remotely with area governance and GP practice managers in order to raise awareness of the issues, support evaluation and action planning. Following on from the above, the Patient Safety and Experience team in conjunction with managers and staff to promote the utilisation of the self-evaluation Toolkit to ensure that compliance is regularly monitored and action plans for improvement are developed as appropriate	(See also Above). The risks for this reporting period remain broadly similar to those highlighted in 2019/2020 namely; • Geographic distribution of service points, and difficulty of engaging staff and service users in 'remote' locations. • The majority of GP Practices are autonomous and not directly managed and therefore integrating these practices within BCUHB's governance frameworks relies on good will and the skills of the GP Development teams. This still remains a risk within 2020/2021 (see existing controls (left) and additional actions (right))	(See also Above). *Continued development of intelligent reporting of compliance with accessible health care standard by ward/department, speciality, hospital and operating region, and additionally indicate DATIX incidents and complaints relating to, or associated with non-compliance with standards and/or meeting needs on the basis of protected characteristics.* ***By the end of Q3-2020/2021.*** • *Completion of BCUHB audit of Compliance Levels using baseline assessment and action planning by end of* ***Q3 2020/2021****.* (Each speciality and/or service point(s) to develop an action plan for improvement).

	Within 2020/2021 phase II of the ward accreditation process now includes all community hospitals and the associated ward metric (audit tool) include specific reference to compliance with accessible AHCS, (see PE12-14). Within Q2 – 2020/2021 dashboards have been developed to monitor compliance with accessible health care standards from data derived from the baseline evaluation and are currently being adapted to include relevant DATIX™ incident and complaint data.		• *Continued development of the capability to listen, learn and act on service user feedback in relation to service users with sensory loss.* *Specifically during **Q3 2020/2021**; utilise PALS Officers to undertake care2share discovery interviewing, patient stories and continue the roll out and utilisation of BCUHB's real/near time patient feedback system which for 2020/2021 enables improves reporting by protected characteristics at ward/service point level.* • *In collaboration with BCUHB managers and staff, service users and the COSS review the content of the Toolkit to ensure that it is commensurate with the standards, technological developments and the needs of our service users.* ***(By Q4-2020/2021)*** Develop the capacity and capability to utilise digital patient stories in order to raise staff awareness and promote

			the service development necessary to improve compliance with the standards. ***(Each regional patient experience team to curate a patient story relating to an aspect of sensory loss by Q4-2020/2021***)
Accessible appointment systems	(See Above).	(See Above).	(See Above).
Communication models	(See Above).	(See Above).	(See Above).
Implementation of the Accessible Information Standard	As in previous reporting periods within Q1-Q2 20020/2021 key focus of work has continued to be focussed on the following; • Developing the infrastructure for measuring and reporting compliance; utilisation of the self-evaluation/internal audit instrument, ward accreditation audit tool, and continued development and deployment of the Sensory Loss Toolkit. • BCUHB has continued to development partnership working with the third sector to support access to and progression within health care services for people with sensory loss. • Following on from the above, the utilisation of service level	Level of staff and managerial engagement given other priorities. See above note in relation to the non-mandatory nature of sensory loss training. Large geographical distribution of services across three operating areas (East, Central, West), and localised governance arrangements result in a large strategic and operational span of control. Culturally governance and organisational assurance have not always been viewed as an integral component of operational management. The above risks again remain relevant moving forward into Q3&Q4	(See Above) AHCS compliance reportable on a quarterly basis to Trust Board, reinforced operationally via Ward Accreditation, Continued development of the PALS service in all operational areas and reporting and review via BCUHB's Quality & Safety and Patient & Carers Groups executive sub-committees. ***(Quarterly Q3 & Q4 2020/2021)*** Continued development of the PALS model to support service users with sensory loss through engagement in direct enquiries and in relation to

	agreements with the Centre for Sign Sight and Sound (COSS) and WITS to provides access to interpretation services and advocacy services for service users with sensory loss, in line with the requirements of the standards. • Via implementation of Patient Experience Strategy (BCUHB, 2019) and the Patient Advice Liaison & Support Service (PALS), provide the infrastructure required to support service users with sensory loss in relation to access to health care services and as a focus for engagement. • BCUHB has continued to actively support the All Wales Sensory Loss Group to advise and support development of national approach to developing services, which are more responsive to the needs of patients and other service users with sensory loss. • Continued development and utilisation of formal frameworks listening and acting on feedback by categories of sensory loss including real team patient feedback, NHS Inpatient Satisfaction Survey, Patient Stories, PALS Enquiries, Patient Comments and analysis of incidents and complaints.	2020/2021. Key controls (see above) include; • Continued funding of the Accessible Health Care Scheme (AHCS) • Efforts to Improve Staff Awareness • Changes in the reporting of local and Organisational Quality Safety and Effectiveness and Organisational Assurance data to specifically include progress made against agreed organisational plan for improved compliance with AHCS, derived from Patient Safety & Experience Team, project managed work stream.	audit and action planning within service points. ***(On going Q3-Q4 2020/2021)*** Continue to develop the in-house reporting of patient experience in relation to sensory loss, so that managers and staff are able to listen, learn and act on feedback. (***Monthly reports to ward/department managers, Quarterly Q3 & Q4 reporting to Quality & Safety and Patient & Carers executive sub-groups)*** Continue to review the sensory loss and written patient information work streams in line with agreed project deliverables (see above), ***(Monthly throughout Q3-Q4 2020/2021)*** Develop the capacity and capability to utilise digital patient stories in order to raise staff awareness and promote the service development necessary to improve compliance with the standards. ***(Each regional patient experience team to curate a patient story relating to an***

	• And additionally the development of project managed work streams within the Patient Safety & Experience Team, managed by the Deputy Head of Patient Experience to (i) improve compliance and awareness, (ii) integrate other work relevant work streams eg development of the PALS team, Carers Champion Role, improved guidelines on the production of written patient information (ISU02), and continued development of our intra and internet sites.		***aspect of sensory loss by Q4-2020/2021***)

Standards of Service Delivery	**Key Actions Achieved during April to September 2020**	**Risks to Delivery**	**Corrective Actions & by When**
Secondary Care. Priority areas include:			
Accessible appointment systems	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)
Communication models	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)
Implementation of the Accessible Information Standard	(See Primary & Community Care Above)	(See Primary & Community Care Above)	(See Primary & Community Care Above)

Standards of Service Delivery	Key Actions Achieved during April to September 2020	Risks to Delivery	Corrective Actions & by When
Emergency & Unscheduled Care. Priority areas include:			
Raising staff awareness	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)
Communication models	(See Primary & Community Care Above)	(See Primary & Community Care Above)	(See Primary & Community Care Above)

Concerns & Feedback (CF). Areas include:			
Highlighting current models of CF in place which would support individuals with sensory loss to raise a concern or provide feedback	PTR internet pages have now been migrated to BCUHB's MURA platform and can be read via voice recognition software provide spoken access and provide considerably improved visual, access compared with the previous Cascade™ content management system. This along with latest web browser technology will ensure improved compliance with Web Accessibility Guidelines (QCAG) 2.1 AA and include an ability to change font side and support for a variety accessibility add-ins such as Adobe™ – Read Out Loud. The PTR page is supported by BSL guidance in the form of a pre-recorded video link. As in previous periods, in practice the support of an Accessible Health Care Worker may be required to ensure that service users with sensory loss are able to access the PTR framework on the same basis as	Accessing the PTR process for service users with sensory loss on the same basis as all other users. This risk is partially mitigated by BCUHB's accessible health care scheme (AHCS) and the continued development and roll out of the PALS function across the organisation. Given the potential development of a once for Wales Patient Feedback System and following a careful review of in-house options, BCUHB did not renew its contract with CRT/Viewpoint for the provision of a near/real time patient/service user feedback system. However, delays in the procurement trajectory within this period have resulted in the development of an in-house approach to collecting patient and service user feedback.	(See previously cited controls) Continue to develop the in-house reporting of patient experience in relation to sensory loss, so that managers and staff are able to listen, learn and act on feedback. (***Monthly reports to ward/department managers, Quarterly Q3 & Q4 reporting to Quality & Safety and Patient & Carers executive sub-groups)*** In-house, development, implementation and roll out of an on-line Patient/Service user feedback survey. ***(by Q3-2021)*** Continue to review the sensory loss and written patient information work streams in line with agreed project deliverables

	other service users. Thus, funding of this scheme provides an important tenet of BCUHB's approach to supporting patients and service users with sensory loss. As in previous reporting periods service user feedback is regularly collected and fed back to service managers via (i) Real-Time Patient Feedback System (ii) Complaints and Incident Monitoring, (iii) Patient Stories and (iv) NHS Wales Inpatient Satisfaction Survey. The data from these sources is segmented by protected characteristic and reported in near time to managers and staff, monthly to site Quality & safety groups and quarterly to the organisational Quality & safety and Patient & Carers Experience groups. Additionally the experience of service users with sensory loss is reported bi-annually to equalities operational group and is a standard agenda item.. When issues in relation to accessing services and/or the PTR process are identified these are communicated to the relevant managers for action. The continued development and roll out of the PALS function throughout the organisation, means that BCUHB now has the capacity to resolve	Whilst the currently deployed system offers similar functionality to the CRT/Viewpoint system and improved capability in relation to segmenting feedback by protective characteristics. The dependence on paper surveys coupled with delays in developing an on-line survey, restrictions on ward visiting, and a reduction in elective activity have resulted in a significant reduction in returns; and in the context of this report a potential reduction in the ability to listen, learn and act from the experiences of the patients and service users with sensory loss. This risk is currently recorded on the organisational risk register and steps are being taken to mitigate its consequences, see controls op cited et alia.	(see above), ***(Monthly throughout Q3-Q4 2020/2021)*** Continued management of organisational risk (id=3450) resulting from delays in the procurement of the proposed Once for Wales, Patient Feedback System and the ongoing uncertainty in relation to the procurement trajectory. ***(See controls cited above and risk reviewed monthly and is a standard agenda item BCUHB's Quality Management Systems Group)*** Develop the capacity and capability to utilise digital patient stories in order to raise staff awareness and promote the service development necessary to improve compliance with the standards. ***(Each regional patient experience team to curate a patient story relating to an aspect of sensory loss by Q4-2020/2021***) As detailed in the PALS work stream for Q3-Q4 2020/2021 utilise telephone care2shares to identify and share feedback relating to compliance with the accessible information and

	issues relating access and participation in health services for peoples with sensory loss in real time, without result to the formal complaints (PTR) process. Additionally, during this period the Patient Safety & Experience team has been developing the capability to undertake and curate patient stories in digital format, which will provide a useful alternative framework to listen and learn from the experiences of patients and service users with sensory loss.		communication standards. ***(Monitored by Pt Experience Managers within monthly PALS activity returns, reported using the PALS dashboard and associated IRIS report)*** Continued funding of the Accessible Health Care Scheme for 2020/2021 and into 2021/2022. **(Asst Director for Patient Safety & Experience by Q4-2020/2021)**
Highlight any CFs received in sensory loss and actions taken	Within the reporting period, Q1-Q2 2020/2021 BCUHB managers in conjunction with out PALS team have dealt successfully with n=1 OTS complaint (id=COM45142) relating to the lack of availability of a BSL interpreter associated relating to sensory loss. In this case, Factsheets 1-4 from the Toolkit were utilised to increase awareness that it is the responsibility of BCUHB staff to book interpreters and the patient's brother was willing to be proactive in reminding the ward of their responsibility prior to any future treatment. During Q1 & Q2 there were no reported incidents which we due directly to noncompliance with the standards.	As in previous reporting periods, Making, changing and emending hospital and other health care appointments remains challenging for many service users with sensory loss, and this finding is reinforced through engagement events. Capturing and acting on this experience in real-time also remains a challenge and whilst the current approach 'to design out' such situations is to be commended, it has to be recognised that these will arise and BCUHB needs to ensure that we are able to respond to these in a proactive manner. Service users with sensory loss are very willing to tell us about their	(See Above) And is in previous reporting periods; Continued monitoring of service user experience by protected characteristic including complaints and incidents to ensure that any issues are acted on in as close to real time as possible, and scrutinised by the BCUHB's organisational quality & safety, and listening & learning groups, as well as within local PTR scrutiny groups. *(Produce **monthly and quarterly Q3 & Q4 2020-2021** exception reports for site Quality*

	Additionally, within the period Q1-Q2 2020-2021 the PALS team were called upon to support the request for the provision of BSL interpreter for a patient presenting in ED (id = 10025), and were able to successfully respond to this request	experiences, the challenge for the Health Board remains to incorporate these into the learning and planning processes. Ward audits as an integral component of the ward accreditation framework and PALS care2share activity and other interactions with clinical services, sometimes highlight that the Sensory Loss Toolkit and/or other supporting materials eg Hospital Communication Book, are either out of date or not available in hardcopy within some service points, this is immediately ameliorated as an integral component of the work of the PALS teams.	*& Safety Groups, Governance Teams, and quarterly for organisational Quality & Safety and Patient Carer & Experience executive sub-groups).* Following on from the above; *development of intelligent real time reporting for incidents, complaints and PALS activity data relating to Accessible Health Care Standard, using interactive dashboards. (**November 2020**)* Continued engagement with service user with sensory loss in order to identify and ameliorate issues impacting on access to and progression within health care services. *(Meet **monthly** with Centre for Sign Sight and Sound to review patient experience in relation to the accessible health care scheme).* Develop the capacity and capability to utilise digital patient stories in order to raise staff awareness and promote the service development necessary to improve compliance with the standards. ***(Each regional patient experience team to curate a patient story relating***

			to an aspect of sensory loss by Q4-2020/2021)

Patient Experience*	Key Actions Achieved during 2020	Risks to Delivery	Corrective Actions
Mechanisms are in place to seek and understand the patient's experience of accessible communication and information	Within this reporting period BCUHB continues to utilise a variety of mechanisms to survey and learn from service user experience – see above. The DATIX complaints monitoring enables the segmentation of feedback via equality/discrimination, which provides an indirect ability to monitor concerns via protected characteristics. The Real Time Patient Feedback Survey and the NHS Inpatient Survey enables the self-reporting of service user feedback by protected characteristics and a report is forwarded to BCUHB's strategic Equality Group on a quarterly basis and included in the Listening and Learning and Quality Safety & Effectiveness reports. Such feedback has been reinforced by the operational deployment of PALS officers in all operating areas within Q1&Q2 2020/2021. Continued development and deployment in Q1&Q2 2020/2021 of in-house provision for real/near time feedback and the utilisation of PowerBi™ and Excel VBA™ to	As in previous reporting periods the utilisation of the real/near time feedback tends to be greater in acute than community and primary care settings and it is constant challenge to ensure sufficient returns to provide meaningful feedback and universal coverage, especially in relation to reporting on protective characteristics Q1&Q2 2020/2021. This has been particularly challenging during Q1 – 2020/2021 due to the restrictions on ward/departmental visits due to BCUHB's response to the C19 pandemic. Given that this is likely to be a feature of operating environment throughout 2020/2021 and into 2021/2022 it is recognised that there will need to be shift towards the utilisation of web based collaboration tools to gather feedback remotely eg collection of digital patient stories, utilisation of Skype™/Teams™/Telephone for discovery interviewing and administration of patient satisfaction survey(s). (see also above)	(See Above) Continued development of awareness of the importance of patient feedback and the availability of relevant data sets to support learning and service improvement – many of these actions have been cited above, but in summary, the key controls here are; Develop the capacity and capability to utilise digital patient stories in order to raise staff awareness and promote the service development necessary to improve compliance with the standards. ***(Each regional patient experience team to curate a patient story relating to an aspect of sensory loss by Q4-2020/2021***) *The development of intelligent real time reporting for incidents, complaints and PALS activity data relating to*

	develop interactive dashboards has significantly enhanced BCUB's ability to harvest service user experience and report this in real/near time be protected characteristic including sensory loss. This work has been enhanced with the restructuring with the Patient Safety and Experience team resulting in the appointment in Q1-2020/2021 of a Head of Transformation & Learning and a Business Analysist		*Accessible Health Care Standard, using interactive dashboards. (**November 2020**)* *(Produce **monthly and quarterly Q3 & Q4 2020-2021** exception reports for site Quality & Safety Groups, Governance Teams, and quarterly for organisational Quality & Safety and Patient Carer & Experience executive sub-groups).* Continued development of BCUHBs intra and internet sites, and local SharePoint(s) – in line with the objectives inherent in the Patient Safety and Experience project managed work streams relating to (i) sensory loss, (ii) production of patient information and (iii) learning and reporting. (***Reviewed monthly as per project plans throughout Q3&Q4 2020/2021)***

	Key Themes	Corrective Actions
The key themes to emerge from patient experience feedback (both positive and negative)	(See above comments in relation to the booking of WITs interpreters and the controls cited). Within Q1&Q2 2020/2021 the following feedback has been received from service users who identify as (deaf or hearing impaired) or (blind or visually impaired)	(See Above).

	Whilst the detail responses for each of the NHS Wales PREMs metrics is included in the above reports for each of the cited protected characteristics, and the size of the samples in each case is relatively small; it is pleasing to note that the general level of patient satisfaction amongst each of the potentially vulnerable groups is high and similar to participants who do not identify themselves as having a sensory loss. (In summary, within Q1&Q2 2020/2021; blind or partially sighted patients/service users average overall satisfaction score was 9.41/10 and deaf or hearing impaired patients/service users average overall satisfaction score was 9.52/10).	
* **Patient experience mechanism and themes to be documented in this return applies specifically to patients with sensory loss who have accessible communication and information needs**. There is a requirement in the NHS Delivery Framework for NHS organisations to provide an update on patient experience for all patients (not just for those with accessible communication or information needs). This is to be reported on a separate pro-forma entitled 'Evidence of how organisations are responding to patient feedback to improve services' and links to the NHS Framework for Assuring Service User Feedback.		

APPENDIX 4

Evidence of how NHS organisations are responding to service user experience to improve services

NHS Organisation	**Betsi Cadwaladr University health Board**
Date of Report	**September 2020**
Report Prepared By	**Patient and Carer Experience team**

The NHS Framework for Assuring Service User Experience explains the importance of gaining service user experience feedback in a variety of ways using the four quadrant model (real time, retrospective, proactive/reactive and balancing). It outlines three domains to support the use and design of feedback methods and is intended to guide and complement service user (patient) feedback strategies in all NHS Wales organisations. NHS organisations are required to evidence that service user experience feedback is gathered and acted upon in all care settings (as applicable).

Reporting Schedule: Evidence of how NHS organisations are responding to service user experience feedback to improve/redesign their services is to be reported annually. This form is to be submitted on 30 September to cover the period April 2019 to March 2020.

	What has your organisation done to encourage feedback from service users on their experience of your services?	**What has your organisation done to respond to service user feedback to improve/redesign your services? Please provide examples of improvements.**	**How have you communicated improvements to your service users? e.g. 'you said, we did'.**
Prevention Services and Health Promotion. This includes Screening Services	Within this sector the following methods are most frequently but not exclusively utilised to encourage feedback from service users; • Concerns/complaints and incident Monitoring • Via Patient Comment Cards • Via Patient Advice & Liaison Service (PALS) • Through the use of Patient Stories and Care2Share discovery interviewing • Via Carers Survey • Via Public engagement and reference groups. • Utilisation of 3D engagement model	There has been continued development of the Patient Advice and Liaison Service (PALS), with a planned progression to PALS Plus before the end of the year. The evolvement of the PALS model will enhance communication flow between service users, and services, with real time resolution and learning taking place. Any areas of concern to service users will be swiftly escalated to the appropriate service leads, and a satisfactory outcome achieved where possible. Within this reporting period the PALS service successfully resolved n=485 enquiries relating to coordination of care and/or receiving	Lessons learnt, and innovations are shared via the Patient & Carer Experience Group, which provides board level assurance that BCUHB is complying with its mandatory responsibility to listen, learn and act on patient/service user experience and is a sub-committee of the organisational Quality Safety and Effectiveness, and Quality & Safety Groups.

	• Monitoring of social media and utilisation of dedicated Patient Experience mailbox Community Public Engagement "You Said We Did' events have identified a number of key concerns amongst the health population service by the Health Board in relation to; (i) rising levels of unhealthy eating, obesity, lack of exercise amongst residents in a defined locality in Bangor (ii) the health of working age population,	information and/or access or delays. Whilst it is not possible to designate specific themes within this segment, the provision of broader themes, does serve to provide overview of the utility of PALS interventions, from the perspective of service users. (i) Developed integrated/collaborative working between the Maesgeirchen development worker and community group, Maesgeirchen Regeneration Board MaesNi with BCU & PHW dietetics and who will now be working together to offer courses to the community. A community cafe has also began on the estate, and we have linked the volunteers with the ICAN team who will explore wellbeing training. (ii) The Wellbeing in the Workplace project brings BCUHB services and partners together to offer support and advice to staff in the form of lunchtime drop-in session for employees. Information on diabetes, healthy lifestyles, ICAN Mental Health, community pharmacy and bowel screening are available from representatives	

	(iii) rise in anti-biotic resistance, (iv) and the promotion and understanding of health promotion and prevention services. Accessing the Kind Eating programme was identified via post course feedback as a key challenge for some particiaptants.	of a number of partner organisations. (iii) Working in collaboration with BCUHB Pharmacy and Health School coordinators developed school e-bug session to raise awareness. (iv) Ensured a BCUHB presence at high footfall events such as Mold & Llangollen Food Festivals, National Eisteddfod etc., to share information and promote a message of early intervention in collaboration with cancer support groups and BCUHB Winter Wellness Programme. Information and promotion of flu immunisation, falls prevention, bowel cancer screening, skin integrity & pressure ulcers were also provided. The Dietetics Team in the West operating region have developed a Skype version of the programme, to support a more blended learning approach to delivery.	

	What has your organisation done to encourage feedback from service users on their experience of your services?	What has your organisation done to respond to service user feedback to improve/redesign your services? Please provide examples of improvements.	How have you communicated improvements to your service users? e.g. 'you said, we did'.
Primary Care/Community Care	Feedback from patients and service users highlight the challenges in registering and accessing appointments within primary care. As with other sectors of care *delays in accessing care* and *lack of information* about the service and *poor coordination* of the pathway is consistently cited as contributing to a *negative experience of care*. Within primary care this has been highlighted via; PALS interactions, Care2Shares, Real Time Patient Feedback, Local Suggestion Schemes, wider public engagement and informal feedback to HCPs. Feedback via local engagement from a number of Sexual Health Service clients who were frustrated when	Managed practices in the East operating region have (i) improved their telephone system so that patients are better able to contact the appropriate HCP at the practice (ii) ensuring that the appointment system takes account of all HCPs & increasing the proportion of follow up appointments and (iii) providing improved messaging to patients and other service users. Within managed practices in the Central operating area following feedback in relation to the difficulties in registering with practices and making appointments, additional training and guidance was provided to staff. Speech and Language Therapy Service in the West operating region has introduced a new improved booking system resulting in a reduction in DNA and ensuring that patients and service users receive where possible an immediate response. To ensure that all clients were in receipt of the necessary information, a 'Script' was development for clients	Lessons learnt, and innovations are shared via the Patient & Carer Experience Group (which provides board level assurance that BCUHB) is complying with its mandatory responsibility to listen, learn and act on patient/service user experience and is a sub-committee of the organisational Quality, Safety and Experience Committee. Examples of effective practice shared via Area Governance Structures/Area Quality & Safety Meetings. Information shared at service point level with patients and carers via notice boards, information leaflets and internet. Feedback in relation to all Wales Patient Related Experience Measures (PREMS) collected primarily via the CRT/Viewpoint real time feedback system are shared via weekly and monthly reports to enable managers and HCPS to monitor changes in real (or near) time and develop improvement plans where appropriate. (Whilst utilisation of this method of feedback is more embedded within secondary care service points it is nonetheless a

	telephoning to book an appointment for a coil to be fitted as they were advised that they needed to attend for a pre coil assessment appointment. Some felt that this was unnecessary and had difficulty in attending. Lack of awareness of the pathway and knowledge of service was a recurring theme of PALS activity, which features as contributing to a negative experience and feelings of disempowerment within patient stories and Care2Share discovery. Feedback from the NHS Inpatient Questionnaire and via PALS enquiries has indicated frustration in relation to access to audiology services in relation to (i) repair and services of hearing aids and (ii) outpatient appointments.	wishing to attend for a coil insertion the risk factors to clients and enables them to self-select if they require a pre insertion appointment. Community Hospital wards in the West (and some in Ysbyty Gwynedd) have in collaboration with the PALS service been ensuring that relevant information about the ward and relevant pathways of care is contemporaneous, made available for patients and other service users. Organisationally, the Patient Safety and Experience Dept have revised the guidelines on written information for patients to ensure that this is research based, bilingual, and available where required in easy read or other formats, commensurate with the accessible information standards (WG, 2013). Within this period and by Q4-2019/2020 (i) waiting times have reduced to successful recruitment to vacant posts, (ii) establishment of volunteer drop in centres in community locations for hearing aid support sessions, (iii) the inclusion of updated guidance for staff within the Sensory Loss Toolkit on hearing aid maintenance and associated audiology support.	prime feedback mechanism for this sector - for more information see planned care below).

	What has your organisation done to encourage feedback from service users on their experience of your services?	What has your organisation done to respond to service user feedback to improve/redesign your services? Please provide examples of improvements.	How have you communicated improvements to your service users? e.g. 'you said, we did'.
Planned Care	Within this sector the following methods are most frequently but not exclusively utilised to encourage feedback from service users; • Concerns/complaints and incident monitoring • NHS Wales Patient Satisfaction Survey (issued on a quarterly basis to 1000 patients who have received inpatient care in a given month) • Via Patient Comment Cards • Via Patient Advice, Liaison & Support Service (PALS) • Through the use of Patient Stories • Via CRT/Viewpoint™ a real time patient feedback system • Via Carers Survey • Ward Quality Audits. • Via Public engagement and reference groups. • Have you say groups • Utilisation of 3D engagement model • Monitoring of social media and utilisation of dedicated Pt Experience mailbox. Within this period the continued use of structured public engagement events in conjunction with feedback derived from the PALS care2share	Feedback from patients and relatives indicated a level of dissatisfaction with the quality of written patient information, which sometimes manifests itself in lack of awareness of the pathway and reduced involvement in decisions about care. This feedback has been reinforced via PALS inquiries, Patient Stories and Care2Share discovery interviews. Within this reporting period, new guidelines for written patient information, have been developed, and a readers panel established with the aim of ensuring that all written patient information is research based, clinically effective, in the language of the receiver, and available in alternative formats commensurate with the Accessible Information Standards for People with Sensory Loss (WG, 2013) and Welsh Language Measure (WG, 2011). Additionally the PALS officers and Patient Experience Coordinators have been working in collaboration with ward managers to ensure that each ward has contemporaneous, bilingual (Welsh & English) ward information leaflet. This commenced	The Patient & Carer Experience Group provides board level assurance that the BCUHB is complying with its mandatory responsibility to listen, learn and act on patient/service user experience. The Terms of Reference of the group reinforce senior management accountability to report on service improvements (changes) made as a result of feedback received from service users including the following key frameworks, CRT/Viewpoint Real Time Feedback System, NHS Inpatient Satisfaction Survey, Care2Share (discovery interviewing), Patient Stories, Secondary analysis of complaints, incidents and harms data. Thus ensuring the universal utilisation of feedback mechanisms to patients and service users such as patient experience notice board, practice changes made as a result of patient stories, the utilisation of 'You Said/We Did' posters etc. The PALS service is working collaboratively with Quality Improvement Team to inform the ward accreditation programme. This cohesive approach is able to highlight and address areas of low

	(discovery interviews) and more formalised patient stories provided the prime mechanisms for listening, learning and acting on service user feedback. In the East operating region continued engagement with service users and staff from the Community Care Collaborative (CCC) Hub[1], utilising the above frameworks has continued to provide a rich source of feedback. *[1]The CCC is a multiagency collaborative, based at Wrexham Maelor Hospital, which aims to provide health, social, medical and emotional care for service users who are otherwise less likely to interact with our services.* Feedback from patients and service users in the Central operating region have highlighted the importance and value of the Park & Ride Facility; feedback from other sources often associated the lack of access to car parking facilities with a negative overall experience. This is often, particularly highlighted as an issue for cancer patients. Feedback from patients and service users during this period often cited that 'wards were [appeared to be]	as an integral component of the Vascular improvement network action plan and is currently being rolled out across BCUHB as an integral component of the PALS Communication Work Plan. Following on from the above, BCUHB has purchased an additional n=118 tablets which have been utilised to support virtual visiting, harvesting of real time feedback and providing access to internet based patient/service user information. Extension of the Park & Ride facility at Ysbyty Glan Clwyd until March 2020 and the provision of extra on-site parking. Provision of designated parking facilities for cancer patients. Establishment and monitoring of safe staffing levels on all wards, is an integral component of BCUHB governance arrangements with clear	feedback data and work with services to develop their numbers and approaches. The PALS teams are supporting timely resolution to enquiries to enable effective communication between staff and patients, carers and their families. This is promoting immediate resolution in many instances, with shared learning and positive influence to the services involved using the 'You Said We Did' model. The utilisation of 'You Said/We Did' posters is an integral component of the ward accreditation system and these are displayed on the patient experience notice boards in each service point. The continued use and development within this period of the CRT/Viewpoint Realtime patient/service user feedback survey, enables change in relation to the following aspects of care to monitored at a service point level in near/real time; • Did staff introduce themselves to you? • Do you feel you were listened to? • Do you feel you were given all the information you needed? • Did you get assistance when needed? • Were you involved as much as you wanted to be in decisions about care?

	short staffed', 'staff were very busy' etc.	escalation frameworks in place. Additionally, the publication of agreed staffing levels on the public notice boards for each ward is an integral component of the ward accreditation process, and clearly communications expectations to patients, relatives, staff and other service users.	• Did staff take the time to understand what matters to you as a person and take account of this when planning and delivering care? • Could you speak in Welsh to staff, if you wanted to? • Using a scale of 0-10, where 0 is very bad and 10 is excellent, how would you rate your overall experience?
	Patients and carers have commented favourably on the cleanliness of wards and treatment areas, (CRT/Viewpoint & NHS Inpatient Surveys).	Continued implementation and monitoring of "Safe Clean Care" standards in all areas, which is monitored via ward accreditation, matrons 'work abounds' and the renovation of wards/clinical areas not commensurate with the Safe Clean Care standards has undoubtedly contributed to such positive feedback.	Summary reports are forwarded to service managers on a weekly and monthly basis – so that they are able to monitor changes, and develop improvement plans where appropriate. The utilisation of such data provides (i) a direct method of measuring change within the scope of the above items at the service point level and (ii) and indirect method of measuring change in relation to organisational improvement programmes e.g. compliance with Welsh Language Standards. A summary of such data is displayed on ward/service point notice boards as an integral component of the ward accreditation system.
	Feedback to PALS officers and via Care2Share interviews highlights how positively BCUHB dementia friendly strategy has been received.	Continued roll out of the dementia friendly strategy, the development of dementia nurse specialist role, dementia friend programme and proactive participation in Wales dementia training programme, and provision of intranet based additional support material.	
	Feedback from real time patient feedback indicates that patients and service users are more likely to be able to speak to staff in Welsh in the West operating region compared to the Centre or East. Whilst this variation may be partially accounted for in relation to the variation in Welsh Language usage across these	Continued development of Welsh Language training provision in order to raise staff awareness of the Welsh language and increase number of welsh speaking staff, in order to support the 'Active Offer' of a service through the medium of Welsh, in line	The Patient & Carer Experience Team awards a weekly 'Feel Good Friday' certificate to the service point in each of the operating regions which is considered to have been the source of the most positive service user feedback comment. This

	geographic regions, BCUHB's Welsh Language strategy clearly highlights the importance ensuring that we are able to support the active offer of service through the medium of Welsh in line with our statutory obligations. Mental Health & Learning Disability services in collaboration with MH Charities, Support Groups e.g. Caniad and the PALS have undertaken a number of innovative engagement activities, e.g. the big conversation, tea parties, patient stories, care2shares and within this period some really positive feedback	with the language requirements of the health population across operational areas. Ensuring the provision of a bilingual PALS service across BCUHB. Raising awareness via intranet/internet and through face-to-face interactions of the expectations that our patients and service users to receive a service through the medium of Welsh if they so require and that it is the responsibility of managers and staff to ensure such provision using translation services where required. Guidelines on written information for patients; developed by the Patient Safety and Experience Dept and approved in Q4-2019/2020, highlights the importance of ensuring effective bilingual (Welsh and English) provision of ALL written information for patients and this is a key function of the recently reconstituted readers panel. Feedback shared with staff, managers and service collaborators as exemplars of practice. During this reporting period Foelas Ward was nominated for the Nursing Times Learning Disabilities Award, a letter received from Jennifer Finch-Saunders (AM) congratulating staff	provides a measure of service improvements which are highlighted by patients and service users to have most strongly contributed to a positive patient/service user experience and are displayed on patient experience notice boards and on shared on social media.

	has been received in relation to the quality of the service and the compassion and attitude of staff. Some examples amongst many include; • "excellent attitude, compassion and commitment". (Cefni Hospital) • "very good which made a huge difference when being given a diagnosis … grateful for your thoroughness and the time you took to explain and answer their questions and concerns following the recent diagnosis of dementia …thank you for all the care and support I have received in the last year … You are all great listeners … You built me up to care for myself again. All of you go the extra mile to help myself and others on a daily basis." (Memory Clinics) • "would like to offer my sincere thanks for not only the care you afforded my son during his stay but also myself during what was a difficult time for all of us" (Parent of a Pt on Dinas Ward) Feedback in the West via Caniad highlighted that whilst receiving treatment (i) some inpatients were 'bored' and (ii) were not aware that they had care plans and/or what was contained within these. While feedback from inpatients at the Ablett Unit, via real time patient	for "this well deserved recognition is not entirely unexpected by me, being keenly aware of the unusually high compassion and dedication which characterises nursing staff in our local health board", was shared with staff, service collaborators and via governance structures to the BCUHB board. Action was taken to ensure that Inpatients in Hergest Unit are now able to access community wellbeing groups with support from the occupational therapists. Caniad are collaboratively designing an addendum to the statutory care plan documentation, which will include what the patient needs to know and what is important to them. Ensure staff develop a documented plan of activities during the weekend.	

	feedback, is positive in relation to staff referring to them as “like family” it also highlights the feeling that staff are very busy and that there is a shortage of staff making communication difficult. Feedback in the matron walkabout echoes this theme and extends to lack of things to do on the ward especially during the weekends whilst citing efforts of the activity coordinators as “excellent		
	A recent rapid review following episodes of serious self-harm in a mental health inpatient unit found that there was limited evidence that staff members had engaged in meaningful conversations and therapeutic engagement with patients. Feedback from patients in the therapeutic observation and engagement audit found that some patients did not know what level of observations they were on and that they had not received information around this	Head of Nursing has designed and delivered refresher training in relation to therapeutic engagement and observation and risk formulation and management. Poster in relation to PPPA has been placed on the wall in the unit to remind staff of the questioning technique when asking about risks.	
	Following comprehensive serious incident reviews and formal feedback from HM Coroner, issues were identified with those patients who experience co-occurring substance misuse and mental health problems	In April 2019 the Division implemented the NHS Wales & WG Service Framework to Meet the Needs of People with a Co-occurring Substance Misuse and Mental Health Problems, to ensure that those with substance misuse and mental health problems get the right support at the right time and prevent people falling between services.	

	What has your organisation done to encourage feedback from service users on their experience of your services?	What has your organisation done to respond to service user feedback to improve/redesign your services? Please provide examples of improvements.	How have you communicated improvements to your service users? e.g. 'you said, we did'.
Emergency & Unscheduled Care	Within this period BCUHB began to implement the first phase of the All Wales Emergency Quality Development Framework (EQDF) and implemented the 'Happy or Not', feedback system, which replaced the All Wales PREMs (CRT/Viewpoint) beginning in Q4-2019/2020. The other methods for obtaining patient/service user feedback remained namely, PALS inquiries, patient stories and care2share discovery interviewing.	Feedback from CRT/Viewpoint (PREM) derived from the Emergency Department for Q1-Q3 2019/2020 consistently reports a lower level of patient satisfaction than from other service points. However, care has to be exercised in associating this with a lower quality of care, as feedback via a Kiosk situated in the waiting area inevitably provides a snapshot of care at a point in the pathway prior to treatment where waiting times are highlighted, for essentially lower levels of triage. However one of the early outcomes of the EQDF project is that unnecessary waiting is neither clinically or organisationally effective, and this is especially so for vulnerable and/or immune supressed patients. Thus, a number of initiatives have been implemented; • Development of the Choose Well Campaign • Ensuring patients are made aware of the waiting times associated with their triage category given other clinical demands on the departments	**(See Above)** Additionally, the organisational Quality, Safety & Experience Committee provides board level assurance in relation to implementation of the Happy or Not project and localised project plan.

		• Providing live waiting time information for all EDs and MIUs through an App • Utilising real time feedback from hand held tablets to respond to patient queries – based on the Happy or Not data set. • Evaluating patient experience at a variety of points in the ED pathway. • Arranging next day or 'soon' booked appointments where these are clinically indicated and commensurate with patient needs • Enabling cancer patients to be contacted by mobile telephone post triage to avoid the need for immune supressed patients to wait in a crowded waiting area. (This initiative has been the result of collaborative work between the PALS service, ED project Manager and the North Wales Cancer Collaborative). The Happy or Not project, feedback from PALS officers, ED Managers and staff and mental health charities and support group, e.g. Caniad amongst others, has indicated that some ED attenders have additional mental health needs and within this reporting period each of the DGH ED have an ICAN mental health support officer. Feedback from a recent patient story highlights the profound importance of this service from the	

		persepective of an ED attender; *“Without ICAN, I would have returned to the bridge and jumped to my death”.* The ED matrons have within this period reviewed the Educational Needs of Emergency Nurse Practitioners in order to enhance the ability to facilitate flow through ED and have been incorporated into the wider work force planning process.	
Patient Transport	**(See Above)**		

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience (QSE) Committee 3rd November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Clinical Audit Update
Cyfarwyddwr Cyfrifol: Responsible Director:	Prof Arpan Guha, Acting Executive Medical Director
Awdur yr Adroddiad Report Author:	Dr Melanie Maxwell, Senior Associate Medical Director/ Improvement Cymru Clinical Lead
Craffu blaenorol: Prior Scrutiny:	Quality Safety Group, QSE Committee, Audit Committee (March 2020) Clinical Effectiveness Group (Oct 2020)
Atodiadau Appendices:	1. Interim 2020/21 Clinical Audit Plan

Argymhelliad / Recommendation:

The Committee is asked to adopt the interim clinical audit plan 2020/21 as the approved plan.

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:

The draft Clinical Audit Plan 2020/21 was presented to the Committee in March. It was agreed to defer this to September to ensure any changes required by Welsh Government to tier 1 and additional any tier 2 audits could be incorporated. However, due to the Covid 19 pandemic, the standing down of most audits from March – September, and redeployment of audit staff, the plan is unchanged except for the addition of a National Covid audit (Tier 1). Therefore the Committee is asked to adopt the attached plan as the formal clinical audit plan for 2020/21.

Cefndir / Background:

National Clinical Audit & Outcome Review Plan (NCAORP) projects are those that have been annually prioritised by Welsh Government and mandated for Welsh Health Board participation. These mandated audits are referred to within BCUHB as 'Tier 1'. All applicable audits are included in the Tier 1 element of the BCUHB Clinical Audit Plan.

'Tier 2' Corporate projects included within this plan, have been prioritised by Executive leads for the services within their remit. Clear identification was requested regarding:

- BCUHB priority that the project will support.
- The responsible Corporate Group.
- An assessment of risk (based upon specified criteria).

Assurance is given to the Committee that under each project there is an accountable lead responsible within the Corporate Group. The plan has been updated to ensure changes in leads has been acknowledged.

More recently, the Audit Committee have requested that the audit plan reflects any claims against the HB where appropriate. This will be clearly articulated in the next round of audit planning and explicit in the tier 2 audit criteria.

Asesiad / Assessment & Analysis

Strategy Implications
The draft plan reflects the breadth of topics embraced by the Welsh Government's NCAORP Plan. Tier 2 audits are linked to key quality and safety concerns, as well as areas for improvement within the HB. It will provide assurance about service quality and also identify improvement opportunities aligned with our quality strategy.

Financial Implications
The financial considerations that relate to this document are broad in terms of direct impact upon service delivery or a number of support departments such as Clinical Audit Group, Medical Records or Clinical Informatics. Clinical Audit enables the measurement of care delivery against evidence-based standards; facilitating optimum use of limited resources and identification of additional resource needs for improvement. These are identified within the individual context of each project. Also, there is the indirect cost of support services that contribute to successful participation of the projects identified as priorities by each team. These support functions need to be resourced if clinicians are to be able to participate and focus upon improvement activity.

Risk Analysis
The Tier 1 element of the 2020/21 Clinical Audit Plan relates to mandatory projects as prioritised by Welsh Government within their NCAORP. Tier 2 includes some projects which are required for accreditation, regulation and licensing; along with management of risk, quality, safety and patient experience. Resourcing to support activity corporately is currently under review and is recorded within the Risk Register (reference: 2961) with a current tier 2 risk rating of 12. This has been mitigated by reducing the scope of activity of the corporate team for example introducing a digital solution to register tier 3 audits. There is work in progress to articulate the additional resources required to support a fully functional audit programme.

There is a risk of a lack of assurance for services where there is patchy or non-compliance with the plan. Where these are Tier 1 audits, it is usually due to lack of resources; mitigation might be more localised audits and other sources of assurance. Actions to address this are predominantly with the secondary care HMT and include ensuring audit leadership is included within robust job planning, embedding audit reporting within the governance structures from speciality to Board; once commenced, quarterly reporting will identify issues earlier for action. Additional resources are likely to be required to support the audit function. Going forward the clinical strategy includes the development of pathways that explicitly links to relevant national audits, will be developed.

Legal and Compliance
The Tier 1 element of the 2020/21 Clinical Audit Plan relates to mandatory projects as prioritised by Welsh Government within their NCAORP. Reporting on progress will be scheduled for the Clinical Effectiveness Group (CEG) on a quarterly basis leading to a full annual report in line with the new Clinical Audit Policy.

Impact Assessment

An Equality Impact Assessment (EqIA) has been completed for the recently approved BCUHB Clinical Audit Policy that relates closely to participation with the Tier 1 and Tier 2 elements of the 2020/21 Clinical Audit Plan. The premise of clinical audit is to establish the extent to which evidence-based standards are delivered in practice in a manner that reduces variance and optimises standardisation of excellent care and treatment for all. The policy will:

- Promote good practice as outlined above and encourages adherence to National guidance and standards.
- Promote standardisation and equality of access to good practice.
- Encourage patient and public involvement in clinical audit activity.

Reference:	Title of National Audit	BCUHB Lead	East area Lead	Central Area Lead	West Area Lead	In year Data Submission	In year Report
NCAORP/2020/01	National Joint Registry	No BCUHB lead at present	Mr Ian Wilson (Consultant Orthopaedic Surgeon)	Mr Madhusudhan Raghavendra & Mr Balasundaram Ramesh. (Consultant Orthopaedic Surgeon's)	Mr Koldo Azurza (Consultant Orthopaedic Surgeon)	Yes	Yes
NCAORP/2020/02	National Emergency Laparotomy Audit	Dr Stephan Clements (Consultant Anaesthetist)	Mr Duncan Stewart (Consultant Surgeon) / Dr Sianedd Elliott / Dr Kiran Dasari (Consultant Anaesthetists)	Mr Richard Morgan (Consultant Surgeon) / Dr Magdy Khater (Consultant Anaesthetist)	Dr Stephan Clements (Consultant Anaesthetist) / Mr. Nik Abdullah (Consultant Surgeon)	Yes	Yes
NCAORP/2020/03	Comparative audit of critical care unit adult patient outcomes (casemix) ICNARC	No BCUHB lead at present	Dr Andy Campbell (Consultant Anaesthetist)	Dr Richard Pugh (Consultant Anaesthetist)	Dr Alison Ingham, (Consultant Anaesthetist)	Yes	Yes
NCAORP/2020/04	Trauma Audit & Research Network (TARN)	No BCUHB lead at present	Dr Ben Sasi (Anaesthetics Associate Specialist)	Dr Tom O'Driscoll (Emergency Medicine Consultant)	Dr Leesa Parkinson / Dr Rob Perry (Consultants: Emergency Department)	Yes	Yes
NCAORP/2020/05	National Diabetes Foot care Audit	Gareth Lloyd Hughes (Head Of Podiatry & Orthotics - East Area)	Dr Anthony Dixon (Consultant Physician) & Nicola Joyce (Podiatrist)	Dr Aye Nyunt (Consultant Physician)	No Medical Lead at present & Jamie O'Malley/Iola Roberts (Diabetic Podiatrists)	Yes	Yes
NCAORP/2020/06	Diabetes Inpatient Audit (NaDia)	No BCUHB lead at present	Dr Stephen Stanaway (Consultant Physician) / Cheryl Griffiths (Diabetes Specialist Nurse)	Dr Stephen Wong (Consultant Physician) / Kirstin Clark (Diabetes Specialist Nurse)	Dr Muhammed Murtaza (Consultant Physician) / Ceri Roberts (Diabetes Specialist Nurse)	Yes	Yes
NCAORP/2020/07	Pregnancy in Diabetes Audit Programme	No BCUHB lead at present	Dr Stuart Lee (Consultant Physician), Lynda Vergheese (Locum Physician) , Gill Davies (Diabetes Specialist Nurse), Rao Bondugulapati (Consultant Physician)	Dr Steven Wong (Consultant Physician), Miss Maggie Armstrong (O&G Consultant), Kirstin Clark (Diabetes Specialist Nurse)	Dr Leela Ramesh (Consultant Physician), Dr Noreen Haque (Registrar),Dr Tony Wilton (Consultant Physician), Ceri Roberts (Diabetes Specialist Nurse)	Yes	No - Reports are biennially
NCAORP/2020/08	National Core Diabetes Audit: (Primary / Secondary Care & Insulin Pump elements)	No BCUHB lead at present	**Primary Care element**: Dr Gareth Bowdler (Area Medical Director) Insulin Pump Element: Dr Rao Bondugulapti (Consultant Physician)	**Primary Care element**: Dr Liz Bowen (Area Medical Director). **Insulin Pump element:** Julie Roberts (Lead Diabetes Specialist Nurse), Dr Minesh Shah (Associate Specialist)	**Primary Care element:** Dr Bethan Jones (Area Medical Director) Insulin Pump element: Dr Muhammed Murtaza (Consultant Physician)	Yes	Yes
NCAORP/2020/09	National Paediatric Diabetes Audit (NPDA)	Dr Michael Cronin (Consultant Paediatrician)	Dr Kamal Weerasinghe (Consultant Paediatrician),	Dr Pramod Bhardwaj (Consultant Paediatrician)	Dr Michael Cronin (Consultant Paediatrician)	Yes	Yes
NCAORP/2020/10	National Asthma & COPD Audit Programme (NACAP): Children and Young People Asthma	No BCUHB lead at present	Dr Liz Richards (Locum Consultant)	Dr Lee Wisby (Consultant Paediatrician)	Dr Mair Parry (Consultant Paediatrician)	Yes	Yes
NCAORP/2020/11	NACAP: Adult Asthma	No BCUHB lead at present	Erin Humphreys (Interim Deputy Head of Nursing)	Dr Daniel Menzies (Consultant Physician)	Dr Claire Kilduff (Consultant Physician)	Yes	Yes
NCAORP/2020/12	NACAP: COPD	No BCUHB lead at present	Erin Humphreys (Interim Deputy Head of Nursing)	Dr Sarah Davies (Consultant Physician)	Dr Claire Kilduff (Consultant Physician)	Yes	Yes
NCAORP/2020/13	NACAP - Pulmonary Rehabilitation workstream	Dr Daniel Menzies (Consultant Physician)	Michelle Owen (Clinical Specialist Physiotherapist / Pulmonary Rehab Coordinator)	Ann Ellis (Respiratory Occupational Therapist)	Ffion Edwards (Occupational Therapist) & Caerwyn Roberts (Physiotherapist)	Yes	Yes
NCAORP/2020/14	Renal Registry	No BCUHB lead at present	Dr Stuart Robertson (Consultant Physician)	Dr Mick Kumwenda (Consultant Physician)	Dr Mahdi Jibani (Consultant Physician)	Yes	Yes
NCAORP/2020/15	National Early Inflammatory Arthritis Audit (NEIAA)	No BCUHB lead at present	No lead at present	Dr Alessandro Ciapetti (Consultant)	Dr Yasmeen Ahmed (Consultant Physician)	Yes	Yes
NCAORP/2020/16	All Wales Audiology Audit	Paediatrics: Dafydd Hughes-Griffiths (Head of Paediatric Audiology) Adult Rehabilitation: Jane Wild, Head of Adult Audiology (BCU) Susannah Goggins, Head of Adult Rehabilitation and Balance, Audiology, BCU	Adult Rehabilitation: Anna Powell, Head of Adult Rehabilitation & Balance (East)	Adult Rehabilitation: Suzanne Tyson, Head of Adult Rehabilitation & Balance (Central)	Adult Rehabilitation: Heidi Turner, Head of Adult Rehabilitation and Balance (West)	Yes	Yes
NCAORP/2020/17	Stroke Audit (SSNAP)	Dr Walee Sayed (Consultant Physician)	Dr Walee Sayed (Consultant Physician)	Dr Krishnamurthy Ganeshram (Consultant Physician)	Dr Salah Elghenzai (Consultant Physician)	Yes	Yes
NCAORP/2020/18	Falls & Fragility Fractures Audit Programme: National Hip Fracture database	No BCUHB lead at present	Mr Ian Starkes (Consultant Orthopaedic Surgeon)	Mr Amir Hanna (Consultant Orthopaedic Surgeon)	Mr Ashok Goel (Consultant Orthopaedic Surgeon)	Yes	Yes
NCAORP/2020/19	Falls & Fragility Fractures Audit Programme: In-patient Falls Audit	No BCUHB lead at present	No lead at present	Dr Geralt Owen (Consultant Physician)	Eleri Evans (Interim Head Of Nursing For Medicine - YG)	Yes	Yes
NCAORP2020/20	Falls & Fragility Fractures Audit Programme: Fracture Liaison Service	No BCUHB lead at present	No FLS Service	No FLS Service	Dr Swapna Alexander (Consultant Physician: Care of the Elderly)	Yes	Yes
NCAORP/2020/21	National Dementia Audit	Dr Indrajit Chatterjee (Consultant Physician) Interim	Dr Sam Abraham (Consultant Physician)	Dr Indrajit Chatterjee (Consultant Physician)	Dr Conor Martin (Consultant)	Yes	Yes
NCAORP/2020/22	National Audit of Breast Cancer in Older Patients (NABCOP)	Mr Walid Samra (Consultant Surgeon)	Mr Tim Gate (Consultant Breast Surgeon)	Miss Mandana Pennick, (Consultant Breast Surgeon)	Mr Ilyas Khattak (Consultant Breast Surgeon)	Yes	Yes
NCAORP/2020/23	National Audit of Care at the End of Life (NACEL)	Dr Helen Mitchell (Consultant Palliative Medicine)	Mrs Geeta Kumar (Deputy Hospital Medical Director - Q&S)	Dr Tania Bugelli (Deputy Hospital Medical Director - Q&S)	Dr Karen Mottart (Hospital Medical Director - West)	No - Suspended until Apr 2021 due to COVID 19 pandemic	Yes
NCAORP/2020/24	National Heart Failure Audit	Dr Richard Cowell (Consultant Cardiologist)	Fiona Willcocks (Heart Failure Specialist Nurse)	Dr Mohammad Aldwaik (Consultant Cardiologist) / Andy Bennett (Heart Failure Specialist Nurse)	Dr Mark Payne (Consultant Cardiologist) / Nia Coster (Heart Failure Nurse)	Yes	Yes

NCAORP/2020/25	Cardiac Rhythm Management	Dr Richard Cowell (Consultant Cardiologist)	Dr Rajesh Thaman (Consultant Cardiologist)	Dr Mohammad Aldwaik (Consultant Cardiologist)	Dr Mark Payne (Consultant Cardiologist)	Yes	Yes
NCAORP/2020/26	PCI Audit (previously Coronary Angioplasty Audit)	Dr Paul Das (Consultant Interventional Cardiologist)	N/A	Dr Paul Das (Consultant Interventional Cardiologist)	N/A	Yes	Yes
NCAORP/2020/27	MINAP	Dr Richard Cowell (Consultant Cardiologist)	Dr Richard Cowell (Consultant Cardiologist)/ Lucy Trent (Nurse Practitioner)	Dr Eduardas Subkovas (Consultant Interventional Cardiologist)	Dr Mark Payne	Yes	Yes
NCAORP/2020/28	National Vascular Registry Audit (inc. Carotid Endarterectomy Audit)	Mr Soroush Sohrabi (Clinical Director – North Wales Vascular Network) & Joanne Garzoni (North Wales Vascular Network Manager)	Mr Soroush Sohrabi (Clinical Director)	Mr Soroush Sohrabi (Clinical Director)	Mr Soroush Sohrabi (Clinical Director)	Yes	Yes
NCAORP/2020/29	Cardiac Rehabilitation	Catrin Warren (Cardiac Rehabilitation Physiotherapist)	Jacqueline Cliff (Cardiac Rehabilitation Nurse Lead)	Catrin Warren (Cardiac Rehabilitation Physiotherapist)	Dale Macey (Cardiology Rehab Lead Specialist Nurse) / Iorwerth Jones (Exercise Physiologist- Cardiac Rehab)	Yes	Yes
NCAORP/2020/30	National Lung Cancer Audit	Dr Ali Thahseen (Consultant Respiratory Physician)	No lead at present	Dr Sakkarai Ambalavanan (Consultant Physician)	Dr Ali Thahseen (Consultant Respiratory Physician)	Yes	Yes
NCAORP/2020/31	National Prostate Cancer Audit	Mr Kyriacos Alexandrou (Consultant Urologist)	Mr. Iqbal Shergill (Consultant Urologist)	Mr. Kingsley Ekwueme (Consultant Urologist)	Mr Kyriacos Alexandrou (Consultant Urologist)	Yes	Yes
NCAORP/2020/32	National Gastrointestinal Cancer Audit Programme	**Bowel**: Dr Claire Fuller (Consultant Oncologist) **Oesophago-gastric** Mr Andrew Baker (Consultant Surgeon)	**Bowel:** Mr Micheal Thornton (Consultant Surgeon) **Oesophago-gastric:** Mr Andrew Baker (Consultant Surgeon) / Dr Thiriloganathan Mathialahan (Consultant	**Bowel:** Mr Andrew Maw (Consultant Surgeon) **Oesophago-gastric:** Mr Richard Morgan (Consultant Surgeon)	**Bowel:** Dr Claire Fuller, (Consultant Oncologist) & Mr Anil Lala (Consultant Surgeon) **Oesophago-gastric:** Dr Jonathan Sutton (Consultant Gastroenterologist)	Yes	Yes
NCAORP/2020/33	National Neonatal Audit Programme (NNAP)	Mandy Cooke (Neonatal Services Manager)	Dr Brendan Harrington (Consultant Paediatrician)	Dr Geedi Farah (Consultant Paediatrician), Dr Mohammed Sakheer Kunnath (Consultant Paediatrician)	Dr Shakir Saeed (Consultant Paediatrician)	Yes	Yes
NCAORP/2020/34	National Maternity & Perinatal Audit	Fiona Giraud (Director of Midwifery and Women's Services)	Maureen Wolfe (Womens Lead, Clinical Risk & Governance)	Dr Niladri Sengupta (O&G Consultant)	Fiona Giraud (Director of Midwifery and Women's Services)	Yes	Yes
NCAORP/2020/35	Epilepsy 12 - Clinical	Dr Kathryn Foster (Consultant Paediatrician)	Dr Praveen Jauhari (Consultant Paediatrician)	Dr Mohammed Sakheer Kunnath (Consultant Paediatrician)	Dr Kathryn Foster (Consultant Paediatrician)	Yes	Yes
NCAORP/2020/36	National Clinical Audit of Psychosis	Dr Mike Jackson (Consultant Psychologist)	No EIP service	No EIP service	Dr Mike Jackson (Consultant Psychologist)	Yes	Yes
NCAORP/2020/42	National Covid-19 Audit	No BCUHB lead at present	Dr Liz Brohan (Consultant Physician)	Dr Daniel Menzies (Consultant Physician)	Dr Claire Kilduff (Consultant Physician)	Yes	No
NCAORP projects not applicable to BCUHB: (due to commissioned services elsewhere):							
NCAORP/2020/37	National Adult Cardiac Surgery Audit						
NCAORP/2020/38	National Congenital Heart Disease Audit						
NCAORP/2020/39	Paediatric Intensive Care Audit (PICaNet)						

Project Ref Number	Project Title	Int/ext guidance	Corporate policy	External review	Reaudit / continuous	Risk Register	Which BCUHB priority does this support?	Proposed Start Date	Proposed Finishing Date	Objectives	Responsible Corporate Group	In year Data Collection	In-year Report	Risk Assessment *(see key below)*
Acute/20/01	Ward Manager Weekly Audit			Y	Y	Y	Highly reliable clinical care	1st July 2020	Ongoing - no end date	Data is owned by wards for own quality improvements	Secondary Care Quality Group	Yes	Yes	Critical
Acute/20/02	Shine Tool (Emergency Department Safety Checklist)	Y		Y		Y	Reduce patient harms	Wxm Jun-20	Wxm Jul-20	The importance of completing the ED safety checklist to be discussed during documentation study day.	Secondary Care Quality Group	Yes	Yes	Critical
Acute/20/03	Patient assessment for suitability to outlie		Y			Y	Reduce patient harms	Wxm Jul-20	Wxm sep-20	Completion of outlier matrix to assess suitability of patients who have been outlied for non-clinical reasons	Secondary Care Quality Group	Yes	Yes	High
Acute/20/04	Oxygen Competencies	Y	Y			Y	Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	Ensure Compliance	Medical Gases Committee	Yes	Yes	High
Acute/20/05	IV Morphine (compliance against guidelines and record keeping)		Y		Y	Y	Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	Ensure Compliance	Professional Advisory Group (PAG) / Safe Medication Steering Group	Yes	Yes	High
Acute/20/06	Enhanced care observation audit	Y		Y		Y	Highly reliable clinical care	Wxm Sep-20	Wxm Sep-20	Education package being developed for BCU with particular focus on delirium 10 measure	Secondary Care Quality Group	Yes	Yes	Medium
CORP/04/20	Ward Accreditation Monthly Metrics	Y		Y			Highly reliable clinical care. Reduce patient harms	Ongoing	Ongoing - no end date	Data is owned by wards for own quality improvements	Senior Nursing Team	Yes	Yes	Critical
IP&C/20/01	Hand Hygiene audits	Y	Y	Y	Y		Quality and Safety. Reduction in healthcare associated infections	Across financial yr 20/21	Ongoing - no end date	Reduction in healthcare associated infections	Local IPG. Infection Prevention Strategic Group (IPSG)	Yes	Yes	High
IP&C/20/02	Decontamination Audits	Y	Y	Y	Y	Y	Quality & Safety. Reduction in healthcare associated infections	Across financial yr 20/21	Ongoing - no end date	Reduction in healthcare associated infections	Exceptions to Strategic Decontamination Group then IPSG	Yes	Yes	Critical
MH&LD CEG/2020/01	Side effects of patients on long acting antipsychotic medication	Y			Y		Reduce patient harms. Quality and Safety.	Across financial yr 20/21	Ongoing - no end date	Reduce patient harm	MH&LD Clinical Effectiveness Group	Yes	Yes	High
MH&LD CEG/2020/02	Physical health monitoring	Y	Y	Y			Reduce patient harms. Quality and Safety.	TBC	TBC	Reduce patient harm	MH&LD Clinical Effectiveness Group	Yes	Yes	High
MH&LD CEG/2020/03	Introduction of scale to monitor depression	Y					Highly reliable clinical care. Reduce patient harms. Quality and Safety.	TBC	TBC	Reduce patient harm	MH&LD Clinical Effectiveness Group	Yes	Yes	High
MH&LD CEG/2020/04	PPE within MH&LD	Y			Y		Reduce patients harm. Quality and Safety	Across financial yr 20/21	Ongoing - no end date	Reduce patient harm	MH&LD Clinical Effectiveness Group	Yes	Yes	High
CORP/01/20	Record Keeping	Y	Y		Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Ongoing - no end date	Reduce patient harm	Secondary Care Quality Group	Yes	Yes	Critical
Corp/OMD/Consent/20/01	Informed Consent within Secondary Care – A Retrospective Re-audit of Consent forms.	Y	Y		Y	Y	Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Ongoing - no end date	Ensure that consent to treatment processes are compliant with Welsh Language Legislation	Consent and Capacity Strategic Working Group	Yes	Yes	Critical
RES/20/01	2222 Audit	Y	Y	Y	Y	Y	Highly reliable clinical care. Reduce patient harms. Quality and Safety	Dec-20	Ongoing - no end date	Establishment of uniform process for emergency call responses across all sites of BCUHB in line with existing BCUHB Resuscitation Policy	BCUHB Resuscitation Committee, & Rapid Response to Acute Illness Learning Set (RRAILS), sepsis and Acute Kidney Injury (AKI) Steering Board	Yes	Yes	High

HTA/HA/2020	Auditing compliance with the Human Tissue Act - Human application	Y		Y	Y		Highly reliable clinical care.	Apr-20	Apr-21	Individual audits on a rolling schedule to monitor continual compliance	Pathology Management and Stem Cell Service	Yes	Yes	Critical
HTA/PM/2020	Auditing compliance with the Human Tissue Act - Post Mortem Sector	Y		Y	Y		Highly reliable clinical care.	Apr-20	Apr-21	Individual audits on a rolling schedule to monitor continual compliance	North Wales Managed Clinical Services (NWMCS) Quality Committee	Yes	Yes	Critical
BSQR/2020	Auditing compliance with the Blood Safety and Quality Regulations	Y		Y	Y		Highly reliable clinical care. Reduce patient harms	Apr-20	Apr-21	Individual audits on a rolling schedule to monitor continual compliance	NWMCS Quality Committee	Yes	Yes	Critical
ISO15189/2020	Annual audit calendar (minimum 12 audits per site/service) Auditing compliance with ISO 15189. Blood Science service on 3 sites, and Cellular Pathology service on one site.	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Apr-20	Apr-21	Individual audits on a rolling schedule to monitor continual compliance	NWMCS Quality Committee	Yes	Yes	Critical
MedPhys/2020	Accreditation and on-going compliance with ISO9001:2015 Quality Management System. External accreditation on 36 month cycle, each section has tailored internal audit schedule.	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Ongoing - no end date	Consistently provide products and services that meet our service users and applicable statutory and regulatory requirements	NWMCS Quality Committee	Yes	Yes	Medium
IRR/2020	BCU Ionising Radiation Protection Regulations compliance audits (Minimum 2 a year performed by Head of Quality & Governace and Medical physics expert at any site or department in BCUHB where imaging takes place)	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	Overarching Radiation Protection Committee	Yes	Yes	Critical
IRMER/PI/2020	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Patient Identification completed annually for each Radiology service	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	NWMCS Quality Committee	Yes	Yes	Critical
IRMER/RPD/2020	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Recording of Patient Dose completed annually for each Radiology service	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	NWMCS Quality Committee	Yes	Yes	Critical
IRMER/PS/2020	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Pregnancy Status completed annually for each Radiology service	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	NWMCS Quality Committee	Yes	Yes	Critical
IRMER/RP/2020	Radiology Ionising Radiation (Medical Exposure) Regulations {IR(ME)R} compliance Audit - Recording of Practitioner completed annually for each Radiology service	y	y	y	y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	NWMCS Quality Committee	Yes	Yes	Critical
QSI/2020	Annual audit calendar (minimum 6 audits per site) Auditing compliance with Ionising Radiation (Medical Exposure) Regulations, Ionising Radiation Regulations, requirements for clinical audit and audits of the service as part of the requirements for Quality Standards in Imaging Accreditation	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	NWMCS Quality Committee	Yes	Yes	Critical
P&MM/20/01	Antimicrobial Point Prevalence Audit (Inpatients)	Y		Y	Y	Y	Safe, Clean, Care. Keeping People Safe from Avoidable Harm	Nov-20	Nov-20	Keeping people safe	Antimicrobial Steering Group	Nov-19	May 2020 (by Public Health Wales)	High
P&MM/20/02	Antibiotic Review Kit (ARK)/Start Smart then Focus audit via Public Health Wales tool	Y		Y		Y	Safe, Clean, Care. Keeping People Safe from Avoidable Harm	Apr-21	Mar-22	Training development package for Junior Doctors	Antimicrobial Steering Group	April 2020 provided PHW tool available	Awaiting report scheduling from PHW (May 2021 suggested)	High
P&MM/20/03	All Wales Inpatient Medication Safety Audit	Y		Y	Y	Y	Keeping People Safe from Avoidable Harm	Across financial yr 20/21	Mar-21	Ensuring safety and following compliance	Safer Medicines Steering Group	Ongoing monthly audit	Ongoing monthly audit	High
P&MM/20/04	Safe and Secure Handling of Medicines in Clinical Areas	Y	Y	Y	Y	Y	Keeping People Safe from Avoidable Harm	Across financial yr 20/21	Mar-21	Ensuring safety and following compliance	Safer Medicines Steering Group	Ongoing	Yes	High
P&MM/20/05	Controlled Drugs: storage, handling and record keeping in pharmacies and clinical areas	Y	Y		Y		Keeping People Safe from Avoidable Harm	Across financial yr 20/21	Rolling 6 months	To audit compliance in relation to: Storage/Security/Record Keeping	Controlled Drugs Local Intelligence Network	Ongoing quarterly audit	Quarterly	Critical
P&MM/20/06	Compliance with the BCUHB Unlicensed Medicines Policy (MM42)	Y	Y		Y		Keeping People Safe from Avoidable Harm	Across financial yr 20/21	Mar-21	Ensure Compliance	Drug & Therapeutics Group	Yes	Yes	High
P&MM/20/07	Assessment of BCUHB Homecare Service compliance with the Royal Pharmaceutical Society Professional Standards for Homecare	Y		Y			Highly reliable clinical care. Care closer to home.	Apr-21	TBC	Ensuring compliance with RPSP Standards for homecare	Pharmacy and Medicines Management: Secondary Care Group	Mar-20	Yes	Medium
P&MM/20/08	Audit of Prescribing Standards within Cancer Services	Y	Y				Keeping People Safe from Avoidable Harm	TBC	TBC	Awaiting update	Pharmacy Cancer Services group	Yes	Yes	High
Research 20/01	Audit and monitoring of hosted studies (for high a nd medium risk categorised studies) following Assess, Arrange, Confirm process	Y			Y		Highly reliable clinical care. Reduce patient harm	Across financial yr 20/21	Mar-21	To review study procedures and research documentation to determine whether the approved study protocol, Good Clinical Practice, BCUHB SOPs and Sponsor specific SOPS have been followed as appropriate for the study type.	Research senior management team group	Yes	Yes	Low

Research 20/02	Audit and monitoring of sponsored studies	Y			Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 20/21	Mar-21	To review study procedures and research documentation to determine whether the approved study protocol, Good Clinical Practice, BCUHB SOPs and Sponsor specific SOPS have been followed as appropriate for the study type.	Research senior management team group	Yes	Yes	Low
Research 20/03	Research policies and Standard Operating Procedures (SOPS)	Y			Y		Reduce patient harms	Across financial yr 20/21	Mar-21	Review and compare practice against the standards and procedures as detailed in the Betsi suite of research SOPs and any applicable research policies.	Research senior management team group	Yes	Yes	Low
Q&S20/01	Compliance with relevant LocSSIPs in each specialty	Y		Y	Y	Y	Avoid never events	Across financial yr 20/21	Mar-21	Ensure Compliance	Q&S site leads	Yes	Yes	High
NICE20/21	Compliance with NICE Quality standards/Clinical pathways linked to NICE guidance	Y		Y	Y	Y	Safe Value-based health care	Across financial yr 20/21	Mar-21	Ensure Compliance	BCUHB NICE Assurance Group	Yes	Yes	High

Risk classification criteria:	
Critical	Control weakness could have a significant impact on the system, function or process and achievement of organisational objectives in relation to compliance with laws and regulations or the efficient and effective use of resources.
High	Control weakness could have a significant impact on the system, function or process but does not have an impact on the achievement of organisational objectives (as above)
Medium	Control weakness has a low impact on the achievement of the key system, function or process or a low degree of risk associated with exposure.
Low	Control weakness has no impact on the achievement of the key system, function or process objectives; however, improved compliance would improve overall control.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 3rd November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Mortality Review Quarter 2
Cyfarwyddwr Cyfrifol: Responsible Director:	Prof Arpan Guha, Acting Executive Medical Director
Awdur yr Adroddiad Report Author:	Dr Melanie Maxwell , Senior associate Medical Director/Improvement Cymru Clinical Lead
Craffu blaenorol: Prior Scrutiny:	Early Draft Circulated to the Reducing Avoidable Mortality Steering Group (RAMSG). Responsible Director
Atodiadau Appendices:	1. Mortality Review Q2 presentation slides

Argymhelliad / Recommendation:

The Committee is asked to discuss the newly developed quarterly mortality report to determine if this provides an acceptable level of assurance around learning from deaths within BCUHB acute & community inpatient services and the Mental Health & Learning Disabilities (MH/LD) Division, recognising that a process for learning from deaths in primary care requires development.

Please tick as appropriate

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

Sefyllfa / Situation:

This newly developed report aims to provide assurance that the review process for learning from deaths is in place across BCUHB services. It will ensure the Board is aware of any concerns reported either through internal surveillance systems or external sources such as national clinical audit, and the action taken to resolve them. The report also highlights good practice identified through this process.

Cefndir / Background:

The Committee has not been assured by previous reports relating to the deaths review process, in particular ensuring that any lessons learnt are identified and shared across the Health Board.
At the last Committee meeting, an overview of the process used was presented that has three distinct phases – reporting – reviewing – learning. This report aims to provide assurance against that framework in relation to inpatient care and MH/LD services.

At the current time there is no formal process within primary care; there is a meeting with the Area Medical Directors to consider how we take this forward (November 2020). There are ongoing discussions at the National Mortality Review Group to develop and test a primary care tool.

The Medical Examiner service is now active in Ysbyty Glan Clywd and plans to be in all sites by December 2020; part of this independent role is to consider whether there is learning from a death and to highlight this to the service for further review and follow up. Going forward we will report on

the activity of the Medical Examiner to ensure all insights into care are captured and emergent themes are acted upon.

Asesiad / Assessment & Analysis

REPORTING:

Surveillance: The Crude death rate for inpatients is on a par with our Welsh peer. It did rise temporarily in the period April to June in line with other Health Boards, this related to Covid-19 related deaths with non-covid deaths at the expected level. There are no particular areas of concern related to non-covid conditions. There were no concerns raised externally in Q1 or Q2.

REVIEWING:

All inpatient sites have been reminded of the need to ensure stage 1 screening is completed; the target of 95% has been exceeded. The number of referrals for stage 2 has been 16% with some site variation. Anecdotal discussion with the Lead Medical Examiner is an expectation that around 15% are expected to be suggested for further review. There has been some action on Wrexham Maelor Hospital (WMH) and Ysbyty Glan Clwyd (YGC) to address the backlog of Stage 2 reviews. However, within Ysbyty Gwynedd (YG), there is a discrepancy between the reported activity through Morbidity & Mortality meetings and that reported centrally; they are keen to use the Datix module to address this. Training sessions have been arranged. MH/LD has a higher conversion rate to stage 2 due to the reporting requirements by Welsh Government. They aim to review all deaths. Women and Children's services deaths are subject to additional scrutiny. They have completed all reviews to the end of Q2. In discussion at RAMSG agreement was made to review the stage 2 backlog and remove any review that has been/is in the complaints and litigation process as these have been extensively reviewed. This work is delayed due to lack of resources within the Office of the Medical Director (OMD). There is currently a mix of community and acute stage 2 reviews in YGC and YG. No avoidable deaths have been reported. There are positive findings identified – these predominantly relate to good end of life care across all reporting services

LEARNING:

There are a small number of learning points raised. Across all sites the paperwork for Do Not Resuscitate agreements have been documented as incomplete. There is a discussion in process with the Associate Medical Director for Clinical Law and Ethics about auditing this as part of policy review. Women's services are re- developing guidance and patient education for reduced foetal movements. The condition of the case notes for inpatient care is a concern; this has been raised by the Medical Examiner's Office as well and a business case/ paper is being developed that should address this whilst options for scanned casenotes is examined.

Strategy Implications

Reducing avoidable mortality is a key outcome within the Quality Improvement Strategy. Having a robust review process will also identify learning from sub-standard care that may not have played a part in the death; acting on these insights will support delivering high quality evidence based care going forward.

Options considered

The Committee is asked to review the attached report to determine if this will provide the information required going forward and to identify any further amendments required.

Financial Implications

Learning from deaths could potentially reduce claims and litigation going forward. As we introduce more robust processes and mortality reviews within primary care, there may be costs associated with GPs time (as independent contractors); if required a business case will be developed.

Risk Analysis

Legal and Compliance

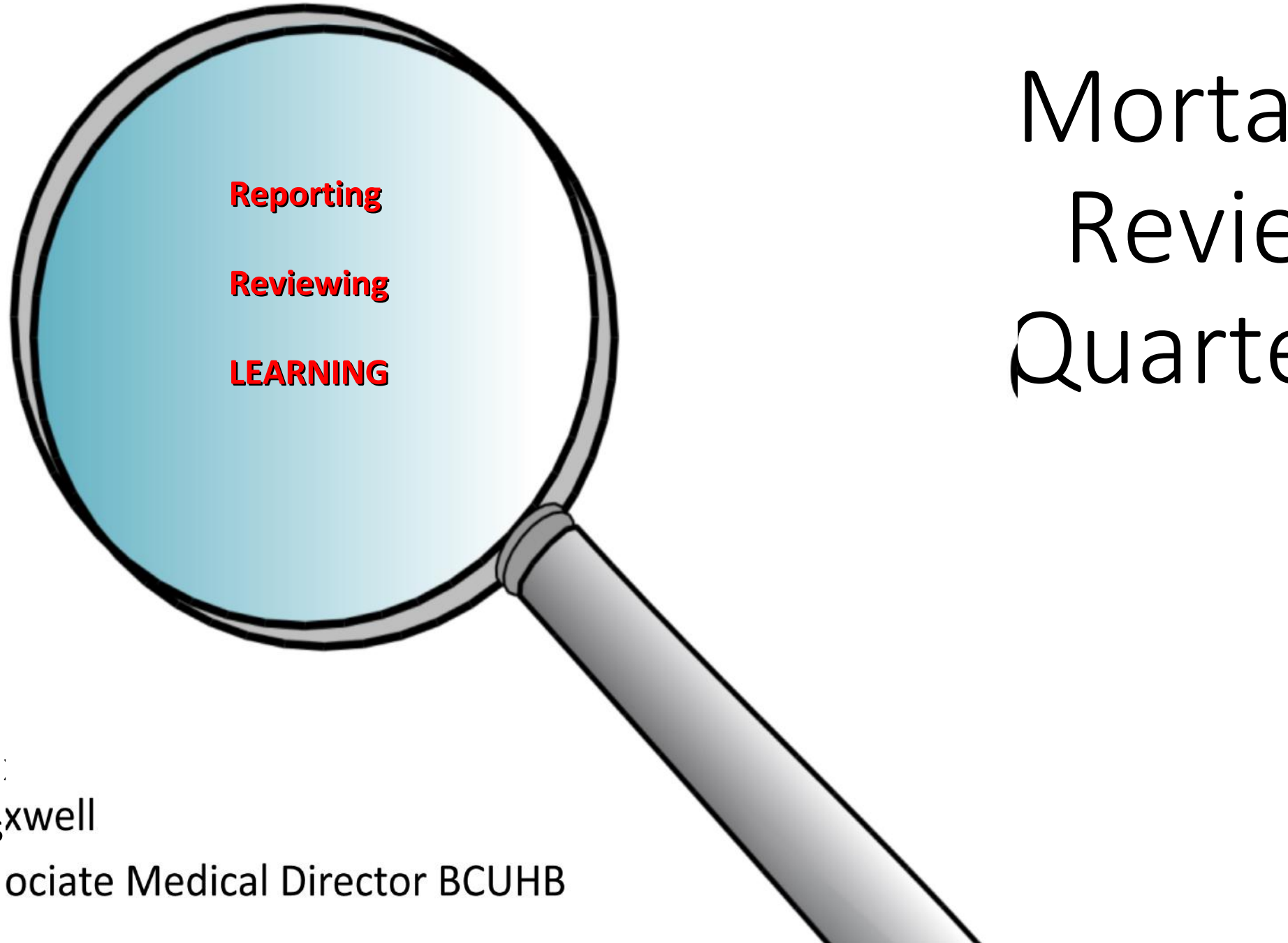
Improving the robustness of the review process will support compliance with the Medical Examiners system. The Medical Examiners Service will remove the requirement for stage 1 and identify those deaths, not requiring Coronal review where there is the potential to learn.

Specialities will report learning through their divisional structures using a similar format to the quarterly report. This information will be collated for RAMSG and presented to the Clinical Effectiveness Group for agreement on the actions required.

Impact Assessment

All deaths within an inpatient setting are currently screened and a decision to refer for further review is based on care given during the stay or concerns expressed by the relatives/friends of the deceased. The ability to extract learning from those reviews and change practice accordingly will benefit other patients requiring similar care. All deaths across North Wales will be subject to an independent review by the Medical Examiner and so be treated equitably (anticipated to start April 2021)

Mortality Review Quarter 2



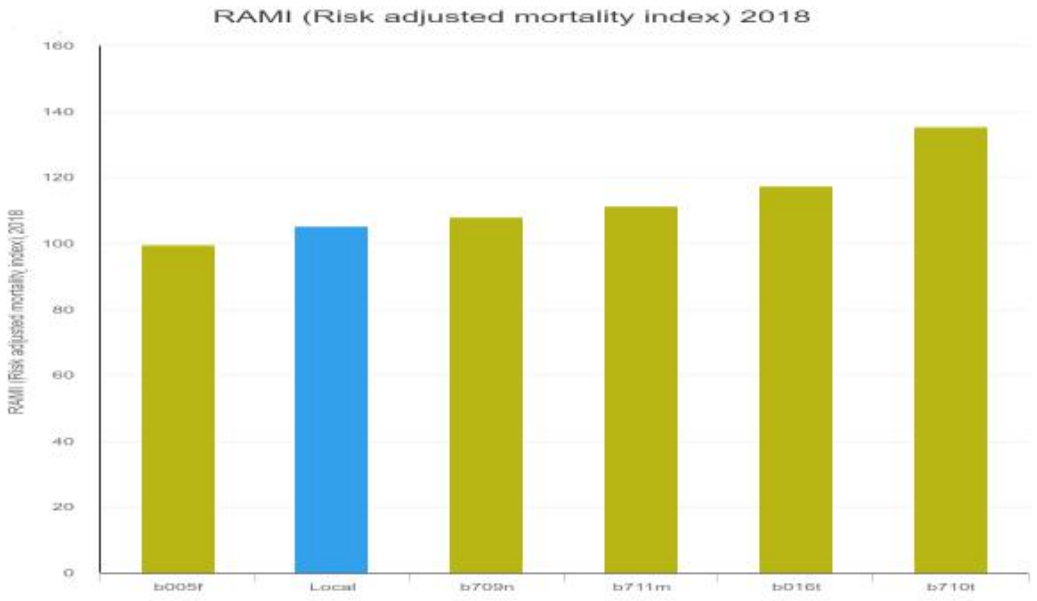
Dr M J Ma
Senior Ass xwell
22/10/20 ociate Medical Director BCUHB

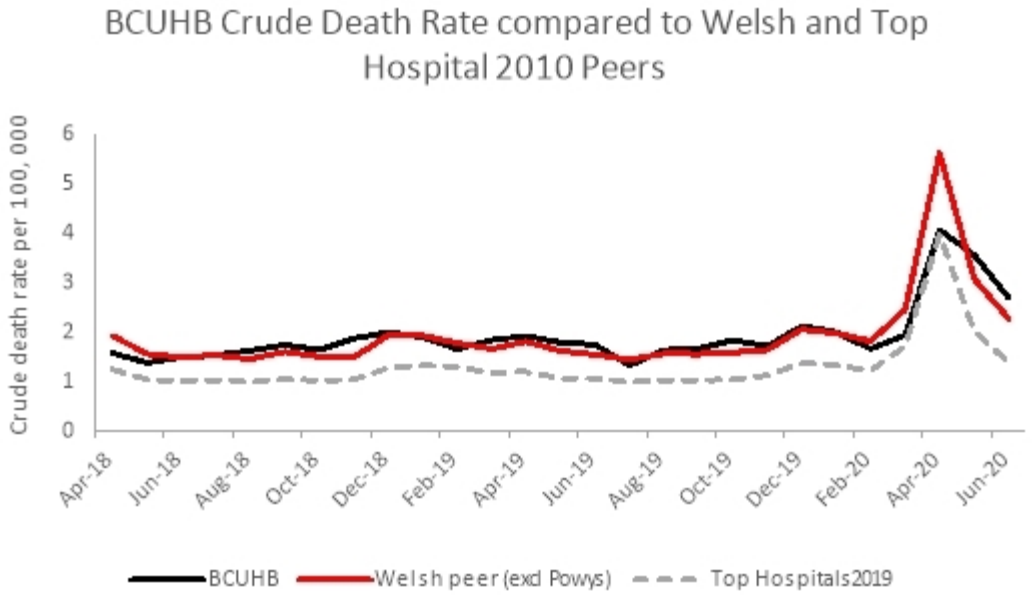
Surveillance - INPATIENTS

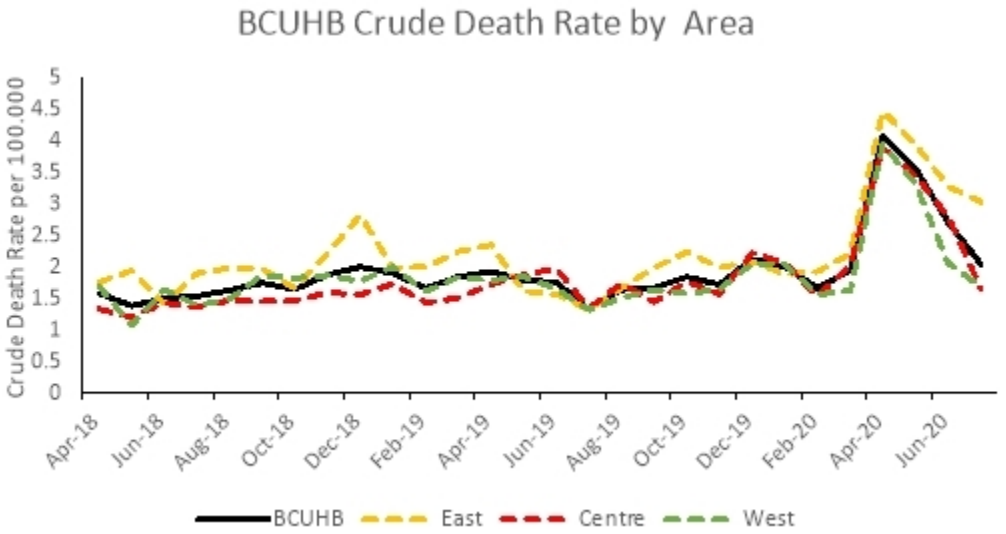
BCU:

- has a Crude Death Rate (CDR=2.25), similar to the Welsh peer (2.3) but higher than the CHKS Top Hospitals 2019 (These are predominantly English Trusts and do not include community beds therefore less inpatient deaths)
- has seen no significant change in the last 2 years until Covid pandemic
- has the second lowest risk adjusted mortality (Aug19-July20) in Wales (RAMI 2018) (blue column on chart below)

East area has a higher in patient mortality than BCUHB as a whole; this is a CDR and takes no account of differing casemix such as the older population in the East.







MEDICAL EXAMINERS

Activity	Nos
Referral to the Coroner	
Referral for further review by division: • Acute • Mental Health • Area East • Area Centre • Area West	
Reason for review (need list): • Concern about medical care • Concern about nursing care • Concern raised by the family	
Reported in advance to incidents/ concerns& complaints team	

Outcome	Nos
Referred to PTR (immediate)	
Referral to stage 2	
Decision pending	

Commenced pilot in YGC in Aug 2020 – nothing to report in quarter

OUTLIER REPORTS From EXTERNAL SOURCES

Quarter 2020	Report – Source/Content	Investigation agreed
Jan-Mar	None	None required
Apr– Jun	None	None required
Jul – Sep		
Oct – Dec		

Mortality Reviews – INPATIENT DEATHS – ACUTE SITES

QUARTER 2020	Adult Inpatient Deaths	UMR1/ ME screen completed	UMR2 Referred	Completed	PTR Escalation
Jan-Mar	767	777	124 (16%)	39 (31%)	
BCU					
WMH	241	250	42 (17%)	27 (64%)	2
YGC	293	292	49 (17%)	11 (22%)	1
YG	233	235	33 (14%)	1 (3%)	0
Apr– Jun	763	728 (95%)	115 (16%)	36 (31%)	
BCU					
WMH	271	240 (89%)	45 (19%)	24 (53%)	2
YGC	333	333 (100%)	35 (11%)	12 (34%)	0
YG	159	155 (97%)	35 (23%)	0 (0%)	0
Jul – Sep					
BCU					
WMH					
YGC					
YG					
Oct – Dec					
BCU					
WMH					
YGC					
YG					

Avoidable Mortality:
WMH – Information not provided
YGC – Information not provided

Positive findings?
WMH – Effective communication with patients and family. Evidence of good documentation. Good EOL care provision
YGC – Good documentation in case notes of discussions held with relatives both before and after patient passed away.
YG - History of multiple co-morbidities & falls with fracture – not for surgical intervention. RIP following collapse. Appropriate DNACPR in place.

REVIEWING

Mortality Reviews – INPATIENT DEATHS – COMMUNITY SITES

QUARTER 2020	Adult Inpatient Deaths	UMR1/ ME review completed	UMR2 Referred	Completed	PTR Escalation
Jan-Mar BCU EAST CENTRE* WEST*	23	23	Nil -	Not required	
Apr– Jun BCU EAST CENTRE* WEST*	35	35	Nil	Not required	
Jul – Sep BCU EAST CENTRE* WEST*					
Oct – Dec BCU EAST CENTRE* WEST*					

** Centre and West Community beds in centre from COTE are in the hospital acute sites process for reporting currently in progress.*

Avoidable Mortality:

East - nil noted. All patient reviewed died as a result of end stage disease usually associated with advanced age i.e. Parkinson's disease, dementia, advanced cancer, frailty, sepsis & heart failure

Positive findings?

East - Appropriate admission where palliative management was difficult i.e. pain, nausea, agitation and secretion.

Appropriate use of Last Days of Life document, DNAR present

REVIEWING

Mortality Reviews – Primary care Area:

QUARTER 2020	Deaths identified	Nos reviewed	Nos PTR review
Jan-Mar			
Apr– Jun	No process in place – to be developed		
Jul – Sep			
Oct - Dec			

Avoidable Mortality:

Positive findings?

REVIEWING

Mortality Reviews – MH/LD SERVICES – predominantly community

QUARTER 2020	Deaths (in patients or in service – Receipt of MHLD services within Last 12 months for MHLD)	Nos reviewed	Nos PTR review	Physical Health care issues identified
Jan-Mar	62	35 MRG stage 1 & 2 (56%)	27 (77%)	0
Apr– Jun	91	66 MRG stage 1& 2 (73%)	25 (38%)	0
Jul – Sept				
Oct – Dec				

Avoidable Mortality: 0

NB: MRG is Mortality Review Group

Positive findings?

Appropriate admission where palliative management was difficult i.e. pain, nausea, agitation and secretion. Appropriate use of Last Days of Life document, DNAR present

REVIEWING

Mortality Reviews – WOMEN'S SERVICES

QUARTER 2020	Deaths identified	Nos reviewed	Nos PTR review	Nos Completed PTR reviews
Jan-Mar **BCU** EAST CENTRE WEST	**5** • 1 maternal death in the community following TOP 1 early NND • 1 Stillbirth 1 unexpected Gynae death • 1 Stillbirth	4 reviewed internally. Maternal death reviewed by Cheshire BPAS and report shared with BCU	4	4
Apr– Jun **BCU** EAST CENTRE WEST	**12** • 6 Stillbirths 1 early NND • 2 Stillbirths • 2 Stillbirths 1 maternal death in the community	12 rapid reviews	12	12
Jul - Sep **BCU** EAST CENTRE WEST				

Avoidable Mortality: 0

Positive findings?
Plans of care well documented

REVIEWING

Mortality Reviews – CHILDRENS SERVICES

QUARTER 2020	Deaths identified	Nos reviewed	Total reviews Completed
Jan-Mar	**18**	**18**	**18**
BCU			
EAST	10	10	10
CENTRE	6	6	6
WEST	2	2	2
Apr– Jun	**7**	**7**	**7**
BCU			
EAST	4	4	4
CENTRE	3	3	3
WEST	0	0	0
Jul - Sep			
BCU			
EAST			
CENTRE			
WEST			
Oct – Dec			
BCU			
EAST			
CENTRE			
WEST			

Avoidable Mortality: 0

Children's services have a robust governance structure for death reviews within the statutory framework. There has been no evidence of avoidable mortality from 'clinical practice' - complications of medical or surgical care for the time period.

All child deaths are reviewed through various processes in addition to WG 72hr review and SIR process:

- Unexpected Deaths – PRUDIC
- BCU Child Death Overview Panels (by area) under BCUHB Safeguarding Childrens Board
- Neonatal Death Review Panel
- Perinatal Mortality Panel Meeting
- Welsh Paediatric Surveillance Unit (WG)
- Child Death Review Programme (PHW)

Other external and medical causes of death in this period have been reviewed by BCU and multi agency panels to identify common learning, patterns and causes of child death, including any trends, and to recommend actions to reduce the risk of avoidable factors contributing to child deaths in North Wales.

REVIEWING

Learning & Actions from Outlier Reports

No reports received – Quarters 1&2

INPATIENT DEATHS – ACUTE SITE – Speciality Learning and Actions

Wrexham Maelor

1) Improve coding and provide death certificate to consultant for stage 2 review
2) Casenotes need to be re-binded
3) More attention could be paid while completing DNAR
4) Possibly acquired Covid during hospital admission, should be communicated to family
5) Improve inpatient care practices on surgical wards

Ysbyty Glan Clwyd		Themes	Action	By whom	Assurance	By when
1		NEWS scores not always completed, nor actioned appropriately	Discussed at site QSE meeting 6/8/20	Head of Nursing to remind all matrons of the importance of these scores	Reduction of comments about NEWS score in mortality reports	To be decided (tbd) at Nov QSE
2		Doctors need to be more specific with conditions/diagnosis for coding to be captured in all cases	opportunity to involve coding to train/update doctors re coding	TB to link in with coding and post grad to arrange training session	Coding no longer reported an issue in mortality reports	tbd
3		Issues with notes: large untidy volumes of notes; loose sheet 37.5% report issues with quality of notes. This is a worsening score	Health Records working with clinicians on reducing size of very large case notes and introduced a new folder for current admission in some wards	Health Records + clinicians	Improve score by 5%	April 2021
4		DNACPR: not countersigned by Consultant; no reason ticked; not dated	Discussed at QSE meeting 6/8/20	Clinical directors and clinical leads to discuss within their departments	No longer reported an issue in mortality reports	tbd

Ysbyty Gwynedd

90 year old with CAP and AF was making steady progress then died from natural causes but no DNACPR in place

LEARNING

Learning & Actions from Area & MH/LD Divisions

Community:

East - Continued use of Last Days of Life document, engagement with GPOOH

Primary care:

This section will require development – NO PRIMARY CARE SYSTEM IN PLACE .

Mental Health/ Learning Difficulties:

All deaths related to COVID 19 have been subject to MRG stage 2 review. Whilst the reviews identified both good and excellent care at the end of life and demonstrated good MDT working between MHLD, Palliative are and Care of the Elderly Medics, it was identified that consideration must be given to discharging patients from a section under the MHA once they progress to the last days of life.

LEARNING

Learning & Actions from Women and Children's Services

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Women's Services:

.Task & Finish Group set up to develop an improvement plan to address education of women re altered fetal movements and the development of local management guidance, in the absence of an updated national policy

Children's Services:

- Staff need to document information provided in conversation within the medical nursing notes to enable other services to take the opportunity to explore further.

Positive Findings:

- Effective communication and evidence of good documentation of the clinical diagnosis, prognosis and discussion with parents regarding end of life care.

- Compassion and empathy in relation to Parental / Family wishes - Allowing parents to stay in hospital accommodation for two days after their baby had passed away.

LEARNING

Emerging Themes

Division	Theme	Action to be taken	By Whom?	By When?
Inpatients Acute Sites				
Inpatients Community				
Primary Care				
MH & LD				
Womens Services				
Childrens Services				

This will be completed as themes emerge

LEARNING

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience (QSE) Committee 3rd November 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Vascular Services Update
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Dr Arpan Guha, Executive Medical Director
Awdur yr Adroddiad **Report Author:**	Joanne Garzoni, Vascular Network Manager
Craffu blaenorol: **Prior Scrutiny:**	Vascular Task and Finish Group
Atodiadau **Appendices:**	Appendix 1 – 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 fifth meeting of the group was held on 15th October 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

Holywell man's quality of life restored following vascular surgery at Glan Clwyd Hospital

A keen cyclist and hiker who became unable to walk due to a debilitating vascular condition is back on his feet following vascular surgery at Glan Clwyd Hospital. Holywell resident David Pearson is on the road to recovery after undergoing reconstructive surgery on a blocked abdominal aorta. David, who lives with severe anxiety following the death of his wife Paula seven years ago, was coping with the effects of from intermittent claudication, which is muscle pain caused by a lack of blood flow due to obstructed arteries. By the time of his surgery, blood flow David's leg had become severely blocked, causing great pain and difficulty walking. He was treated at Glan Clwyd on August 7 this year, with vascular surgery continuing to take place at despite the impact of COVID-19.
He spent a week on the Intensive Therapy Unit (ITU) following surgery, and is now recuperating at home.

David said: "I've always been a keen walker and a cyclist, I noticed while walking my two dogs it was beginning to feel uncomfortable and hard work. Within a minute of setting off it felt like walking through mud, and I started to feel complete numbness at the top of my leg to the point where you would feel nothing at all. I'd have to stand for a couple of minutes to wait for those symptoms to subside, and then the distances you could walk before it happened again became shorter and shorter. It got to a point where it was difficult to walk across the supermarket car park, or even the car park at Glan Clwyd. For someone who's 47 years old and otherwise fit and healthy, it was destroying me and having an awful impact on my mental health. I have severe anxiety and depression, and hospital wards are a difficult place as you twitch at every noise and bleep you hear. My depression and anxiety was brought on by severe grief after tragically losing my brave wife, Paula, to a rare cancer seven years ago, and therefore found it difficult to return to a hospital setting as it brings back so many difficult memories that have been part of my anxiety and depression.
But the team working in ITU were instrumental in not only managing the post-operative side of things but my mental health as well. They've been magnificent."

David's six-hour operation took place in the hospital's hybrid theatre, which opened last year as part of the concentration of complex vascular procedures at Glan Clwyd Hospital. The hybrid theatre allows Interventional Radiologists and Vascular Surgeons to work together to perform both traditional, open surgery and minimally invasive endovascular procedures on the same patient, at the same time, in the same place. Mr Aidas Raudonaitis, part of the team of vascular surgeons recruited by the Health Board to provide the revised service, carried out the operation. David said: "I live on my own and am reliant on being self-sufficient, so can't thank Mr Raudonaitis enough for making this happen for me. I was fearful that a second wave of COVID-19 would close that door of

opportunity for me, so took the opportunity to have an operation. Within a week I'd heard that there was a chance of being operated on, so went in at Friday 7 August. I was obviously frightened as any normal person would be, with the anxiety I suffer from, but the nurse in the Day of Surgery department was great and really put my mind at rest. The next thing that I remember was arriving on ITU and being assigned a nurse who pretty much provided one-to-one care. Their ability to put your mind at rest is phenomenal. They were all so humorous and warm, I was actually worried they would make me burst my stitches at times. They made me feel like I was part of a family. The whole team who were on the ward, they were all great. It didn't matter what time of day it was or how trivial your issue, they were always looking out for how I felt or what I needed."

David is continuing his recovery, and is aiming to get back up Moel Famau as soon as he feels well enough.

"It'll take me some time to make a full recovery, but I'm really impressed about how quickly I appear to be recovering. My goal now is just to be able to walk my dogs as I promised my wife I would, and head up Moel Famau as soon as possible. I think that day's coming fast, and I can't wait for it. I want to extend my thanks to everyone in ITU, I'm forever indebted to their care. The same goes to Mr Raudonaitis and the vascular team as well, and my GP Dr Bala for referring me in, who I wouldn't be here had it not been for his care and compassion. Finally, I would like to emphasise to any patients who are nervous and frightened of hospital or major surgery, not to put their surgery off. Talk to your GP, your surgical team, and support staff, so that they can help provide the additional support you need to help you prepare for your treatment and surgery and not to be frightened by any recovery that requires intensive care as it is first class, you couldn't ask for anything more."

Vascular Task and Finish Group

Five 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 Community Health Council (CHC) presence. Terms of reference have been agreed following feedback from QSE. 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

At the end of September 2020, the Royal College of Surgeons of England (RCS England) and the Surgical Specialty Association confirmed that they would undertake an external, independent multi-disciplinary review of the service. This is subject to the agreement of final terms of reference between the Health Board and the invited review team, and receipt of a formal deed of indemnity from the Health Board. The RCS have begun to identify reviewers and potential dates for the review.

North Wales Vascular Network Action Plan - Progress against actions within the Vascular Network Action Plan is good (appendix 1), and all actions were reviewed at the last meeting of the Vascular Task and Finish Group on 15 October 2020.

Key points include:

Pathways

The pathway action plan detailing the key actions and progress to date for the pathways was reviewed. The submission dates to the Clinical Advisory Group for the pathway for patients that use drugs intravenously presenting with groin abscesses and the pathway for patients undergoing vascular angioplasty were amended recognising the progress that has been made in engaging with stakeholders but further time needed to ensure agreement of all involved.

Dr Kate Clark advised that the Health Board's National Diabetic Lead had shared the current overview of services and compliance with the National Diabetic Foot Pathway and NICE guidelines. The Health Board's Diabetic Delivery Group will support the development of the non-arterial diabetic foot pathway. Awaiting confirmation of the next meeting.

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. A secondary data analysis of patient experience data relating to vascular patients was undertaken for the time period 2019/20. Within the constraints of the data model underpinning the recording of Complaints, Incidents and Patient Advice & Liaison Service (PALS activity within Datix, namely that data is recorded by location i.e. Ward 3, Ysbyty Clan Clwyd (YGC) or Dulas Ward Ysbyty Gwynedd (YG) and not by operating procedure code (OPCS4) international classification of diseases (ICD10), or broader diagnosis related group (DRG) or pathway, there is little evidence statistical or otherwise to suggest that patient experience has been adversely impacted by the reconfiguration of vascular services. It is important to acknowledge that patient, carers and families may be more open in their feedback with CHC than they are with BCUHB.

Review of patient reported outcome measures (PROM) and patient reported experience measures (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. Whilst the survey provides a real-time snapshot of one point in the care pathway, within the context of providing care during the COVID-19 pandemic, the care reported by our patients and other service users was of a very high quality and different to the picture provide by the NWCHC report, which was retrospective and within the context of the whole pathway. The differences in method are important and make direct comparisons problematic. Notwithstanding these caveats the data from the survey paints a picture of a service where our staff are committed to 'going the extra mile' to provide a service experience which is universally reported in a positive light across all of the NHS Wales PREMS measures.

A review of the vascular patient information led by the patient experience team is currently underway. We are working collaborative with the CHC and patient and carer representatives and held a joint review of patient information meeting on 09/10/20. The next step will be to trial and evaluate the information with patient groups. Access to be improved through developing online resources once complete.

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 Patient Safety and Experience department advised that the baseline safety culture survey is now an organisational wide survey and not specific to an area / service. The results will be available by the end of October 2020.

Clinical Effectiveness
The group were given an update on the development of the quality and safety E-Dashboard for the vascular service. The dashboard is now live and is aligned to corporate dashboards that aids the service in triangulating complaints, incidents, compliments and lessons learnt trends to provide assurance.

The COVID recovery plan for the service was ratified by the Clinical Advisory Group and the Executive Team in September 2020. This has been circulated widely. The service is currently reviewing performance and patient outcome metrics with the Secondary Care teams to monitor the impact of the pandemic on the service.

Governance and Risk
Following a discussion point in the August 2020 QSE Committee meeting (QS20/171.2) regarding the remit of the Vascular Task and Finish Group in relation to governance and risk, this was discussed in the 17th September meeting. It was clarified that the task and finish group has a specific terms of reference; the governance and risk arrangements for the vascular network are in line with the Secondary Care reporting structure. If issues are identified in relation to governance and any associated risks, the terms of reference allow this particular group to make enquiries of the normal governance processes.

The next meeting of the Vascular Task and Finish Group will be held on Friday 20th November.

Financial Implications

The scope of this report does not include financial implications.

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.

CONTENTS

Vascular Task and Finish Group (commenced June 2020)

PLEASE NOTE ANY EMBEDDED DOCUMENTS CAN BE REQUESTED BY MEMBERS

Version 0.9

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* Reason for revision	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		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		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		PMO support identified and initial scoping work being undertaken. Update to be provided to T&F on 15/10/20
2.2		Review and refine angioplasty pathway	Jo Garzoni	Clinical Advisory Group	22 May 2020	09/10/2020					**Overdue OR In Progress**		Stakeholder engagement meeting held on 09/09/20. Pathway principles agreed. Pathway to be circulated. Further discussion with General Surgery in YG reached agreement. Requiring clarification with Interventional Radiologists following T&F discussion. Pathway to be submitted to CAG October 2020. 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	02/11/2020					Not yet due OR In Progress		Discussions already underway to develop pathways. Follow up meeting for 11/09/20 was unable to go ahead due to issues with representation due to sickness. Meeting held 07/10/20. Challenging pathway but progress made. Second draft to be circulated week commencing 12/10/20. Discussion in T&F (15/10/20) SS advised that whilst progress has been made there is no final consensus at present. SS to discuss with KM regarding next steps and for discussion at CAG. See Pathways of care for detailed
2.4		Review and refine pathway for patients post major arterial surgery requiring rehabilitation	Jo Garzoni	Clinical Advisory Group	22 May 2020	02/11/2020					Not yet due OR In Progress		Discussions already underway to develop pathways. Meeting to agree with Medical Directors 15/09/20. Communication from Hospital medical directors to teams across NW. Aiming for ratification at CAG week commencing 19/10/20, however requiring discussion with COTE in YG therefore revised date. See Pathways
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					**Overdue OR In Progress**		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 Revised as the initial deadline was the first T&F group meeting date		01/09/2020	Completed		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 Revised as the initial deadline was the first T&F group meeting date		01/09/2020	Completed		Action plan updated for 08/09/20 by Patient Experience team and Vascular Manager. 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	Arpan Guhu	Arpan Guhu	22/05/2020	15/10/2020		01/11/2020 Revised as the initial deadline was the first T&F group meeting date			**Overdue OR In Progress**		DF updated that he had met with the Safehaven team and there would be a report to the October meeting.
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		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		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		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 This was extended due to the logistics of undertaking the survey across the Health Board			In progress and on track		This will be an organisational wide survey rather than an area/service specific – but there is an option to identify this if staff wish. The survey is to be completed cohesively across the health board and not service specific, therefore the vascular service will be involved in the organised plan.
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 Deadline extended as team unable to provide		13/08/2020	Completed		Action plan updated for 17/09/20 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		15/10/2020	**Completed Late**	Completed	Action plan updated for 17/09/20 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 Revised as the initial deadline was the first T&F group meeting date		08/10/2020	Completed		Patient experience data to be incorporated. Further workforce metrics to be reviewed and included as data available. Development team continuing to work on accessing data. Workforce indicators monitored through accountability with DGM and HoN.
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		30/09/2020	Completed		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		
4.7		Issues of significance report from vascular Task and Finish group to Quality, Safety and Experience Committee	Kate Clark Jo Garzoni	Arpan Guhu	22/05/2020	Ongoing		01/09/2020		01/09/2020	Completed on time		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 Revised as the initial deadline was the first T&F group meeting date		17/09/2020	Completed		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	Arpan Guhu	22/05/2020	Ongoing		01/03/2021			Not yet due OR In Progress		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			Completed		Report for October 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		Kate Clark to re-criculate reporting template. Action closed.
5.4													
5.5													
5.6													
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5.9													
6.0													
6.1													

Vascular Task and Finish Group – actions and preparation for 15th October 2020 meeting

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	
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. Continued discussion of shared care with specialties to facilitate patients who require vascular input to remain as close to home as possible.	Vascular Network Manager	9/17/2020	

Vascular Task and Finish Group – actions and preparation for 15th October 2020 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: ○ Clinical lead ○ Project lead	Secondary Care Director	8/28/2020			PMO resource confirmed 14/08/20. Meeting held with project lead and Vascular Network Manager 14/08/20. PRAID log commenced. Project lead met with therapies on 27/08/20. Dr Kate Clark advised that the Health Board's National Diabetic Lead had shared the current overview of services and compliance with the National Diabetic Foot Pathway and NICE guidelines. The Health Board's Diabetic Delivery Group will support the development of the non-arterial diabetic foot pathway. Awaiting confirmation of the next meeting.
	Project initiation document – what is the problem?	Project Lead	9/18/2020			
	Define and scope: • Identify stakeholders • Process mapping	Project Lead	9/18/2020	NICE Guidance National Diabetic Foot Pathway		

• National benchmarking					
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:	Project lead	To be agreed			
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					
Design and plan – agreed action plan to be developed	Project lead	To be agreed			
Establishment of an operational steering group					
To ensure effective communication between all stakeholders	Clinical Lead	To be agreed			
i. Meet and engage with key stakeholders through communication strategy.	Project Lead				
iii. Liaise with strategic and operational management groups					
Identify all issues and risks associated with the project.	Project Lead	To be agreed			
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					
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 ii. Draft Pathway development and national bench marking iii. Pathway discussion pan-BCUHB	Vascular Network Manager Clinical Leads	8/31/2020 9/25/2020 9/25/2020		Ongoing	Meeting held on 09/09/20 with stakeholders from radiology, vascular and nursing. Agreed pathway principles. JG and Interventional Radiographer lead to draft and circulate final pathway by 18/09/20. Further discussion with General Surgery clinical lead to agree patients

	iv. Ratification at the Clinical Advisory Group		10/9/2020			requiring overnight stay. 07/10/20 - JG discussed with clinical lead for General Surgery. Confirmed cover from on-call team if overnight stay required. Final draft circulated 07/10/20 to all stakeholders. Submission to CAG w/c 02/11/20 following further clarification required.
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 Pathway v0.4 DF
	iii. Pathway discussion pan-BCUHB		9/21/2020		Complete	Meeting arranged for 11/09/20 with key stakeholders. Cancelled due to representation issues. Meeting held on 07/10/20. Revised draft to be sent out w/c 12/10/20
	iv. Ratification at the Clinical Advisory Group		11/2/2020			Due to the delay of the meeting it will not be possible to submit to CAG. Discussed with Karen Mottart and w/c 19/10/20 possible for submission. Discussion in T&F (15/10/20) SS advised that whilst progress has been made there is no final consensus at present. SS to discuss with KM regarding next steps and for discussion at CAG.
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 patients po
	ii. Draft Pathway development and national bench marking		Jan-20		Complete	Meeting held with vascular and Hospital Medical Directors 15/09/20 to agree repatriation to acute sites for patients awaiting long community bed waits.
	iii. Pathway discussion pan-BCUHB		9/21/2020			
	iv. Ratification at the Clinical Advisory Group		02/10/2020 - revised to week commencing 02/11/20			Aiming for ratification at CAG week commencing 19/10/20, however requiring discussion with COTE in YG therefore revised date. JG to action.
Refine and review pathway for	i. Engagement with stakeholders	Vascular	End of August 2020			Contact with palliative care CD 20/07/20

non-surgical arterial condition for ‘palliative’ patients, in conjunction with palliative care team	ii. Draft Pathway development and national bench marking iii. Pathway discussion pan-BCUHB iv. Ratification at the Clinical Advisory Group	Network Manager	9/18/2020 10/5/2020 10/23/2020			and further meeting 29/10/20.

Vascular Task and Finish Group – actions and preparation for 15th October 2020 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 complaints, feedback.do
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	Validation of patient experience questionnaire.	PM	2nd June	Completed. Patient feedback questionnaire was reliable and did not require amendment as the content met the needs of the

additional items related to access to and coordination of the service identified as reported issues within the CHC report.	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.			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	7/31/2020	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 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 October	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

	internet.			To commence on the 10/08/20. Fay Taylor to liase with Llinos Roberts. Questionnaires delivered. 8.9.20 Extended due to poor and quality of returns. 08.10.20 Summary below of service user feedback gained utilising a variant on the standard BCUHB patient and service user feedback survey, utilised within Vascular OPD clinics within YG and YCG during July 2020, as an integral component of the agreed vascular network improvement plan. Word document summary. Also received n=8 from Ward 3-YGC since the attached ward report was created, however the small number of returns from Ward 3 has not change the fundamental findings. The attached updated the Excel Spreadsheet has the additional data and the associated graphs. RE names of specialist nurses and ward sisters ward 3.msg \\cymru.nhs.uk\bcu\WMH\Home\jo068213\A Vascular\REVIEW of VASCULAR - ToR\Vascular Service Action Plan\ Patient Experience\ \\cymru.nhs.uk\bcu\WMH\Home\jo068213\A Vascular\REVIEW of VASCULAR - ToR\Vascular Service Action Plan\ Patient Experience\
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	6/24/2020	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. 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. Discussion at clinical governance 09/09/20. Issue is limited PROMS for vascular. SS fed back that the development of a PROM would be a research project and require funding.
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.  PT INFORMATIO LEAFLET SCOPE.docx 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.

1a. Reviewing Written Information & create Validated Library of Vascular Patient Information in line with ISUE01 policy guidelines.	Ensure that CHC representation is mandated within the readers/review panel for Written Patient Information Guidance Procedure ISUE01 explicitly states this.	JG	21.9.20 - extended to 30/10/20 due to time to arrange meeting to review information and panels	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. 14/9/20 - Readers panel arrangement to review vascular information. Vascular specialist to be present. EIDO information inadequate therefore needs to be supplemented to meet the needs of the patients. Sheffield NHS have provided permissions to use theirs, avoiding duplication. 08.10.20 Patient & Carer Experience & Engagement –'Patient Information Procedure and Readers Panel' evidence attached to support the Vascular Service with this development. Stakeholder meeting with patient and carer representation 09/10/20 to review vascular patient information. JG discussed with comms who confirmed that the service can create access on the internet for vascular service information.  Patient Information leaflets vasc.msg
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 requested from Information 11/08/20 and 08/09/20 by JG - outstanding. Response 11/09/20 from Ali Edwards - The patient experience section will require input from the development team as the data is currently unavailable via the data warehouse. JG requested timeframe.

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. 08.10.20 Patient & Carer Experience & Engagement service information sent to services outlining virtual care to shares.
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 achievement 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 08.10.20 As detailed above, Care2Shares, patient stories and the online questionnaires will further support PREMs

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 15th October 2020 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 Patient 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. 8/9/20 JWJ has sourced Microsoft forms. 17/9/20 The culture survey is ready to roll out via a link. Katie Sargeant Communication team is leading the promotion; posting/sharing etc. This will be an organisational wide survey rather than an area/service specific – but there is an option to identify this if staff wish. The survey is to be completed cohesively across the health board and not service specific, therefore the vascular service will be involved in the organised plan.
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. Plan for introducing You Said/We Did to Incidents & Complaints – development of SOP, using PALS You Said/We Did Pro-forma	CO/YW CO/JO	20th August 20TH August	Complaints aspect completed YW completing incident review YW collected data and providing incidents analysis 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	Ongoing	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.

WORKFORCE INDICATORS				
Task/Action required	**How Task will be achieved & Outcome**	**Respon sible to**	**Current Status**	
			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 - mandatory training compliance, appraisal and revalidation, vacancy rates, sickness. Integration to the dashboard is currently with the development team - awaiting timeline.

Vascular Task and Finish Group – actions and preparation for 15th October 2020 meeting

Aims: Engagement and communication:

Communication Plan

Task/Action required
Evaluate and report to Quality, Safety and Experience Committee compliance with agreed service implementation plans
Monitor vascular waiting times
Reporting template and submission to be drafted by the Secondary Care leadership team and to be ratified

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

Task/Action required

Development of a Vascular Dashboard
Agree the Dashboard and Performance Metrics

How Task will be achieved & Outcome	Responsible to
COMMUNICATION	
Monthly reports to the QSE committee	Secondary Care Medical Director
Monthly reporting	Head of Planned Care
	Secondary Care Medical Director
Audits will be undertaken utilising the NVR data submitted. 1. The timeframe for lower limb bypass or endovascular revascularisation procedure for patients admitted as emergency with CLI (standard within 5 days) 2. Amputation audit (numbers of BKA, AKA, through knee and conversions since centralisation of the vascular services) against the VSGBI QIF amputation guidance 3. Carotid endarterectomy audit (time from referral to surgery, time from symptoms to referrals, number of patients having conservative treatment, total number of carotid endarterectomies and outcome) 4. AAA audit ,timeline from referral to surgery (open and EVAR), including outcomes 5. Audit of complex aneurysm repair EVAR and open , EVAR complex includes (off IFU, Endo anchors, IBE, endoleaks), Open complex include para and suprarenal clamping 6. Audit of BKA to through knee and AKA conversion	Executive Medical Director
DASHBOARD	
How Task will be achieved & Outcome	**Responsible to**

The group discussed dashboards and shared information. JG had a meeting on 5th June and will forward any useful information after that.	JG
Agree Minimum Data set for Vascular dashboard and ensure that Patient Experience Data (legacy and prospective) is linked.	JG/CO

Current Status	
By When	**Progress update and notes**
Monthly	Ongoing
November T&F	Report to be considered for November 2020 meeting.
Complete	
Complete	SS updated the group regarding the audits currently underway within the service and the opportunities to benchmark.

Current Status	
By When	**Progress update and notes**

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
9/17/2020	Vascular Network Manager Awaiting response from the Information team re: inclusion of available Patient Experience viewpoint data. Update to be provided18/08/20. Dataset agreed.

ACTIONS LOG

The purpose of this template is to record all actions from project-related meetings, and to record the action's owner, status and any further notes.

Action Number	Action Description	Action Date	Action Deadline	Revised Action Deadline	Action Owner	Issues affecting delivery	Remedial Action - In Place or Planned	Action status - see dropdown options
1	Agenda Item 1 - ToR ACTION: Member of Vascular Service Educational team to be asked to contribute. SS to liaise with Emma Woolley.	6/16/2020	7/17/2020		Soroush Sohrabi			Completed
2	Agenda Item 4 - Copy of the points and actions for areas to be reviewed to be shared with ADL so this can be shared with CHC and returned with CHC guidance	6/16/2020	7/10/2020		Jo Garzoni Adrian Drake Lee			Completed
3	Agenda Item 4 - KC /JG / SS / Geoff / Carol / ADL and RB To meet to draw draft ToR for the external invited review before next meeting in July	6/16/2020	7/17/2020		Kate Clark Jo Garzoni Geoff Ryall-Harvey			Completed
4	Item 6 - EC to Share Pathways with ADL and RB for comment	6/16/2020			Eve Callahan			Completed
5	Item 6 - AG and KC to come back at the next meeting with clear pathway plan after CAG with timeframe and resources required.	6/16/2020	7/17/2020		Kate Clark Arpan Guhu			Completed
6	Item 7 - Communication and Engagement Carolyn Owen to circulate membership and action plan	6/16/2020	6/30/2020		Carolyn Owen			Completed

7	Arpan Guhu to create work plan for CAG for next meeting	7/17/2020	9/17/2020		Arpan Guhu			Completed
8	JG to share final figures VA with the group	7/17/2020	8/13/2020		Jo Garzoni			Completed
9	JG to contact WAAASP programme manager about quality assurance visit	8/13/2020	9/17/2020		Jo Garzoni			Completed
10	COVID Recovery plan to be circulated once reviewed by CAG	8/13/2020	9/17/2020		Jo Garzoni	Recovery plan has been ratified by CAG. Now awaiting Exec approval.		Completed
11	Criteria for patient admission to spoke sites to be developed for 17/09/20.	8/13/2020	9/17/2020		Soroush Sohrabi Jo Garzoni			In progress and on track

12	CHC discussed intention to undertake an independent patient experience assessment on Ward 3, YGC at the meeting on 13/08/20. Awaiting plan for this. JG to contact Carol Williams from the CHC.	9/17/2020	9/28/2020		Jo Garzoni	Email to Carol Williams on 18/09/20 and 07/10/20. Awaiting response.		Completed
13	Confirmation of the RCS submission required. JG to contact Kate Clark for update.	9/17/2020	9/30/2020		Jo Garzoni			Completed
14	JG and SS to discuss with cluster leads ways to improve communication with Primary Care	9/17/2020	10/16/2020		JG/SS		Contact made with Jodie Berrington (Senior Cluster Coordinator) (07/10/20)	In progress and on track

15	Update required from Kate Clark regarding the Diabetic Foot Pathway. JG to contact KC.	9/17/2020	10/15/2020		JG			Completed
16	Extraction and presentation of data from the NVR to be discussed within the service	9/17/2020	10/15/2020		SS			Completed
17	SS to discuss with KM the IR perspective regarding standard of care for angioplasty patients requiring on site vascular presence	10/15/2020	10/15/2020		Soroush Sohrabi			Completed
18	Confirmation of the Diabetes Delivery Group meeting required	10/15/2020	10/31/2020		Kate Clark			

19	SS to discuss with KM regarding next steps and for discussion at CAG.	10/15/2020	10/21/2020		Soroush Sohrabi			
20	SS to discuss with Kate Clark regarding feedback for any potentials changes to EIDO information.	10/15/2020	10/31/2020		Soroush Sohrabi			
21	JG to circulate Action 7 on the Communication and Engagement tab.	10/15/2020	10/23/2020		Jo Garzoni			
22	JG to discuss with Dr Maxwell regarding amputation audit	10/15/2020	10/30/2020		Jo Garzoni			
23	JG to discuss with outpatient programme lead in relation to Attend Anywhere	10/15/2020	10/31/2020		Jo Garzoni			Completed
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Action Complete Date DD/MM/YYYY	Action Completed By	Assurance (how do we know the action has been delivered and embedded?)
17/07/2020	Soroush Sohrabi	Mr Sohrabi advised that Mr Laszlo Papp is the Educational Lead for Vascular. He will be invited to subsequent meetings.
17/07/2020	Jo Garzoni	Pathways have been sent to ADL and RB via email
17/07/2020	Kate Clark	Meeting held on 02/07/20 and follow up on 15/07/20. JG to ask KC to circulate final version to the group.
17/07/2020	Jo Garzoni	
		Meeting held on 24/07/20 with KC /AG /JG
		CO emailed on 23/06/20 

		Pathway plan presented by JG 13/08/20. Timeline for submission to CAG required
		The BCUHB Centralised Vascular Services have reduced the number of waiters from 116 to 41 in 11 months (last year's meeting was in June 2019), with 9 patients waiting for procedure in YG, 10 in YGC and 22 in WMH.
07/09/2020	Jo Garzoni	Response received from Llywela Wilson. The Quality Assurance visit will not take place in November. This is due to be discussed by the PHW Programme Board on 22/09/20. Update provided to WAAASP on 16/09/20
07/10/2020	Jo Garzoni	Approval received 25/09/20. Circulated internally 28/09/20. Sent to CHC 07/10/20.
		Meeting with Emma Hosking, Jo Garzoni, Steve Stanaway and Soroush Sohrabi 15/09/20

10/8/2020		Response received from Carol Williams: 08/10/20 Hello Joanne Sorry for the delay in getting back to you. The NWCHC is very keen to undertake a patient experience survey, however having given the matter some consideration and following discussion with our Executive Committee it has been agreed that we do not wish to survey patients at the current time. We believe that it would be more meaningful for the NWCHC to seek patients feedback once the work of the Vascular Task and Finish Group is completed and when the service has achieved a position that has reached the objectives of the Review. We recognise that continuous engagement is important and understand that BCUHB is undertaking this as developments take place. We are keen to monitor the feedback received and look forward to receiving this on a regular basis. Should you wish to discuss, please do not hesitate to contact me
9/24/2020	Jo Garzoni	Response received from the Royal College of Surgeons on 30/09/20.

10/15/2020	Kate Clark	Update provided to the T&F group 15/10/20
		Audits will be undertaken utilising the data submitted. 1. The timeframe for lower limb bypass or endovascular revascularisation procedure for patients admitted as emergency with CLI (standard within 5 days) 2. Amputation audit (numbers of BKA, AKA, through knee and conversions since centralisation of the vascular services) against the VSGBI QIF amputation guidance 3. Carotid endarterectomy audit (time from referral to surgery, time from symptoms to referrals, number of patients having conservative treatment, total number of carotid endarterectomies and outcome) 4. AAA audit ,timeline from referral to surgery (open and EVAR), including outcomes 5. Audit of complex aneurysm repair EVAR and open , EVAR complex includes (off IFU, Endo anchors, IBE, endoleaks), Open complex include para and suprarenal clamping 6. Audit of BKA to through knee and AKA conversion
10/15/2020		Email to KM sent on 15/10/20

16-Oct	Jo Garzoni	Vascular will now join this pilot. SS to lead.

Cyfarfod a dyddiad: Meeting and date:	Quality Safety & Experience (QSE) Committee 3rd November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Holden Report – Update
Cyfarwyddwr Cyfrifol: Responsible Director:	Debra Hickman, Acting Executive Director of Nursing and Midwifery
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:	None

Argymhelliad / Recommendation:

The Quality, Safety and Experience (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:

The former Executive Medical Director and Executive Director of Nursing and Midwifery/Deputy CEO (not Acting CEO) commissioned work to validate that the recommendations from the Holden Report have been implemented and remain sustained. The Acting Associate Director of Quality Assurance is overseeing 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.

Due to recent changes in key personnel, the evidence collection work has been delayed and it is not possible to present the outcome of that work at the November 2020 meeting of the Committee. The outcome will therefore be presented at the next full meeting of the Committee in January 2021. Due to the need to offer evidence based assurance on the recommendations to the Health Board and its community, this work is being completed thoroughly hence why no outcome is available at the present time arising from the unavoidable delays.

The Committee can be assured that a robust task and finish group is now in place to facilitate this work and no further delays will occur, with closer oversight from the Acting Associate Director of Quality Assurance and Acting Divisional Director of Nursing for Mental Health and Learning Disabilities .

Cefndir / Background:

In May 2013, the Health Board arranged for the NHS Delivery Unit of Welsh Government to undertake a review of the Hergest Unit and to assess compliance in relation to the Mental Health Measure. A full report from the Delivery Unit was received by the Health Board in June 2013. The actions from the report were prioritised in the Hergest Improvement Plan (HIP) for implementation.

The Health Board commissioned an Invited Review by the Royal College of Psychiatrists (RCP) which took place during October 2013, with a report received by the Health Board in December 2013.

HIW commenced an unannounced inspection on the 2nd December 2013. Following the 3 day inspection, HIW provided a report to the Health Board on the 17th December 2013 with 21 recommendations.

Healthcare Inspectorate Wales undertook a follow-up unannounced visit on 12/13/14 May 2014 where the main focus of the visit was to establish progress in addressing the issues highlighted in their visit of December 2013.

Further HIW Inspections took place at the unit in January 2016 and September 2018.

The HIW inspection reports, and the associated improvement plans from the Health Board are available publically on the HIW web site.

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, 42 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, previously Head of Nursing for the Hergest Unit's predecessor organisation (Gwynedd Community Health Trust), was commissioned to undertake an investigation and produce a report – the Holden Report – under the auspices of the Raising Staff Concern / Whistleblowing Policy (WP4). A report was finalised and submitted on 08 December 2013.

These collective matters from various reports continued to be monitored by the Health Board's Mental Health Improvement Group established in June 2015 under the leadership of the former Chief Operating Officer with the former Vice Chair of the Health Board in attendance. The work from the group was reported publicly as part of the 100 day plans and continued to be monitored as part of the special measures programme. However, as previously reported, there has not been a specific Holden Report action plan update prepared for the health Board or its Committees.

The Holden Report provided the Board with an independent review and assessment of the issues that were causing staff concern at that time. Under the Health Board's whistleblowing arrangements,

staff have the opportunity to raise concerns confidentiality, therefore, to avoid breaching these arrangements and to ensure staff are not discouraged from raising concerns in the future, the Health Board agreed it would not be publishing the full report.

Following a request from the Public Accounts Committee the Health Board took advice and were able to share a report summary and recommendations in a redacted form.

The Holden Report has since been requested under Freedom of Information legislation and the Health Board declined 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 Information Commissioner's Office ruled the report should be released, and the Health Board has since appealed. A tribunal hearing is expected in early 2021.

Asesiad / Assessment & Analysis

The Holden Report made 19 recommendations. As mentioned above, the evidence collection is underway including cross-reference and triangulation to the other reviews and action plans mentioned above and wider reviews and actions plans.

Due to the thoroughness of the work, it is not possible to provide an outcome position given the delays – however at this time no immediate concerns are noted and there are no issues of concern to raise to the Committee.

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 3rd November 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Mental Health and Learning Disabilities Exception Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Teresa Owen, Executive Director of Public Health and Executive Lead for Mental Health & Learning Disability Services (MHLDS)
Awdur yr Adroddiad **Report Authors:**	Mike Smith, Interim Director of Nursing MHLD Iain Wilkie, Interim Director for MHLD
Craffu blaenorol: **Prior Scrutiny:**	Divisional Directors MHLD
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

The Committee is asked to:-

1. Note the content of the report which has been re-structured around the Division's four priorities of:
   - Review of capacity and capability
   - Delivery of safe and effective in partnership
   - Stronger and aligned management and governance
   - Engagement with staff, service users and stakeholders

   (These relate to the key risks of the Division being in special measures, and the Health Board's strategic aim – for the safe and integration and improvement of Mental Health Services)

2. Provide feedback on the report structure and any recommendations for future reporting.

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 is an exception report for the Quality Safety and Experience (QSE) Committee from the Mental Health and Learning Disabilities Division (MHLD). The report highlights key issues of significance, and management actions in place.

Cefndir / Background:

This is the latest report from the MHLD Division to the QSE Committee.

Asesiad / Assessment & Analysis

Strategy Implications

This report outlines planning activity within the Division, and compliance with the Mental Health Measure (MHM).

Financial Implications

A financial assessment has not been included within this exception report.

Risk Analysis

The report provides an update to QSE on changes to the corporate risk strategy and register and the consequent Divisional reporting of tier 1 risks.

Legal and Compliance

This report provides data on compliance with the Mental Health Measure.

Impact Assessment

There are no proposed service changes within this report, and all policies follow due process for EQIA.

Mental Health and Learning Disability Services

1.0 Purpose of report

To provide an update on quality, safety and experience actions (and performance) aligned to the four priority areas in MHLD, and to provide the Committee members with an exception report on the key metrics.

This is the first of this new style report for the Health Board QSE Committee. To provide context for Committee members, we have detailed the scrutiny processes within the Division:

- Divisional quality and experience data, and any exceptions issues are shared in a timely way in across service areas, and with the leadership team. There are daily safety huddles in every area of MHLD.
- Any exceptions are dealt with through the PTR process (Putting Things Right), and each week a Divisional PTR meeting is held. These meetings are chaired by the Assistant Director of Nursing (MHLD), and the Head of Governance to consider progress. Weekly updates are provided to the Senior Leadership Team (SLT) (via written briefings).
- Each of the four operational areas holds an area QSE meeting that considers its QSE data. The area Head of Nursing reports the exceptions, actions and progress (for instance Heddfan Quality Improvement Plan or Health Inspectorate Wales action plans) to the Divisional QSE meeting where it is scrutinised.
- The Division holds a monthly SLT QSE meeting, as one of the four regular cycles of governance meetings. This is underpinned by the monthly sub-group which specifically receives, commissions, and scrutinises patient and carer experience information. This is chaired by the MHLD Director of Nursing and the reports from this sub-group are a standing item on the Divisional QSE meetings.
- The Division then reports its quality and safety exceptions corporately to the current BCUHB Quality and Safety Group (QSG) meeting, which is chaired by the Executive Director of Nursing.

This new formatted report to the Health Board QSE meeting has been structured around the four priorities within the Division, with a focus on key risks and quality issues.

2.0 Summary of Significant Quality Safety and Experience Issues

2.1 Review of Capacity and Capability

The Division has experienced significant churn and change in management positions since the report last given to the QSE (28-8-2020). The Division is pleased to report here a significant improvement in the number of managerial positions filled at SLT level. The triumvirate is now restored and the senior management team is nearly at full strength once more.

There has also been significant attention given to the middle level of management roles with numerous people also similarly returning to work, and actions taken to appoint to vacant positions in this period. This is fundamental to enable the Division to have capacity, review and recover undelivered historical actions, have stronger governance and begin a journey of re-engagement with staff, service users and stakeholders. Our aim continues to be the delivery of safe and effective services in partnership.

The Divisional leads have received anecdotal feedback internally of a noticeable feeling of a “temperature change”. From the Divisional perspective, we view this as culturally significant, although this is still very early days for the new triumvirate. The team have been actively re-connecting with partners and our own workforce, to improve visibility. However, we reflect as a Divisional team that we have much work to do to embed the new approach across the Division.

Senior Leadership Team Capacity

There has been significant return to work in key posts, since the last update to Health Board QSE. The Division has prioritised regrouping within the Division as a key action.

1. The Executive lead for MHLD has transferred from Dr David Fearnley to Teresa Owen. The Division would formally like to thank David for all his support to the Division during his time as Executive lead for MHLD.
2. An interim Director of Mental Health – Mr Iain Wilkie, has been appointed for a period of six months (until April 2021). This is covering the substantive Director’s absence.

3. The MHLD Medical Director – Dr Alberto Salmoiraghi role remains in post, this is a key role in the triumvirate given the renewed focus on clinical leadership.
4. An interim MHLD Director of Nursing – Mr Mike Smith, has been appointed interim for a six month period (until April 2021). Mike is covering the substantive Director's leave.
   Therefore the triumvirate is now in place.
5. The MHLD Chief Finance Officer role remains unchanged.
6. The MHLD Workforce and OD lead, commenced her role in May 2020
7. The MHLD Director of Transformation is returning to work imminently.
8. The MHLD Director of Strategy and Partnerships role is vacant currently due to a secondment.
9. Two MHLD Deputy Directors have joined the Division on a six month contract. They are supporting activities relating to roles transformation, service improvement, performance reporting, and partnership and strategy development.
10. The four area Heads of Operations roles are now filled.

Throughout October 2020, the triumvirate has and is focussing on increasing their collective visibility and presence throughout Divisional areas and specialities, engaging with staff and patients, and re-instating capacity as detailed above.

2.2 Delivery of Safe and Effective Services in Partnership

In this section, we will detail the planning work underway to restore and improve our services, our work to date on mortality reviews and unexpected deaths. We will also report our primary care MHLD services and our compliance with Part 1 and Part 2 of the measure, and an update on the Heddfan Unit.

COVID 19 Divisional Plan

The Division is currently re-grouping and stabilising. Our immediate plan is about ensuring a safe Covid response and the continuation of our work on the integrated care pathways. In addition, we are undertaking focussed work to ensure an appropriate plan for the coming months, as the original Phase 2 plan has been set aside. Throughout our Covid19 response we have followed the five principles:

- Patient and staff safety is paramount.
- Our resources are focussed on supporting the most vulnerable and high-risk patients to avoid unnecessary social contact, travelling or hospitalisation. Patients should be treated as close to home as practically achievable.
- We continue to make decisions which are clinically informed by emerging evidence (through the clinical reference group in the Division), and this is regularly reviewed.
- There remains an urgent need to reduce travel and maintain social distancing, and so the use of technological approaches has to remain an important means for assessments, reviews and delivery of therapies by all staff, together with other means of interventions and assessment. Consultant Connect and Silver Cloud being already implemented or piloted within the Division.
- Robust area operational management will oversee implementation plans.

Current Situational Update

North Wales has seen an increasing number of positive cases in recent weeks. The MHLD Division are also seeing an increased number of cases, whilst at the same time demand for general services is also returning towards the historical levels seen across the Division.

During October, the Division has already re-opened one adult ward in the East area, and transferred the additional older persons ward from the East area to the Central area to manage the demand.

A project group is currently working on the enablement plan to re-open the Psychiatric Intensive Care Unit (PICU) at Heddfan as soon as it is safe and practically achievable. This Unit requires considerable physical restoration to return it to its Intensive Care Unit standard, as it was converted to operate as an older adult ward.

Our community teams continue to prioritise care based upon need. We maintain various methods of connection to our patients, and we are also providing face to face contact where specifically needed by the patient and/or when clinically indicated. The Division has received helpful feedback via CANIAD on the patient experience given the current use of digital approaches. They report that some patients are preferring digital connection, with comments relating to reduced travel times/inconvenience and child care benefits. Other comments highlighted the less positive aspects for some of our service users – not all people are digitally enabled or confident, and the issue of digital poverty was also noted.

Regarding the Division's current planning of its response to Covid 19, this is a live process. We are now preparing a detailed Covid 19 management and response plan aligned to the emerging second wave. This plan will outline the daily actions across the Division to ensure effective operations during the next phase. This includes identifying the daily demand and capacity position, related workforce issues and clinical priorities. The information will be captured by daily Sitrep reports and will feed into the Division's Covid 19 daily briefing. This will also be the conduit for any local or national communication to be cascaded to the workforce. Plans are also being developed, building on our previous experience to ensure robust communication exists with the wider stakeholders.

Mortality Review

To date, there have been eighteen COVID19 related deaths across the MHLD Division, all of which occurred during the first wave of the pandemic.

Due to the exceptional circumstances of COVID 19, the "Stage 2" review of all deaths in Older Persons Mental Health (OPMH) services have been conducted in a fully multidisciplinary manner, which includes colleagues external to the MHLD Division ie the palliative care and care of the elderly team.

Thus far, the mortality review considers that the overall care delivered to inpatients in the MHLD Division was comparable to the care offered in the general hospitals. The relationship with the medical colleagues and palliative care team was noted as excellent and very effective. It has been agreed that this approach will form the

basis of our pathway design work (across Divisions) as clearly it has supported improvements in care.

The Division has also considered the emerging key themes:

- The first theme noted that some patients receiving end of life care were discharged from the MHA. The MHLD Medical Director has reviewed the legislation (with legal advice sought). The Division now understands that this procedure is advisable given that patients on End of Life Care do not meet the criteria for detention under the Mental Health Act. We will continue to work with legal colleagues to ensure actions are appropriate

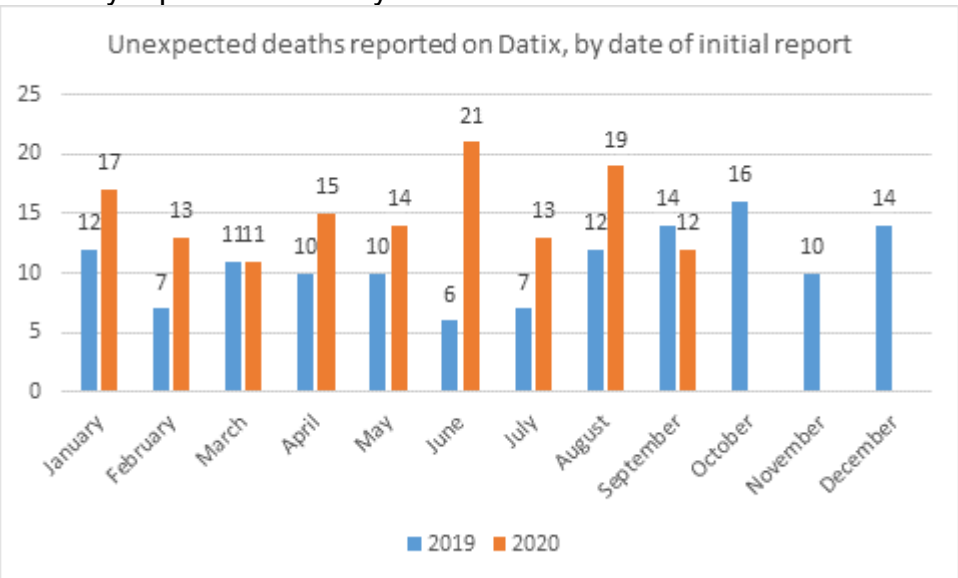
- Another theme that emerged is that the pathways for admission to a medical ward need to be reviewed. This is especially so given our learning on the use of Dexamethasone and oxygen in patients who have COVID. This area of work will be overseen through the Clinical Reference Group of the Division and in turn, into the executive-led Clinical Pathway Group, and this will in turn will strengthen our clinical pathways going forward.

From a learning disability perspective, all Covid-19 related deaths are progressing to a full multidisciplinary "Stage 2" review. The final date for the multidisciplinary review has been confirmed as 04 November 2020.

MHLD Unexpected Deaths and Suspected Suicides

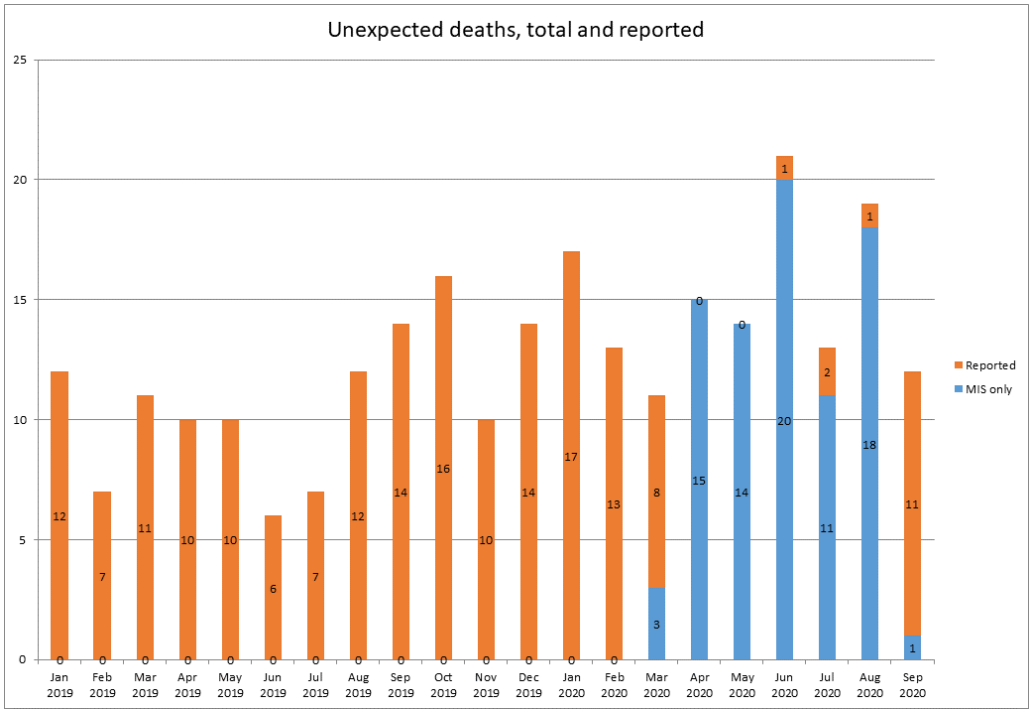
As previously reported to the Health Board QSE Committee, the Serious Incident Reporting, Mortality Reviews and Coroner Inquests have recommenced. The return to full reporting incorporates serious incidents which are Covid-19 related (including for example, indirect harm as a consequence of being unable to provide care in a timely way). In addition, any serious harm or death which is associated with a delay in diagnosis and/or treatment, including when the patient has remained on a hospital waiting list, constitutes a serious incident and is reported and investigated as such.

Datix reporting does not contain sufficient detail to produce a report of suspected suicides. However, the charts below detail the numbers of unexpected deaths currently reported on the system.



Since March 2020, the majority of these unexpected deaths have been managed through the Make It Safe (MIS) process. The return to previous reporting practices is

reflected in the increasing number of deaths reported to Welsh Government for September 2020.



The Division has previously reported on the implementation of the learning project, which combines identified themes and trends from the closure of 134 Legacy Serious Incidents and the Divisional Thematic Review of Suicides in 2018/2019. All of the action plans and lessons learnt have now been triangulated. Work is currently ongoing to rate each individual action underway and the impact.

Locality workshops have also taken place. Staff have provided generic feedback on any barriers to learning from Serious Incidents, and have kindly shared their experiences too. The issues raised included the need to improve information sharing and listening to staff. From this piece of work, the Division intend to generate recommendations and develop a robust action. The findings and draft recommendations will be presented to the Divisional QSE meeting in December 2020. A series of presentations will then be conducted in the areas including a learning programme, to engage and support all staff within the Division. The new triumvirate are considering how learning can be disseminated more effectively, including the roles of the Investigating Officer and the Learning Champions in each area.

Local Primary Mental Health Support Services (LPMHSS)

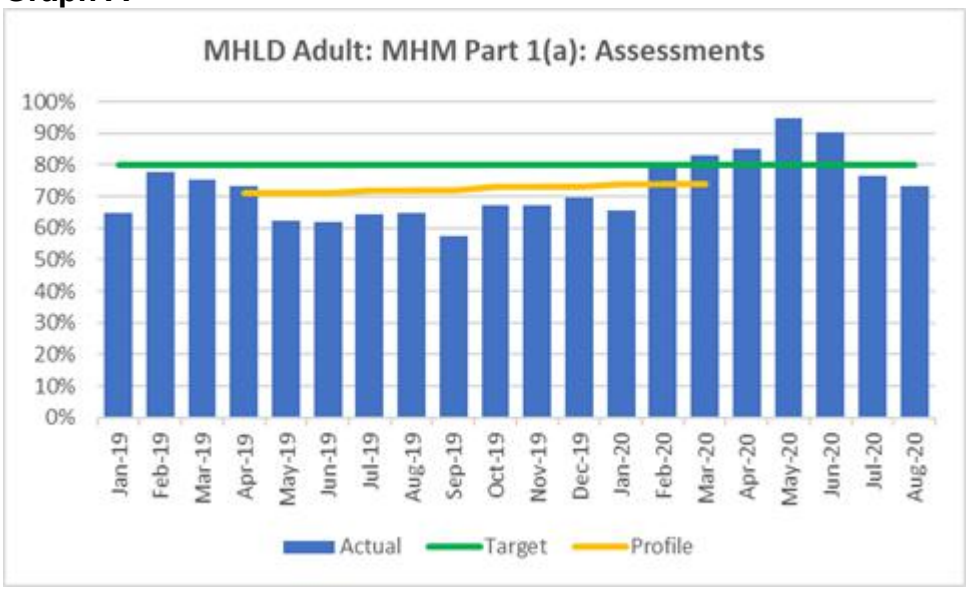
- **Compliance with Part 1 Mental Health Measure**

  The MHLD Division achieved compliance in Part 1a (assessments) throughout the months of March, April, May and June 2020; however did not meet compliance in July and August due to an increase in referrals. Non-compliance with the measure Part 1a is mainly in the East area, due to the discharge of the patients from LPMHSS, and the need to review and reassess a high number of these. This has had a negative impact on our ability to achieve assessments within 28 days for referrals. See Graph A below.

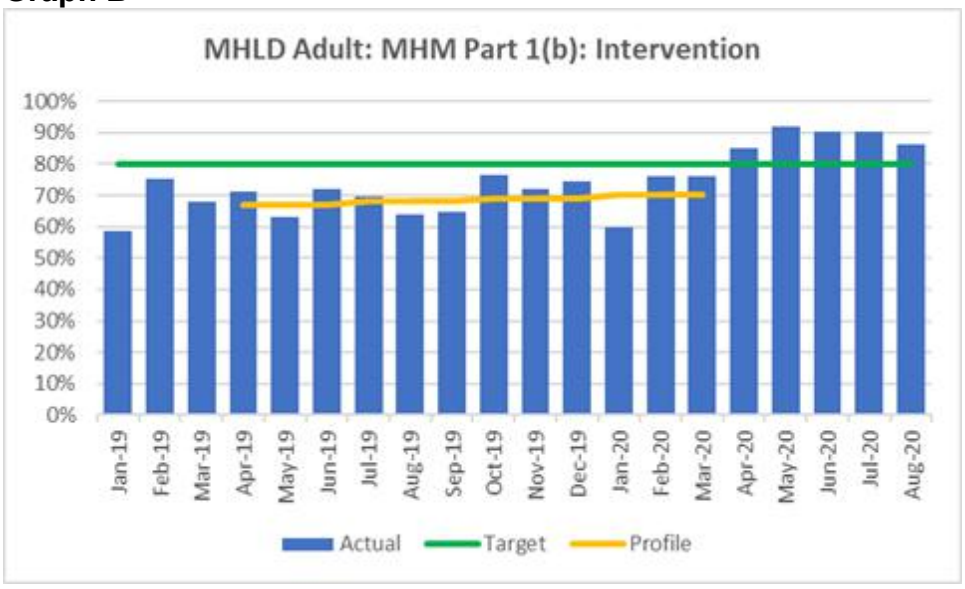
There are now robust recovery plans in place, and we are on track to be compliant with Part 1a by the end of November 2020. All teams continue to strive to achieve the target. Teams are anticipating their demand, and this is monitored daily with increased scrutiny in the weekly meetings led by the service managers. Reports are provided at the local operational and accountability meetings. Additional MHM monies are being utilised to increase resource into the primary care teams.

Part 1b (interventions) was non-compliant in March 2020 (Graph B), however throughout the months of May, June, July and August the compliance has improved and is above the KPI target level. The numbers of patients commencing intervention has been lower than usual due to restrictions e.g. group therapy, and we expect the Part 1b performance to decrease over the coming months. The Division will be monitoring the situation carefully, and considering further actions as appropriate.

Graph A



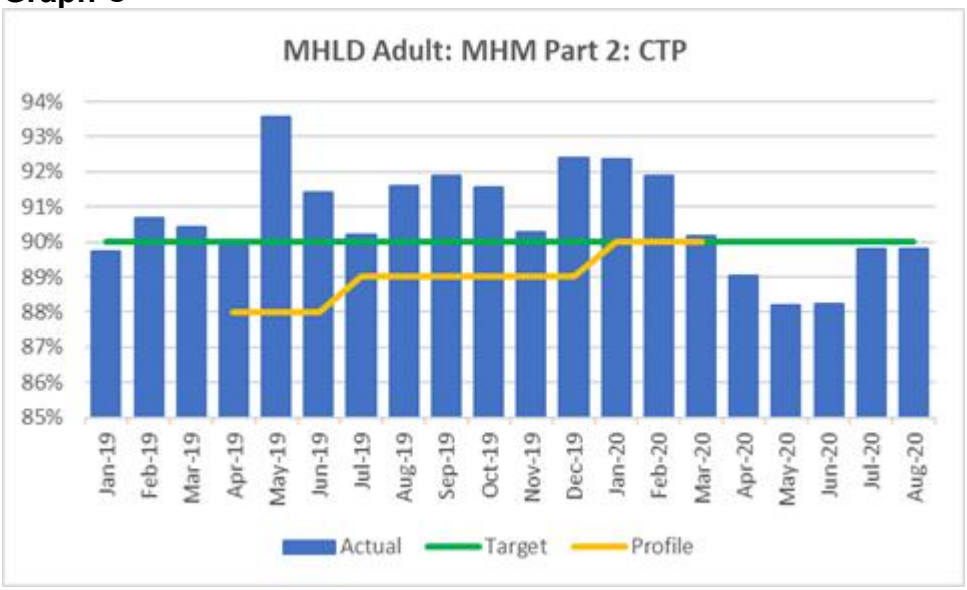
Graph B



- **Compliance with Part 2 Mental Health Measure**

The Division is currently compliant (September 2020) with the 90% target in Part 2 of the Mental Health Measure (Graph C). However the Division was non-compliant for the months of April, May, June, July and August. In the main, the issues were in the East. The East Adult Community Mental Health Teams (CMHT) have produced recovery plans. These are being monitored by the new triumvirate.

Graph C



- **Compliance with Part 3 Mental Health Measure**

  We are compliant across the region with Part 3 MHM. We now have embedded processes which alert us to potential breaches to enable the Division to put in rectifying actions in place, and in a timely manner.

Heddfan Unit Improvement - Wrexham

The Heddfan Quality Improvement Plan (HQIP) draws together all of the actions from the recommendations of a number of reports, and the action plan following the Health Inspectorate Wales' (HIW) unannounced visit to the Heddfan Unit. The actions listed on the action plan are being progressed and monitored, however there has been limited slippage on some actions. These are being addressed and all actions are expected to be completed by November 2020 as required.

2.3 Stronger and Aligned Management and Governance

The new BCUHB Risk Management Strategy (RM01) has now been ratified by the Board, signalling some fundamental changes in the way risk is managed. With these changes in mind, MHLD transitioned its risk register from five to three tiers. This has enabled a review of all existing risks. The Corporate Risk Management team supported the Division to achieve the transition date of 01.10.2020. A programme of training will be rolled out throughout the Division over the coming months to embed the new approach to risk management.

In terms of the reporting and escalation of risks, the Divisional Directors receive a monthly risk register report. This is reported formally in the Divisional QSE meeting.

- Tier 1 risks will be reported to the Corporate QSE Committee of the Board.
- Locality risks will be agreed and reviewed in the locality QSE meetings.

Work will now commence to update the Divisional RM04 to reflect the changes to the Risk Management Strategy. Only one Tier 1 risk remains relating to Mental Health being in special measures across the Health Board.

2.4 Engagement with staff, service users and stakeholders

The Division has recommenced its "Patient and Carer Experience" (PCE) subgroup of its QSE which receives and solicits data on the experience of people who use our services. This group was stood down in the initial response to Covid-19. The terms of reference have been reviewed and agreed, and following consultation now reflect the Terms of Reference (TOR) of the BCUHB PCE corporate group. This group is now reviewing its membership and developing its work plan and business cycle. This is a priority area of work for Division and the triumverate team.

3.0 Analysis

The Division has four priorities of work in response to its current Tier 1 risk relating to MHLD being in special measures, and in order for the Health Board to deliver its over-arching strategic aim of delivering safe, integrated and improved Mental Health services.

Priority actions based on the four priorities are summarised below:

1 **Review of Capacity and Capability**

This QSE report has detailed the current situation

Current Actions:

- Continue with managing return to work and sickness/absence of SLT
- Review capability to deliver effective mangement in SLT

2 **Delivery of Safe and Effective Care in Partnership**

This QSE report has detailed the key areas of work:

Current Actions:

- Continue Mortality review.
- Sctutinise unexpected deaths - as inquests re-open and intelligence emerges.
- Continue with the immediate Covid-19 response plan
- Provide regular reports onDivisional operational capacity to the Health Board QSE meeting
- Provide report to the Health Board QSE on the HQiP progress.

3 **Stronger and Aligned Management and Governance**

Going forward, we intend to focus on quality, safety and experience issues, and to provide the best service to our public. Alongside this we will provide accurate and clear data and information. We have approached the Governance team for support.

Current Actions

- Review the reporting to the Health QSE Committee following this report, and acty on the value feedback from the members.
- Continue to work on the alignment on our MHLD Divisional governance tso that it closely reflects the corporate BCUHB structure.
- Improve our analysis and presentation of our data with a focus on actions.

4 **Engagement with Staff, Service Users and Stakeholders**

As already described, work is developing in this area. The Division acknowledges that we have significant work to do, alongside stakeholders, internal and external to the organisation.

Current Actions

- The triumverate will be visible and connected throughout the pandemic
- Develop the membership of the PCE sub-committee to align with the corporate QSE approach
- Develop the workplan of the PCE sub-committee
- Develop an engagement plan

4.0	**Recommendations**

The Committee is asked to:-

1) Note the content of this QSE report. This report has been re-structured around the Division's four priorities of:

- Review of capacity and capability
- Delivery of safe and effective in partnership
- Stronger and aligned management and governance
- Engagement with staff, service users and stakeholders

(These relate to the key risks of the Division being in special measures, and the Health Board's strategic aim – for the safe and integration and improvement of Mental Health Services)

2) To provide feedback on the report structure and any recommendations for future reporting.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 3rd November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quality Governance Review (Updated Terms of Reference of the 4 Groups reporting into QSE)
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, Senior Quality Assurance Manager
Craffu blaenorol: Prior Scrutiny:	Review by new Groups/Chair of new Groups
Atodiadau Appendices:	Appendix A - Terms of Reference Strategic Occupational Health and Safety Group Appendix B - Terms of Reference Patient Safety and Quality Group Appendix C - Terms of Reference Patient and Carer Experience Group Appendix D - Terms of Reference Clinical Effectiveness Group

Argymhelliad / Recommendation:

The Committee is asked to approve the terms of reference as presented.

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

Sefyllfa / Situation:

On 03 July 2020, the Quality, Safety and Experience (QSE) Committee were asked to approve a review of the Quality and Safety Group (QSG) function. This followed the Quality Governance Self-Assessment undertaken by the Health Board at the end of 2019/20.

On 28 August 2020 a paper, outlining the review of the Quality & Safety Group (QSG) was presented to the Committee, with a proposal to replace QSG with 4 new Groups reporting into QSE.

The Committee agreed the recommendations in the paper, however requested changes to the 4 Groups Terms of Reference (TORs).

Cefndir / Background:

Work has taken place with the new Groups, Chairs of the new Groups, Lead Officers and Executive Directors and updated terms of reference are attached for approval.

Strategic Occupational Health and Safety Group
Chair: Executive Director of Workforce and OD
Vice Chair: Executive Director of Planning and Performance
TORs agreed at meeting on 21st October 2020

Patient Safety and Quality Group
Chair: Executive Director of Nursing and Midwifery
Vice Chair: Executive Medical Director
TORs agreed at meeting on 09 October 2020

Patient Carer Experience Group
Chair: Executive Director of Nursing and Midwifery
Vice Chair: Executive Director of Therapies and Health Sciences
TORs agreed by the Chair direct due to the meeting being after the QSE paper deadline

Clinical Effectiveness Group
Chair: Executive Medical Director
Vice Chair: Executive Director of Therapies and Health Sciences
TORs agreed by the Chair direct and also presented on 15 October 2020 (chair not in attendance)

A review of the sub-groups reporting into the 4 groups has commenced with terms of reference in place to support a consistent approach. The review will be completed by the end of November 2020. This is aligned with the wider work being progressed by the new Interim Director of Governance.

Asesiad / Assessment & Analysis

Strategy Implication - Undertaking a review of QSG reporting arrangements and the setup of 4 new Groups to replace QSG provides a strengthened, coordinated, standardised and comprehensive approach to Board assurance and quality governance.

Financial Implications - None identified

Risk Analysis - Ongoing work on Phase 2 to review Sub-groups reporting into the 4 new Groups will improve risk management processes by improving ward/team/patient to Board structures and the flow of information and assurances.

Legal and Compliance - Standing Orders (SOs) are the regulation for the Health Boards proceedings and business. The review of the QSG function will be completed in accordance with the Health Board Standing Orders.

Impact Assessment - No impact assessments required.

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 occupational 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 Health Board has agreed to establish the Strategic Occupational Health and 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 SOHS 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 SOHS will ensure that an integrated governance approach to the identification and management of workplace Health and Safety risk is maintained throughout the organisation.

2.3 The SOHS 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:-

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 approach through to the Health Board.

3.2 The SOHS in respect of its provision of advice and assurance will and is authorised by the Board 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 Health and Safety 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 QSE on the Group's activities. Including the presentation of an Annual Report for the Committee to consider on behalf of the Health Board.

3.2.8 Submit the Group's minutes and issues of significance to the QSE for consideration as part of the Integrated Governance approach 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 and hold to account all clinical and corporate Departments.

3.2.15 Monitor the delivery of the Health Board's Risk Occupational Health and 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 the Health Board 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 on behalf of the Health Board and advise QSE on the appropriateness of the scoring and mitigating actions in place.

5) GROUP

5.1 The Group may, establish Sub-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 Sub-groups reporting into the SOHSG include;

Health and Safety Leads Sub-group
Operational Occupational Health and Safety Sub-group
Health and Wellbeing Safety Sub-group
Asbestos Management Safety Sub-group
Security Management Safety Sub-group
Fire Safety Sub-group
Water Safety Sub-group
Electrical Safety Sub-group
Ventilation Sub-group

6) MEMBERSHIP

6.1 Chair: Executive Director of Workforce and Organisational Development

6.2 Vice Chair: Executive Director of Planning and Performance

6.3 Members:

Trade Union Health and Safety Representatives (in line with the Local Partnership Terms of Reference including representatives of employee safety)
*Nominated Acute Site Director
*Nominated Area Director

*Nominated Senior Mental Health and LD representative
Associate Director of Health, Safety and Equality
Associate Director of Quality Assurance
Director of Estates and Facilities
Fire Safety Lead
Associate Director of HR
Assistant Director of Infection Prevention and Control
Head of Risk Management
Head of Health and Safety
Head of Occupational Health and Wellbeing
Local Security Management representative

(*Nominated representatives to be in place for a minimum of 12 months for continuity)

The Chairs of the Sub-groups will be in attendance if not already a member:

Health and Safety Leads Sub-group Chair or Representative
Operational Occupational Health and Safety Sub-group Chair or Representative
Health and Wellbeing Sub-group Chair or Representative
Asbestos Management Sub-group Chair or Representative
Security Management Sub-group Chair or Representative
Fire Safety Sub-group Chair or Representative
Water Safety Sub-group Chair or Representative
Electrical Safety Sub-group Chair or Representative

6.4 Invites are extended to:

6.4.1 Public Health Wales Representative

6.5 Lead Officer:

6.5.1 Lead Officers are responsible for practically managing the agenda and business of the meeting.

6.5.2 The Lead Officer for SOSH is the Associate Director of Health, Safety & Equality supported by the Secretariat.

6.6 Secretariat

6.6.1 Determined by Executive Director of Workforce and Organisational Development.

6.6.2 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.

6.7 Support to Group Members

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

6.7.2 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 and must include at least one representative of occupational health and safety and one representative of Acute or Area or Mental Health) must be present to ensure the quorum of the Group.

7.2 Frequency of Meetings

7.2.1 Meetings shall be held bi-monthly or otherwise, as the Chair of the Group deems necessary. Meetings of the Group will be held in private.

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 the Health Board for its performance in exercising the functions set out in these Terms of Reference. The Group reports to QSE for assurance and oversight of performance against the 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 and to the Health Board as required. 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 and the Health Board of any urgent/critical matters that may affect occupational health and safety.

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 Strategic Occupational Health and Safety.

Date of Approval by SOHS Group – 21st October 2020

Chair of SOHS Group Signature

Date of Approval by QSE Committee

Chairs Signature

Patient Safety & Quality Group (PSQ)

1) INTRODUCTION

1.1 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 PTR 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 coordinate outstanding action plans;

3.1.8 Provide assurance on the adequacy of safeguarding and infection, prevention and control, safer medicines and safe staffing arrangements;

3.1.9 Provide assurance of compliance with safety 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 Tier 1 risks including appropriate scoring and mitigating actions;

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 and the Patient Safety Strategy.

3.1.14 Provide Quality Assurance, Quality Regulation, Inquests,/Claims and Redress, Safe Staffing and External Reports.

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 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 Sub-groups reporting into PSQ Group include;

Divisional Quality Groups (6)
Medical Gasses Sub-group
Medical Devices Oversight Sub-group
Safer Medicines Sub-group
Falls Sub-group
HAPU Sub-group
Safeguarding Governance and Performance Sub-group
Infection Prevention Control Sub-group
Personal Protective Equipment Sub-group
Quality and Concerns Management Systems Sub-group
HASCAS/Ockenden Group
Quality Dashboard Task and Finish Group
Quality Strategy Task and Finish Group

6) MEMBERSHIP

6.1 Chair: Executive Director of Nursing and Midwifery

6.2 Vice Chair: Executive Medical Director

6.3 Members:

Executive Director of Therapies and Health Sciences
Associate Director of Quality Assurance
Deputy Executive Director of Nursing
Deputy Executive Medical Director
Senior Associate Medical Director
Clinical Director of Therapy Services
Director of Estates and Facilities
Divisional Nurse/Midwifery Directors or agreed representative (6)
Associate Director of Safeguarding
Associate Director of Infection Prevention & Control
Associate Director of HS&E
Chief Pharmacist or Medications Safety Officer

The Chairs of the Sub-groups will be in attendance if not already a member:

Safeguarding Governance and Performance Sub-group Chair or Representative
Infection Prevention Control Sub-group Chair or Representative

Personal Protective Equipment Sub-group Chair or Representative
Medicines Safety Sub-group Chair or Representative
Falls Sub-group Chair or Representative
HAPU Sub-group Chair or Representative
Quality and Concerns Management Systems Sub-group Chair or Representative
Medical Gasses Sub-group Chair or Representative
Medical Devices Oversight Sub-group Chair or Representative
HASCAS/Ockenden Group Chair or Representative
Quality Dashboard Task and Finish Group Chair or Representative
Quality Strategy Task and Finish Group Chair or Representative

6.4 Lead Officer:

6.4.1 Lead Officers are responsible for practically managing the agenda and business of the meeting.

6.4.2 The Lead Officer for PSQ is the Associate Director for Quality Assurance supported by the Secretariat.

6.5 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 In the unusual circumstances that the Chair or the Vice-Chair are unable to Chair the meeting, the Chair can nominate a member of the Group to act as Chair in their absence.

7.3.2 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.

Date of Approval by PSQ Group - 9th October 2020

Chair of PSQ Signature

Date of Approval by QSE Committee – 3rd November 2020

Chair of QSE Signature

Patient and Carer Experience Group (PCE)

1) INTRODUCTION

1.1 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, carers, 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 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):

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

3.1.10 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;

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

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

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

3.1.14 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;

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

3.1.16 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;

3.1.17 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.

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 Sub-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 Sub-group
- Patient Communication & Readers Panels

6) MEMBERSHIP

6.1 Chair: Executive Director of Nursing and Midwifery

6.2 Vice Chair: To be confirmed

6.3 Members:

Associate Director of Quality Assurance
Deputy Executive Director of Nursing
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
Head of Estates and Facilities
Senior Division/Site Representatives (8)

The Chairs of the Sub-groups will be in attendance if not already a member:

Bereavement Sub-group Chair or Representative

6.4 Invites are extended to:

6.4.1.Patient Representative
6.4.2 Carer Representative
6.4.3 CANIAD Representative
6.4.4 North Wales Community Health Council (CHC)
6.4.5 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 Lead Officers:

6.6.1 Lead Officers are responsible for practically managing the agenda and business of the meeting.

6.6.2 The Lead Officer for PCE is the Associate Director of Quality Assurance supported by the Secretariat.

6.7 Support to Group Members

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

6.7.2 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 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 In the unusual circumstances that the Chair or the Vice-Chair are unable to Chair the meeting, the Chair can nominate a member of the Group to act as Chair in their absence.

7.3.2 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.

Date of Approval by PCE Group Chair - 28th October 2020

Chair of PCE Signature

Date of Approval by QSE Committee - 3rd November 2020

Chair of QSE Signature

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;

3.1.10 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;

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

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

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

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

3.1.15 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;

3.1.16 Review clinical effectiveness risks on the Tier 1 Risk Register including appropriate scoring and mitigating actions and forward relevant minutes to the Risk Management Group.

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

Clinical Improvement and Audit Sub-group

North Wales Managed Clinical Services Quality Committee

Mental Health & Learning Disabilities Clinical Effectiveness Sub-group

New Technologies Oversight Sub-group

Reducing Mortality Sub-group

NICE Assurance Sub-group

Strategic Delivery Group for Palliative and End of Life Care

Radiation Protection Committee and Pathology (including Blood Transfusion Committee and Point of Care

Resuscitation Committee

Drugs and Therapeutics Sub-group

BCUHB Trauma Board Sub-group

Clinical Law and Ethics Sub-group

Medical Education Sub-Group

Research & Innovation Strategic Partnership Sub-group

6) MEMBERSHIP

6.1 Chair: Executive Medical Director

6.2 Vice Chair: Executive Director of Therapies and Health Sciences

6.3 Members:
Deputy Executive Medical Director
Deputy Executive Director of Nursing

Senior Associate Medical Director
Divisional Medical Directors or agreed representative
Chief Operating Officer
Public Health Wales Consultant
Associate Director of Medical Physics
Associate Director of Research and Innovation
Clinical Director of Therapy Services
Chief Pharmacist
Divisional representatives (6)
Head of Clinical Effectiveness and Audit
Head of Quality Assurance

The Chairs of the Sub-groups will be in attendance if not already a member:

Clinical Improvement & Audit Group Sub-group Chair or Representative
North Wales Managed Clinical Services Quality Committee Chair or Representative
Mental Health & Learning Disabilities Clinical Effectiveness Sub-group Chair or Representative
New Technologies Oversight Committee Chair or Representative
Reducing Mortality Sub-group Chair or Representative
Strategic Delivery Group for Palliative & End of Life Care Chair or Representative
NICE Assurance Sub-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 Sub-group Chair or Representative
Trauma Sub-group Chair or Representative
Clinical Law and Ethics Sub-group Chair or Representative
Medical Education Sub-Group Chair or Representative
Research & Innovation Strategic Partnership Chair or Representative

6.4 Invites are extended to:

6.4.1. Primary Care Representation
6.4.2 Women's Services

6.5 Secretariat

6.5.1 PA to Executive 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 Lead Officers:

6.6.1 Lead Officers are responsible for practically managing the agenda and business of the meeting.

6.6.2 The Lead Officer for CE is the Deputy Executive Medical Director supported by the Secretariat.

6.7 Support to Group Members

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

6.7.2 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 In the unusual circumstances that the Chair or the Vice-Chair are unable to Chair the meeting, the Chair can nominate a member of the Group to act as Chair in their absence.

7.3.2 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.

Date of Approval by CE Group Chair – 13th October 2020

Chair of CE Group Signature - Prof Arpan Guha, Acting Executive Medical Director

Date of Approval by QSE Committee – 3rd November 2020

Chair of QSE Committee Signature

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 3rd November 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Update report on the investigation of concerns regarding Speech and Language Therapy (SLT) services in the West Area
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Adrian Thomas, Executive Director of Therapies and Health Sciences Dr Chris Stockport, Executive Director of Primary Care and Community Services
Awdur yr Adroddiad **Report Author:**	Ffion Johnstone, Area Director West Gareth Evans, Clinical Director Therapy Services
Craffu blaenorol: **Prior Scrutiny:**	Review by responsible Directors
Atodiadau **Appendices:**	Appendix 1: Recommendations of the Investigation Appendix 2: Summary Action Plan Appendix 3: SLT West Concerns Appendix 4: Steering Group Terms of Reference

Argymhelliad / Recommendation:

The Committee is asked to note the internal investigation that has taken place and its findings.

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:

This paper provides the background and the current position regarding an internal investigation into concerns raised into the Speech and Language Therapy (SLT) service in the West Area. The concerns were raised using the Procedure for NHS Staff to Raise Concerns (WP4a). It is vital that the Health Board is able to give confidence to its community and to its staff that the recommendations from the Speech and Language Therapy investigation have been, or are actively being, implemented.

Recent external attention to this investigation has generated a wider interest into how safe haven concerns are managed within Betsi Cadwaladr University Health Board with links being made in this regard to other investigations. The Executive Director of Workforce and Organisational Development is separately leading a review into the safe haven process.

A steering group has been established and will continue to meet until the recommendations are fully implemented. Progress will be reported to the West Area Quality and Safety group with items of escalation to the BCUHB Patient Safety and Quality group to provide confidence to the Board and community that the improvement work will be completed.

Cefndir / Background:

In June 2016 a member of the Speech and Language Therapy service in the West Area raised concerns about a number of aspects including the treatment of staff in BCUHB and the service being provided in the West generally. This was done using the Procedure for NHS Staff to Raise Concerns (WP4a). A decision to investigate the concerns was made following receipt of a document noting concerns in August 2016. During 2017 a number of similar concerns were also identified and it was agreed that these would be considered within the investigation commissioned by BCUHB to the above.

Asesiad / Assessment & Analysis

The Investigation process

Following receipt of the concern in June 2016 there was a delay in the investigation getting underway following objections to the first three appointed investigating officers (IO) in August, September and November 2016 respectively. An objection was also raised in regard to the initial commissioning officer and thus a new commissioning officer was appointed in October 2016. By December 2016 Mr Jonathan Walters was confirmed as the investigator with a commencement date of January 2017. Whilst an external investigator was appointed the matter has remained an internal process in line with NHS Staff to Raise Concerns (WP4a). In order to ensure consideration of clinical governance an independent senior clinical leader with a background in Speech and Language Therapy was sought unfortunately it was difficult to source someone with this knowledge and experience however we did appoint somebody in June 2017 to support the investigating officer. The initial interviews with the individual who raised the concerns commenced in February 2017 leading to evidence from a further 28 individuals being received before the investigation was completed. Those who participated in the investigation were informed that their anonymity and confidentiality would be respected; noting that circumstances may arise in subsequent proceedings that may involve them losing this privacy.

Following the procedure required the investigating officer to gather and present the evidence to the commissioning officer to determine the findings and recommendations. Due to the volume of the information in this case it was additionally agreed that Mr Walters would provide observations on the evidence in order to be of assistance to the commissioning officer. An electronic copy of the IO's report was received in the organisation in March 2019 with the hard copy appendices available to the commissioning officer in May 2019. An internal review group consisting of the Executive Director of Therapies and Health Sciences, Area Director West and Assistant Director of Workforce was established in September 2019 to receive the report of the commissioning officer which included the findings and recommendations. As part of this process a second opinion of the conclusions relating to the concerns about patient safety and clinical quality was commissioned from a further independent professional Speech and Language Therapist. This was undertaken in order to have assurance in regard to this important aspect of the case. The commissioning officer's report was agreed by the internal review group in November 2019.

Initial feedback to the individual who raised the concern about the investigations findings took place in December 2019. Action to implement the recommendations also commenced in December 2019, in particular those that specifically related to individuals. A steering group, chaired by the Area Director West was set up to oversee these actions and ensure all others are completed. The initial meeting in March 2020 was postponed due to the emerging pandemic at that time. The group has met subsequently on the 14th August 2020 with monthly meetings now established.

It is acknowledged that there were a number of delays during this investigation from the initial receipt of the concerns through to the agreement of the commissioning officer's report. Together they have contributed to a longer than expected timeline which is regrettable. These can be broadly attributed to the delay in the commencement of the investigation, the type of investigation conducted, the scale of the investigation and the unavailability of the external clinical adviser for a period of the investigation.

These delays have been explored further as part of a reflective exercise by those involved in the conduct of the investigation to generate organisational learning. This and other learning identified have been provided to the wider review of the raising concerns process being undertaken within BCUHB. This review will include an options appraisal for making improvements to the current process, including a communications and awareness raising campaign to ensure staff are encouraged to raise concerns and are aware of the channels available to them.

Concerns raised

The terms of reference for the investigation covered a number of themes to capture the concerns raised. These are:

- *Workload Pressures*
- *Risk management*
- *Staff stress*
- *Workplace Culture*
- *Lack of action in response to previous reporting concerns*

Following further correspondence and clarification with the complainant a further theme of *Patient Safety and Clinical Quality* was also added to this list in September 2016 as a primary concern.

Findings and recommendations

A summary of the findings for each these themes is provided below noting the themes of *Risk management* and *Lack of action to previous concerns* have been grouped together.

Workload pressures findings

Many staff felt under pressure from the size of their clinical caseloads. Between 2014 and 2016 there were periods of operational pressure where the different teams were being asked to work together in a different way to address the situation. The evidence identifies that the majority of concerns emanate from an example in paediatric services in 2014 with a temporary decision to move to provide more clinic-based assessment rather than school based. There is evidence that this was a management decision derived from the intention to maximise the impact of delivery of the Speech and Language Therapy service on as many children as possible against a backdrop of the significant operational service pressures at that time. Although the practice of clinic-based assessments is not optimal, it was considered better than not seeing some children at all and it was a pragmatic attempt to ensure the best care within the resources available.

There is evidence that some caseloads were higher than they should have been but the cause is multi-factorial with clinical staff, teams and managers contributing to the situation. The investigating officer considered 17 causal factors including whether service resources were sufficient and whether

some clinical staff and some managers were engaged sufficiently in the use of best practice to manage caseloads most efficiently. There is also evidence that some staff did not assist others to reduce the caseload when the situation was particularly difficult.

Risk management and lack of action in response to previous reporting concerns findings

There were concerns raised about how issues and/or risks were dealt with when raised by staff within the service. In particular it was felt that staff concerns were not always dealt with in line with due process and were often only managed informally. A further concern was that staff would be targeted for raising concerns. There is some evidence that sometimes there was little adherence to organisational process in the way issues were then dealt and that the department did not utilise the risk management framework as effectively as it should have done. There is no evidence of people being victimised for raising concerns, however people's perceptions of the lack of response to their issues had led to a belief that raising a concern was an unwelcome activity.

Staff stress findings

There is evidence that stress had existed in the whole department for a prolonged period. Several therapists and managers had experienced stress and stress related work absence. The cause of that stress was multi factorial and not all work related. Cited work reasons relate to issues raised in particular to culture, lack of support from managers and that caseloads were high, the findings for which are noted in this report.

Workplace Culture findings

Relationships were described as strained with behaviours that meant clinical teams weren't working well as a single service. There were factions within the department between clinical teams and some poor group behaviour which appear to demonstrate that amongst the clinical staff there was a degree of frustration with each other and mild animosity. There are some specific examples of where individual manager behaviour was poor but there is no evidence of a culture of bullying. There is some evidence that the most strident complaints of bullying arise from those themselves alleged to have been failing to meet their own professional obligations and resented the interventions and decisions of line managers.

There is evidence of a significant gap in understanding between some therapists and the managers of the importance to the organisation to deliver an access target. The evidence highlights the belief of some therapists that their caseloads are high because of the adherence to this national and organisational target. In contrast the evidence also highlights the inefficiency of the service and poor adherence from some staff to engage in service improvement designed to help address such pressures and deliver said target.

There was a specific concern raised about a mistrust in the management culture of the use of the electronic patient record system, Therapy Manager, used within the department. There is no evidence of misuse of the system by managers. There is evidence that it is a useful operational and clinical tool and that therapists also use the system to compare their workload with other therapists.

Patient safety and clinical quality findings

As noted earlier there is evidence of therapists holding caseloads which are disproportionate to the clinical time available. The change in provision of care in 2014 by the mainstream school service is perhaps the only significant example from the evidence where there is an impact on the quality of the

service, relating as it does to a decision taken to assess children in a clinic-based setting rather than in schools.

At the time of the decision there were significant operational pressures and the school based provision was extremely limited. The move to clinic based provision necessitated a review of the caseload to identify the highest priority children but it is clear that this model of clinic only based service is not optimal with evidence that school aged children who have SLT needs should be assessed and seen for therapy in both an educational and a clinical setting in order to achieve optimal benefit of the SLT input. It is therefore possible to conclude that the decision to see children in a clinic-based setting will not have served to improve the quality of care those children received, although it possibly may have directed the very limited resource at that time to those most in need. There is evidence that, whilst the practice of clinic-based assessments was less that satisfactory, in the context of why the decision was taken to address the excessive workloads of mainstream therapists it was better than not seeing some children at all. Notwithstanding the potential additional benefit that could have been available to the patients had a fully operational integrated multi agency service been in place there are no clear and specific examples from within the investigation that provide evidence of any outcomes of harm to users of the service.

To address the findings the report made 19 recommendations (Appendix 1) which have resulted in 29 key actions (Appendix 2).

Progress and service improvement

It is important to note that during the period of the investigation there has been a considerable amount of improvement work undertaken by the service in response to the issues raised by staff. In 2017 a phased approach to improvement was initiated with support and guidance from the Workforce and Organisational Development team. Phase one focused on understanding the problem and this was informed by a full staff survey using the Health and Safety Management standards and a number of additional semi structured interviews. The findings were used to develop Phase two, an appreciative inquiry model to engage the staff towards self-determined change in order to develop a desired future state for the service. During 2018 and 2019 the service moved to implementing these changes as part of Phase 3 through a variety of task and finish groups. During the early months of the Covid pandemic the paediatric team utilised their time to review their progress and remodel the service further, in line with the other SLT services in BCUHB.

By 2019 aspects of this improvement work were recognised when the lead SLT for the Additional Learning Needs Team within paediatric Speech and Language Therapy Services across Gwynedd and Anglesey, won a BCUHB Achievement Award for her work in establishing effective joint working with special schools. Furthermore a paediatric SLT also came third place in the BCUHB Welsh Learner of the Year awards in 2019 noting their commitment to providing bilingual interventions within the special schools. There was another positive recognition of the service in 2019 when the Royal College of Speech and Language Therapists awarded the work of one of the Adult SLTs in developing software to create personalised synthetic voices to help patients about to lose their own voices. The project enabled voice banking in Welsh and English so that a digital version of their voices could be built in. The judges were of the opinion that this could transform the lives of people with motor neurone disease or head and neck cancer.

Further consideration to improvements since 2017 can be found. Feedback from staff at a meeting held to discuss the investigation on the 15th September 2020 provided a clear message that the

team felt the service has moved on significantly from the period under the investigation. In particular, relationships were noted as being much improved, especially over the last year.

Staff sickness is currently 7.42% (rolling 12 month average) which is higher than the other two SLT services in BCUHB but has reduced from the previous year and remains an important indicator and factor to monitor. Where stress is identified as a causal factor risk assessments are in place as a proactive measure to support staff. The service has two wellbeing champions and a listening lead within the staff team. The department has a positive approach to promoting wellbeing and work life balance and 34% of the workforce have flexible working arrangements in place.

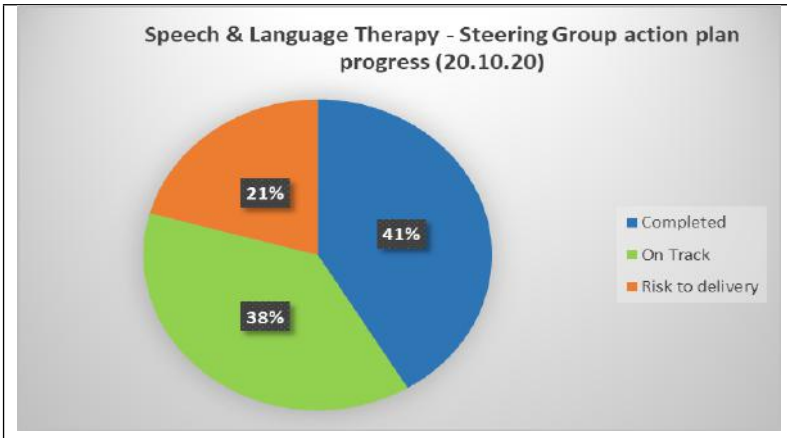
Along with all public services the SLT team recognises that concerns are a useful indicator of when service users feel things aren't right and that monitoring and responding to them is an important contribution to the improvement of our services. The number of both formal and on the spot concerns going back several years (Appendix 3) indicates a greater level of dissatisfaction with the service during the key period within the investigation and a more positive position as improvement work has been implemented.

Current recruitment and retention of staff is in a stronger position than for some time. SLT West has always been the most challenged in North Wales in its ability to recruit new staff, in part due to the need for Welsh speaking essential posts. In 2018, the West service was the first in Wales to advertise, and recruit to Band 5 rotational roles. This has been attractive to qualifying students and enables the department to have SLTs with a range of skills. Since 2018, the West team has been more successful in its recruitment and, for example, has attracted five SLTs who were formerly working in the Central and East Areas. At the end of September 2020 the vacancy rate is 2% which equates to less than 1 WTE post.

A key relationship for the paediatric service is with the Gwynedd and Môn Local Education Authorities (LEA). There are regular partnership meetings with the LEA which have built upon the service level agreement established in 2017 for services provided to school aged children in Gwynedd and Môn. This model of partnership working with Gwynedd and Môn LEA provides recognition of the need to provide a more integrated model of service provision for children with speech, language and communication needs within the schools service. This work has allowed for increased investment of four whole time posts into the West SLT service.

Recommendation 1 of the Investigating Officer's report required the establishment of a steering group (Appendix 4) to ensure oversight of the implementation of the recommendations. The group met in August 2020 and approved the action plan. All actions are in progress or complete as shown in Figure 1 below. Of the 29 actions, 12 are completed and 11 are on track to deliver. All 6 off profile actions were reviewed at the steering group on the 20th October 2020 and recovery actions agreed.

Figure 1



Feedback from the meeting with the West Speech and Language Therapy team on the 15th September 2020 is also assisting the design of the organisational development work that is planned. The key feedback from staff is that due to the service improvement work that has been taking place since 2017 the service is in a better place and has moved on. As relationships between teams are now far healthier the focus of the planned team work will be tailored to what staff feel will add most value.

The steering group will continue to meet until the recommendations are fully implemented. Progress will be reported to the West Area Quality and Safety group with items of escalation to the BCUHB Patient Safety and Quality group to provide confidence to the Board and community that the improvement work will be completed.

Strategy Implications

This report is for administrative purposes is response to the findings of the SLT West investigation. The impact of the recommendations align to BCUHBs strategic improvement work and to a review of the Safe Haven investigation process.

Financial Implications

There is consideration underway by the West Area leadership team in regard to supporting the cost of implementing the recommendations.

Risk Analysis

There is a risk to the deliverability and sustainability of the recommendations through the instability of the SLT leadership team. This risk is mitigated by two interim appointments. Further support is available from the wider SLT service BCUHB.

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.

Report of the commissioning officer for the investigation of concerns raised

Recommendations

This section sets out what I believe are fair and proportionate recommendations that address my findings as commissioning officer. They will require BCUHB to support and, where necessary, provide resource to ensure their successful implementation to address identified issues with the sole reason of improving the current situation.

1. Establish a steering group to oversee the implementation and delivery of the recommendations.

2. Introduce a revised governance framework for SLT within the umbrella of therapy services and the West leadership team to ensure clarity of responsibility and escalation pathways.

3. The BCUHB risk management policy is provided to all SLT staff and team based training on managing risk and escalation delivered.

4. Review existing fora for gaining service user and partner feedback, in particular the Local Education Authorities and Universities, and where necessary revise and improve to ensure this feedback can shape future service planning.

5. A range of short term actions to assist with workload pressures are undertaken whilst work to ensure service sustainability over the longer term is conducted.

   Short term

   - Consideration should be given to an immediate increase in clinical capacity through the employment of additional staff to the school service. Consideration of these posts being permanent to aid recruitment with the view that if the need is not proven as part of the longer time actions then they can be absorbed through natural wastage.
   - Complete the OCP process and, in partnership with the staff, review the remaining structure to ensure it is still fit for purpose
   - Ensure effective triage processes are implemented

- Re-energise the existing improvement action plan devised in conjunction with the staff, reviewing progress to date.
- Establish a clear health and wellbeing framework using existing organisational resources such as Occupational Health to provide all staff with access to support in the post investigation period.
- Review of individual and team caseloads and agree effective escalation process for the management of.

Longer term

- Establish clear job plans setting out clear expectations for all staff.
- Benchmark staffing levels against whole BCUHB SLT departments and external peer organisations to assist in determining appropriate staffing levels to meet population need.
- Adopt the best practice of the All Wales SLT pathways and ensure all staff are supported to utilise them consistently
- Ensure compliance from all staff to agreed evidence-based practice moving away from individual practice behaviour to a more team-based approach.
- [redacted]

6. [redacted]
7. [redacted]
8. [redacted]
9. [redacted]

10. [redacted]

11. BCUHB wide review of the recording of activity on Therapy Manager with a view of reducing the need to record activity to essential activity only.

12. Training need analysis for all staff in respect of Therapy Manager

13. Clearer process for access to formal training on Therapy Manager for all therapy staff.

14. Training for all managers in respect to managing concerns using recommendation 2. above to ensure this is embedded in practice.

15. Introduce an organisational development plan for the service, based around team work with an emphasis on openness and candour for all and the responsibilities of being a HCPC registrant. A clear approach to staff engagement should form part of this plan.

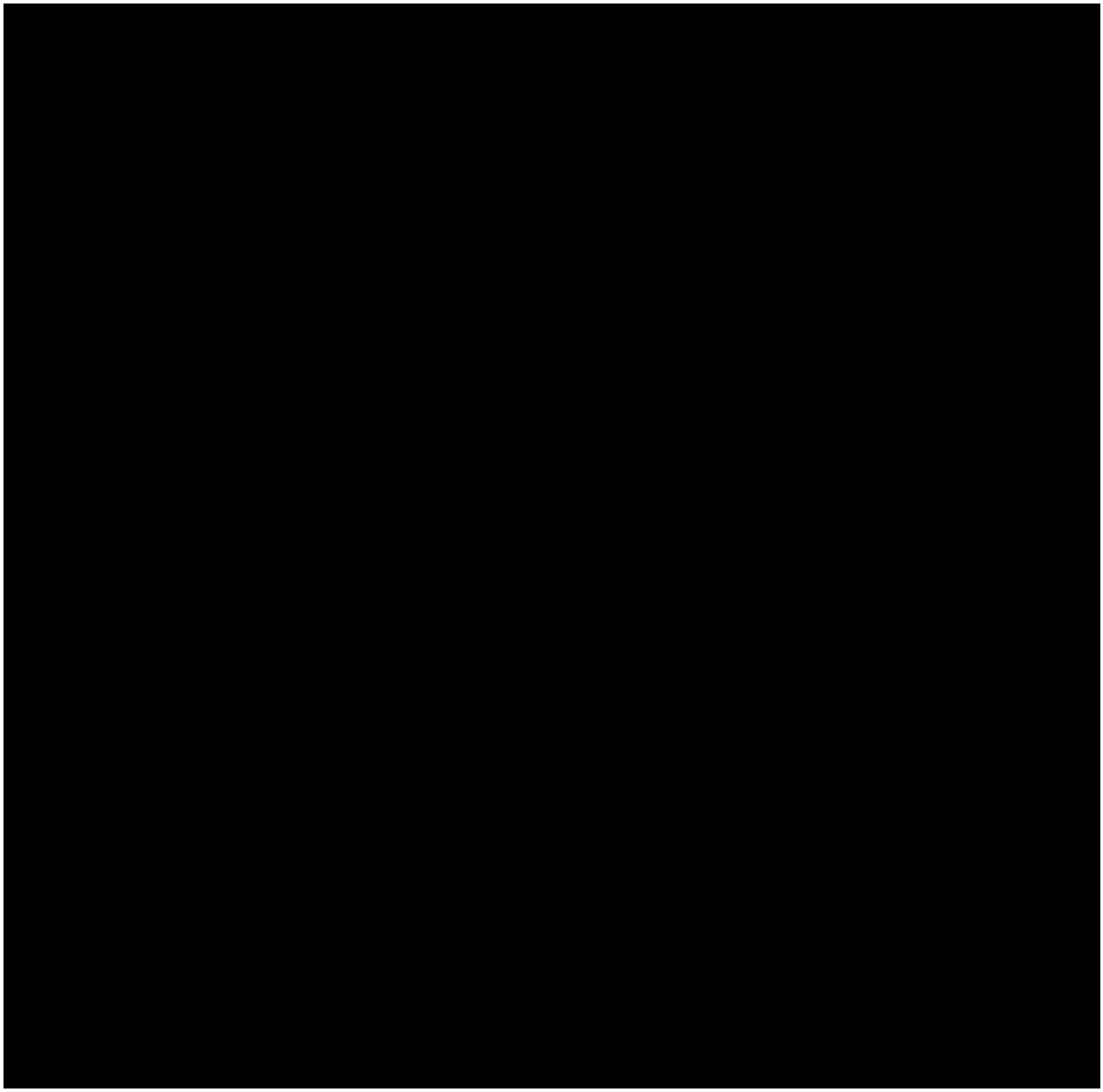
16. Leadership and management training and development within the SLT service should be reviewed with a focus on building and supporting engaged teams.

17. All managers, at all levels from Assistant Area Director down, to be reminded on their responsibilities towards managing concerns.

18. Undertake a rapid review of the current service model for mainstream school provision to provide assurance that the clinic only model is no longer the approach taken by the service and to benchmark with other SLT services to ensure the current model is in line with best practice such as the Bercow (2008) and Bercow 10 years on (ICAN 2018) reports.

19. Although outside of the terms of reference of this investigation it is recommended, as an opportunity for improvement within BCUHB that a desktop review of the way the original concerns were dealt with, and how delays

throughout the whole investigative process occurred, is undertaken that could provide valuable learning for any future events.



Appendix 2 Summary Action Plan based on the Recommendations from the Speech & Language Therapy (West) Investigation

Updated:	20.10.20 (updated at the Steering Group Meeting 20.10.20]

Key:	Currently will not deliver to plan	Risk to delivery, needs attention	On track to deliver as expected	Completed and evidenced

Division / Team	SPEECH & LANGUAGE THERAPY (WEST) STEERING GROUP

THEME	Overarching Actions

No	Recommendation	Expected Outcome	Benefit / Impact	Target Completion Date	Lead	Progress
1.	Establish a Steering Group	To oversee the implementation and delivery of the recommendations	Recommendations managed, actioned and formally reported	March 2020	Area Director	**COMPLETED** Formal delay due to Covid 19. Group commenced 14th Aug 20.
2.	Introduce a revised governance framework for SLT within the umbrella of Therapy Services and the West leadership team.	To clarify areas of responsibility	Staff will be aware of escalation pathways, appropriate response at all levels.	Oct 2020	CD Therapy Services	**Update 20.10.20** Therapy Services Governance document under review with finance section complete Quality and safety section still in draft pending organisational changes e.g. Q&S Exec groups **- Risk to delivery - *changed from green to amber***
3.	BCUHB risk management policy is provided to all staff and team based training on managing risk and escalation delivered.	Staff will understand policy and procedures	Staff awareness of managing risk and escalation procedures	June 2020	HOS SLT	**COMPLETED** Training was provided to all staff in 2018. New action for service: Newer staff to be provided with training, but with a new risk management strategy to be launched in 2020 by BCUHB, updated training to be provided to all again then.

Appendix 2 Summary Action Plan based on the Recommendations from the Speech & Language Therapy (West) Investigation

Updated:	**20.10.20 (updated at the Steering Group Meeting 20.10.20]**

Key:	Currently will not deliver to plan	Risk to delivery, needs attention	On track to deliver as expected	Completed and evidenced

No	Recommendation	Expected Outcome	Benefit / Impact	Target Completion Date	Lead	Progress
4.	Review existing fora for gaining service user and partner feedback, in particular the Local Education Authorities and Universities. Where necessary, revise and improve to ensure this feedback can shape future service planning.	Service user and partner feedback received.	Feedback used to shape future service planning.	Nov 2020	HOS SLT	**Update 19.10.20** Termly meeting dates set for meeting with Local Education colleagues for Mainstream schools, and Special schools In the process of writing a presentation to share with stakeholders on the changed model of SLT delivery in West HOS met with Patient Experience team 5.10.20 Plan to implement Virtual Care to within SLT West as per PALS email **Update 20.10.20** More general ways of collecting feedback from stakeholders identified to help shape the service **evidence to be embedded* ***- On track***
5.	See 'Short Term' and 'Longer Term' Actions captured below					
6.	Redacted			Oct 2020	AAD Therapy Services	Delayed due to Covid. First meeting 21st January 2020 Second meeting 4th August 2020 **Updated 20.10.20**

Appendix 2 Summary Action Plan based on the Recommendations from the Speech & Language Therapy (West) Investigation

Updated:	**20.10.20 (updated at the Steering Group Meeting 20.10.20]**

Key:	Currently will not deliver to plan	Risk to delivery, needs attention	On track to deliver as expected	Completed and evidenced

No	Recommendation	Expected Outcome	Benefit / Impact	Target Completion Date	Lead	Progress
						Third meeting 20.10.20 ***- On track***
7.	Redacted			Oct 2020	BCUHB Officer	Delayed due to Covid. Action now underway. **Updated 20.10.20** **Evidence required using reporting template*
8.	Redacted			Jan 2020	CD Therapy Services	**COMPLETED**
9.	Redacted			May 2020	CD Therapy Services	**COMPLETED**
10.	Redacted			March 2020	HOS SLT	**COMPLETED**
11.	BCUHB wide review of the recording of activity on Therapy Manager with a view of reducing the need to record activity to essential activity only	Essential activity identified	Efficiency saving and less complication for staff	Dec 2020	HOS SLT x 3/ TS Business Manager	**Update 20.10.20** Review of activity recording has commenced Follow up meeting of SLT Therapy Manager User Group 24.10.20 ***- On track***

Appendix 2 Summary Action Plan based on the Recommendations from the Speech & Language Therapy (West) Investigation

Updated:	**20.10.20 (updated at the Steering Group Meeting 20.10.20]**

Key:	Currently will not deliver to plan	Risk to delivery, needs attention	On track to deliver as expected	Completed and evidenced

No	Recommendation	Expected Outcome	Benefit / Impact	Target Completion Date	Lead	Progress
12.	Training need analysis for all staff in respect of Therapy Manager	Understand staff's training requirements	Delivery of targeted training & support as required	Sept 2020	TS Business Manager	**Update 20.10.20** Training need analysis completed – 454 respones across Therapies ***- Completed - Agreed to change to 'blue'*** **Feedback paper to be evidenced*
13.	Clearer process for access to formal training on Therapy Manager for all therapy staff.	Understanding of process and formalisation of training	Standardised approach to Therapy Manager training	Dec 2020	TS Business Manager	**Update 20.10.20** Super User training commenced Training need analysis (as above) results used to formulate training plan for existing staff Training plan for new staff underway Training guides in production and will be made available online ***- On track***
14.	Training for all managers in respect to managing concerns using recommendation 2. above to ensure this is embedded in practice.	Managers trained in managing concerns	Concern process followed correctly	Oct 2020	HOS SLT	**Updated 20.10.20** *Links to Recommendation 2* *Previous update re training was around managing patient complaints not staff* New all Wales policy imminent (WOD receiving training) will build into OD work – reference Recommendation 16 **- On track**

Appendix 2 Summary Action Plan based on the Recommendations from the Speech & Language Therapy (West) Investigation

Updated:	**20.10.20 (updated at the Steering Group Meeting 20.10.20]**

Key:	Currently will not deliver to plan	Risk to delivery, needs attention	On track to deliver as expected	Completed and evidenced

No	Recommendation	Expected Outcome	Benefit / Impact	Target Completion Date	Lead	Progress
15.	Introduce an organisational development plan for the service, based around team work with an emphasis on openness and candour for all and the responsibilities of being a HCPC registrant. A clear approach to staff engagement should form part of this plan.	Organisational development plan produced	Staff engagement, openness and team work	Mar 2021	Organisational Development Manager	**Updated 20.10.20** Revised OD Plan discussed and edited at meeting 23.10.20 To proceed with structure and plan ** OD plan to be evidenced* ***- To remain amber pending evidence at the next meeting***
16.	Leadership and management training and development within the SLT service should be reviewed with a focus on building and supporting engaged teams.	Ongoing process of leadership development	Leaders able to build and support engaged teams	Mar 2021	Organisational Development Manager	Merged with No.15
17.	All managers, at all levels from Assistant Area Director down, to be reminded on their responsibilities towards managing concerns.	Awareness of concerns process within management team	Concerns process managed correctly	August 2020	CD Therapy Services	**COMPLETED**

Appendix 2 Summary Action Plan based on the Recommendations from the Speech & Language Therapy (West) Investigation

Updated:	**20.10.20 (updated at the Steering Group Meeting 20.10.20]**

Key:	Currently will not deliver to plan	Risk to delivery, needs attention	On track to deliver as expected	Completed and evidenced

No	Recommendation	Expected Outcome	Benefit / Impact	Target Completion Date	Lead	Progress
18.	Undertake a rapid review of the current service model for mainstream school provision to provide assurance that the clinic only model is no longer the approach taken by the service and to benchmark with other SLT services to ensure the current model is in line with best practice such as the Bercow (2008) and Bercow 10 years on (ICAN 2018) reports.	To assess the model for mainstream school provision	Service model benchmarked and developed in line with best practice	March 2020	HOS SLT	**COMPLETED** The model of Clinic vs School based services has been redesigned using evidence based practice.
19.	Although outside of the terms of reference of this investigation it is recommended, as an opportunity for improvement within BCUHB that a desktop review of the way the original concerns were dealt with, and how delays throughout the whole investigative process	Understanding of original concerns process	Learning for future situations	Sept 2020	Head of Workforce	**Updated 20.10.20** Desktop review has taken place, reflections and considerations captured. * Paper to be evidenced ***- On track***

Appendix 2 Summary Action Plan based on the Recommendations from the Speech & Language Therapy (West) Investigation

Updated:	**20.10.20 (updated at the Steering Group Meeting 20.10.20]**

Key:	Currently will not deliver to plan	Risk to delivery, needs attention	On track to deliver as expected	Completed and evidenced

No	Recommendation	Expected Outcome	Benefit / Impact	Target Completion Date	Lead	Progress
	occurred, is undertaken that could provide valuable learning for any future events.					

Appendix 2 Summary Action Plan based on the Recommendations from the Speech & Language Therapy (West) Investigation

Updated:	**20.10.20 (updated at the Steering Group Meeting 20.10.20]**

Key:	Currently will not deliver to plan	Risk to delivery, needs attention	On track to deliver as expected	Completed and evidenced

THEME	**Short Term Actions**
	To assist with workload pressures in the short term

No	Action	Expected Outcome	Benefit / Impact	Target Completion Date	Lead	Progress
5a.	Consideration should be given to an immediate increase in clinical capacity through the employment of additional staff to the school service. Consideration of these posts being permanent to aid recruitment with the view that if the need is not proven as part of the longer term actions, then they can be absorbed through natural wastage.	Increase in clinical capacity	Capacity to meet needs of school service	Dec 2019	AAD Therapy Services	**COMPLETED**

Appendix 2 Summary Action Plan based on the Recommendations from the Speech & Language Therapy (West) Investigation

Updated:	**20.10.20 (updated at the Steering Group Meeting 20.10.20]**

Key:	Currently will not deliver to plan	Risk to delivery, needs attention	On track to deliver as expected	Completed and evidenced

No	Action	Expected Outcome	Benefit / Impact	Target Completion Date	Lead	Progress
5b.	Complete the OCP process and in partnership with the staff, review the remaining structure to ensure it is fit for purpose	OCP process completed	Structure is fit for purpose	Oct 2020	HOS SLT	**Update 20.10.20** HoS SLT discussed OCP SBAR with AAD & Director of Therapies – to discuss with Area Director. ECR approved for secondment to the vacant team leader, school services. ***- Remain amber pending meeting between Area Director/Director Therapies***
5c.	Ensure effective triage processes are implemented	Effective triage process established	Triage meets professional requirements and ensures safety of patients	April 2020	HOS SLT	**COMPLETED** A task and finish group have created a new paediatric referral form (preschool and school aged) which has now gone live in June 2020 and sent around to all our stakeholders also advising of the electronic referral system to SLT. There is a new triage pathway, and a range of evidence based decision making tools for therapists to use at triage. Currently, only band 6, 7, 8 carry out triage in paediatrics. In adults, traditionally this has been band 7s, but training and supervision is being provided to band 5 and over.

Appendix 2 Summary Action Plan based on the Recommendations from the Speech & Language Therapy (West) Investigation

Updated:	**20.10.20 (updated at the Steering Group Meeting 20.10.20]**

Key:	Currently will not deliver to plan	Risk to delivery, needs attention	On track to deliver as expected	Completed and evidenced

No	Action	Expected Outcome	Benefit / Impact	Target Completion Date	Lead	Progress
5d.	Re-energise the existing improvement action plan devised in conjunction with the staff, reviewing progress to date.	Updated action plan	Action plan re-energised in partnership with staff	Aug 2020	HOS SLT	**COMPLETED** The pandemic period has supplied us with space and resource to continue to implement service redevelopment and design work. In this time, a small group of shielding staff have been working on a range of the service improvement actions including: Service pathways, referral forms, triage, ICPs, Equipment, caseload management, Helpline, website, telehealth,
5e.	Establish a clear health and wellbeing framework using existing organisational resources such as Occupational Health to provide all staff with access to support in the post investigation period.	Health & Safety framework established	Staff able to access support – during post investigation period and anytime	March 2020	Head of Workforce	**COMPLETED** BCUHB has a broad framework of support available to staff.

Appendix 2 Summary Action Plan based on the Recommendations from the Speech & Language Therapy (West) Investigation

Updated:	**20.10.20 (updated at the Steering Group Meeting 20.10.20]**

Key:	Currently will not deliver to plan	Risk to delivery, needs attention	On track to deliver as expected	Completed and evidenced

No	Action	Expected Outcome	Benefit / Impact	Target Completion Date	Lead	Progress
5f.	Review of individual and team caseloads and agree effective escalation process for the management of.	Improved patients outcomes	Safe and effective caseloads	Nov 2020	HOS SLT	**Update 19.10.20** Working group within SLT setting up training for whole staff on Professional Supervision Contact made with training provider regarding a bespoke training course for 8 staff, in Professional Supervision, to enable local training to be cascaded thereafter. **Update 20.10.20** Links to Governance document, Recommendation 2 ***- On track***

Appendix 2 Summary Action Plan based on the Recommendations from the Speech & Language Therapy (West) Investigation

Updated:	**20.10.20 (updated at the Steering Group Meeting 20.10.20]**

Key:	Currently will not deliver to plan	Risk to delivery, needs attention	On track to deliver as expected	Completed and evidenced

THEME	**Longer Term Actions**
	To ensure service sustainability over the longer term

No	Action	Expected Outcome	Benefit / Impact	Target Completion Date	Lead	Progress / Review
5g.	Establish clear job plans setting out clear expectations for all staff.	Each staff member to have an up to date job plan	Clear expectations of all staff in regard to their activity and role.	Dec 2020	HOS SLT	**Updated 19.10.20** 73% of all SLT staff have now had a 1:1 Face to face meeting and have an updated Job Plan
5h.	Benchmark staffing levels against whole BCUHB SLT departments and external peer organisations to assist in determining appropriate staffing levels to meet population need.	Comparative data of SLT staffing levels across the three SLT departments in BCHB. Comparative data of BCUHB SLT workforce with any suitable external data.	Inform workforce planning assumptions for SLT. To ensure consistency in resource across BCUHB	Jan 2021	HoS SLT x3 and Head of Workforce	**Updated 19.10.20** Draft document has been shared with Director of Therapies and AADs **Updated 20.10.20** Heads of SLT have carried out a very useful benchmarking exercise * Present next meeting ***- On track***

Appendix 2 Summary Action Plan based on the Recommendations from the Speech & Language Therapy (West) Investigation

Updated:	**20.10.20 (updated at the Steering Group Meeting 20.10.20]**

Key:	Currently will not deliver to plan	Risk to delivery, needs attention	On track to deliver as expected	Completed and evidenced

No	Action	Expected Outcome	Benefit / Impact	Target Completion Date	Lead	Progress / Review
5i.	Adopt the best practice of the All Wales SLT pathways and ensure all staff are supported to utilise them consistently	The service is using an evidence based approach to deliver care to service users.	Improved outcomes for service users. Consistency across BCUHB	Nov 2020	HOS SLT	**Update 20.10.20** West and Central SLT HoS and Deputies meeting on 3.11.20 to discuss findings and make amendments with new service pathway ** Amended service document and minutes of meeting where shared with staff to be evidenced* ***- On track***
5j.	Ensure compliance from all staff to agreed evidence-based practice moving away from individual practice behaviour to a more team-based approach.	The service is using an evidence based approach to deliver care to service users.	Improved outcomes for service users. Team based approach ensures greater clinical governance	Dec 20	HOS SLT	Linked to recommendations 2, 5b and 16 **Update 20.10.20** Completion date was set before links with other recommendations were identified ***- Maintain amber – monitor dependencies***
5k.	Redacted			Sept 2021	Head of Workforce	**Update 20.10.20** In progress **Evidence feedback form* ***- On track***

Appendix 3

SLT West Concerns 2013-2020

	Formal	On the spot
2013	2	4
2014	8	10
2015	4	6
2016	1	6
2017	2	6
2018	3	3
2019	0	2
2020	0	0

Betsi Cadwaladr University Health Board

Terms of Reference

SPEECH AND LANGUAGE THERAPY WEST STEERING GROUP

Accountability	The Speech And Language Therapy West Steering Group is accountable to the Area Director West.
Remit	To provide the oversight for the implementation of the recommendations from the commissioning officer's report into concerns about the Speech and Language Therapy service West.
Chair	Area Director West Vice chair - AAD Therapy services
Executive Lead	Executive Director of Primary and Community
Membership	Area Director West Clinical Director Therapy Services Area Director of Nursing West Assistant Area Director (AAD) Therapy Services Head of Speech and Language Therapy West Head of Speech and Language Therapy Central Senior Head of HR West Organisational Development Officer Senior Business Support Manager - Therapy Services North Wales Community Health Council Staff side Co opt Assistant Area Director Childrens services West Local Authority Director
Secretary	PA to the Area Director West

Attendance	Members are expected to make every effort to attend. Appropriate deputies can be used. At the discretion of the Chair, anyone with relevance to the agenda can attend.
Quorum	Four members to include the Chair or Vice chair
Frequency	Meetings shall usually be held monthly, to be reviewed in six months. A schedule of meetings is drawn up in advance and dates and venues agreed.
Authority	The Speech And Language Therapy West Steering Group is authorised by the Executive Director of Primary and Community to oversee the implementation of the recommendations from the commissioning officer's report into concerns about the Speech and Language Therapy service West.
Function	To provide the oversight of the implementation of the recommendations from the commissioning officer's report into concerns about the Speech and Language Therapy service West. To agree the specific actions required to successfully implement the recommendations To identify and agree the resources required for each recommendation To appoint a lead officer for each recommendation To agree a time frame for each recommendation and determine when each recommendation can be closed Where the group cannot resolve issues, to escalate things that prevent the successful implementation of any recommendation. To ensure effective communication to relevant stakeholders including staff. To maintain an accurate and contemporary action plan. To monitor progress of the action plan and escalate issues as required.

Reporting	The minutes of the meetings shall be formally recorded and signed off at each the Speech And Language Therapy West Steering Group meetings. The minutes and issues for escalation shall be presented to the Area West Quality and Safety Group.
Communication	The Speech And Language Therapy West Steering Group will link to all relevant service specific management/staff team meetings and to the Area senior management team. Updates will be provided to relevant Health Board groups as requested.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 3rd November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Healthcare Inspectorate Wales (HIW) Reports
Cyfarwyddwr Cyfrifol: Responsible Director:	Debra Hickman, Acting Executive Director of Nursing & Midwifery
Awdur yr Adroddiad Report Author:	Matthew Joyes Acting Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience Erika Dennis Senior Quality Assurance and Regulation Manager
Craffu blaenorol: Prior Scrutiny:	Bi-monthly reports submitted to the Quality Safety Group (QSG) prior to its dissolution - moving forward HIW will be included in a bi-monthly Quality Assurance Report to the Patient Safety and Quality Group (PSQ).
Atodiadau Appendices:	No Appendices included. External links are provided for HIW Inspection reports

Argymhelliad / Recommendation:

The Committee are asked to note the following reports and subsequent links included;

1. Healthcare Inspectorate Wales Tier 1 Quality Check (Planned), of Ward 11, Ysbyty Glan Clwyd on 26 August 2020

2. Healthcare Inspectorate Wales Tier 1 Quality Check (Planned), of Moelwyn Ward, Ysbyty Gwynedd on 28 August 2020

3. Healthcare Inspectorate Wales Tier 1 Quality Check (Planned), of Bonney Cohort Ward, Wrexham Maelor on 3 September 2020

4. HIW Inspection (Unannounced), Heddfan Psychiatric Unit, Wrexham Maelor Hospital on 7 to 9 July 2020

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 an update to the Committee in relation to any recently published HIW inspection reports. In addition, to provide an update on the progress of actions relating to the inspection(s).

Changes to HIW Process

As previously reported, due to the COVID19 pandemic, HIW have changed their approach to undertaking inspections in healthcare settings. HIW have been planning and refining their routine work programme on an ongoing basis and have been piloting their new way of working over a three month period from August to October 2020.

A key feature of their new approach will be the use of a three-tiered model of assurance and inspection that reduces the reliance on onsite inspection activity as the primary method of gaining assurance.

Tier 1 activity will be conducted entirely offsite and will be used for a number of purposes but, at this stage, primarily where issues cannot be resolved via HIW's standard concerns process and where the risk of conducting an onsite inspection remains high. Tier 2 will introduce a combination of offsite and limited onsite activity, whilst Tier 3 will represent a more traditional onsite inspection.

HIW Tier 1 Quality Checks / Inspections July to September 2020

There have been three recent quality checks undertaken by HIW conducted at Tier 1 level, and one unannounced HIW inspection. The Committee are asked to note the following HIW reports (hyperlinks available to the reports);

1. **HIW Tier 1 Quality Check (Planned),** Ward 11, Ysbyty Glan Clwyd
   Inspection date: 26 August 2020
   Publication date: 23 September 2020
   https://hiw.org.uk/sites/default/files/2020-09/YsbytyGlanClwyd-en.pdf

2. **HIW Tier 1 Quality Check (Planned),** Moelwyn Ward, Ysbyty Gwynedd
   Inspection date: 28 August 2020
   Publication date: 25 September 2020
   https://hiw.org.uk/sites/default/files/2020-09/20200925YsbytyGwynedden.pdf

3. **HIW Tier 1 Quality Check (Planned),** Bonney Cohort Ward, Wrexham Maelor
   Inspection date: 3 September 2020
   Publication date: 1 October 2020
   https://hiw.org.uk/sites/default/files/2020-10/20201001wrexhammaeloren.pdf

4. **HIW Inspection (Unannounced)**,Heddfan Psychiatric Unit, Wrexham Maelor Hospital
   Inspection date: 7 – 9 July 2020
   Publication date: 7 October 2020
   https://hiw.org.uk/sites/default/files/2020-10/20201007HeddfanPsychiatricUnitWrexhamMaelorHospitalEN.pdf

Following the three Tier 1 Quality Checks and inspection of Heddfan, Improvement Plans were received from HIW for the Health Board to complete as per usual process. All Improvement Plans have been completed with a SMART (Specific, Measurable, Achievable, Relevant and Timely) approach and submitted to HIW. These are located at the end of each report.

Subsequently, HIW have accepted all improvement plans as providing 'sufficient assurance'. This is because the improvements HIW identified have either been addressed and/or progress is being made by the Health Board, to ensure that patient safety is maintained.

It is important to note that HIW did not identify any improvements required as a result of the quality check undertaken for Bonney Ward, Wrexham Maelor

Infection Prevention Control Issues

The quality check of Ysbyty Glan Clwyd and Ysbyty Gwynedd both identified issues around Infection Prevention Control (IPC).

HIW made the following recommendations for Ysbyty Glan Clwyd:

1. **The Health Board must provide HIW with details of the action it will take to ensure that:** Effective actions have been taken in response to the IPC audit undertaken on Ward 11 on 21 July 2020
2. **The Health Board should continue to maintain existing and explore further support mechanisms for its staff as the pandemic progresses**.

HIW made the following recommendations for Ysbyty Gwynedd:

1. **The Health Board is to ensure that a documented action plan is put in place:** This is because there were consistently low scores throughout July on care bundles relating to the peripheral cannula care bundle being completed for 100% of patients with a cannula. There was not an action plan in place to address this issue.
2. **The Health Board must provide HIW with details of the action it will take to ensure that:** Appropriate governance mechanisms exist to ensure that IPC issues identified through audit activity are followed up in a timely and effective manner.
3. **The Health Board is to ensure these documents are reviewed, amended and re-issued as necessary:** This is because the Health Board documents called; "Isolation - Procedures for Patients With Infection"; and the "Outbreak Reporting and Control Procedure including Major Outbreaks" were both overdue for review, reviews due December 2019 and January 2019, respectively.

IPC Enquiry 30 September 2020

In addition to the above, an enquiry was received from HIW on 30 September 2020 following a recent Tier One Quality Check of Carreg Fawr Mental Health Unit. This is because, HIW were yet again, unable to gain assurance regarding IPC policies which were noted to be out of date and overdue review.

The Health Board are awaiting the HIW Improvement Plan for completion and in the meantime, have responded to HIW to assure them as follows;

1. The IPC policy content is fit for purpose and support the national guidance in relation to the COVID 19 pandemic. Policies had been previously reviewed clinically in conjunction with IPC and Public Health Wales but review dates had not been updated. The policies have been

reviewed and are pending approval at the Infection Prevention Sub Group on 13th October 2020.

2. There is a web page available for staff to visit which contains links to guidance including posters, Standing Operating Procedures, and FAQs. Regular communications such as weekly bulletins and BCUHB announcements, are cascaded in terms of IPC and PPE guidance, and advice.
3. All patients have access to PPE on arrival and as an inpatient. In addition, the Health Board have updated pamphlets for every patient on best IPC practice and Public Health Wales (PHW) communication.

This is also contained within the Health Board's communication plan for staff and patients.

Overview: Progress against actions

Below is an overview of the Corporate HIW Tracker in relation to the recent inspections.

It is important to note that moving forward, HIW inspections will be captured on Datix which will assist with more effective reports, updates and data outputs. A HIW module has been set up on Datix and is in the process of being tested.

In terms of progress against actions, the table below confirms the following;

- 87% actions relating to Heddfan are overdue. This is because many of the actions which the service set were due for completion/implementation by the end of September and have not been achieved. However, an update from the Mental Health & Learning Disabilities (MHLD) Head of Governance on 12 October 2020 indicates that many of the overdue actions are now complete. Once the appropriate evidence has been received from the service, this will be reviewed by the Quality Assurance Team. Work continues, as previously reported, to move towards a central database for HIW action tracking allowing real-time monitoring and evidence submission.
- Actions relating to Moelwyn Ward and Ward 11 remain in progress. The Quality Assurance Team are working with the relevant heads of service to ensure that updates are received for these actions by the end of October.

Status	**Mental Health & Learning Disabilities**	**Respiratory / Covid**	**Respiratory / Covid**	
	Heddfan Psychiatric Unit, Wrexham	**Moelwyn Ward Ysyty Gwynedd**	**Ward 11 Ysbyty Glan Clwyd**	**Grand Total**
In Progress	4	7	11	22
Overdue	26		1	27
Grand Total	**30**	**7**	**12**	**49**

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.

As previously reported to QSE, 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.

The Corporate Quality Assurance Team is responsible for coordinating and overseeing all HIW activity. This is done historically through a tracking spreadsheet with services also owning local trackers; as reported previously a central database is being developed and implemented to create a "Once for North Wales" approach, improve assurance from evidence availability and reduce delays and duplication.

Asesiad / Assesent & Anaysis

Strategy Implication

The provision of quality care in a safe environment is paramount to the Health Board's Quality Strategy (QIS) and Living Healthier Staying Well.

Financial Implications

None identified

Risk Analysis

Compliance with the Health and Care Standards is a requirement for all NHS Wales organisations.

Legal and Compliance

Compliance with the Health and Care Standards is a requirement for all NHS Wales organisations.

Impact Assessment

This report is purely administrative, there are no associated impacts or specific assessments required.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience (QSE) Committee 3rd November 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Clinical Audit Policy & Procedure v1.15
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Prof Arpan Guha Acting Executive Medical Director
Awdur yr Adroddiad **Report Author:**	Dr Melanie Maxwell Senior Associate Medical Director/Improvement Cymru Clinical Lead
Craffu blaenorol: **Prior Scrutiny:**	QSE Committee January 2020, approved in March 2020
Atodiadau **Appendices:**	Appendix 1 – policy Appendix 2 - EQIA

Argymhelliad / Recommendation:

The Committee is asked to approve the amendments as noted within the attached policy

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 attached policy highlights the following amendments:

A self-registration audit tool for registering Tier 3 has been developed which now states “To register your audit click on the link below: http://7a1a1srvinforep/Tier3ClinicalAuditProjectSubmission *(as noted on page 8)*

Due to changes within sub-Board structure – this has resulted in the Clinical Effectiveness and Audit Sub Group (CEASG) now being called the Clinical Effectiveness Group (CEG) *(as noted on page 2 and page 7)*

Cefndir / Background:

This e-form was designed to make registration more efficient and ensure our corporate audit team are able to focus on Tier 1 mandatory and Tier 2 local audits

Asesiad / Assessment

Strategy Implications
The policy describes the prioritization of audits encompassing the Welsh Government mandated audits (Tier 1), local priority audits based on BCUHB priorities and risks (Tier 2). It supports the delivery of best practice and high quality services – prudent healthcare.

Financial Implications
There is shortfall in the corporate Clinical Audit department - a business case will be developed
There needs to be adequate time within job plans to undertake audit and improvement work – this is inconsistent at present for all professional groups and has not yet been quantified.
There is a paucity of electronic support - data capture or action plan monitoring. Options will need to be explored and a business case made.

Risk Analysis
The policy will require an implementation plan to ensure ownership and leadership at all levels

Legal and Compliance
The expectation is to develop a quarterly monitoring report that builds to an annual report on activity providing evidence of a robust process and changes in practice to improve patients care. Implementation will deliver the mandatory requirements as set out by the Welsh Government annually

Impact Assessment
The Equality Impact Assessment has been amended following discussion with the Head of Equality and Human Rights and is attached.

Version & Reference Number MD 22 Version 0.1

Clinical Audit Policy & Procedure

Author & Title	Clinical Audit Policy. Trevor Smith (Head of Clinical Audit and Effectiveness). Dr Melanie Maxwell Senior Associate Medical Director
Responsible dept / director:	Office of the Medical Director. Dr David Fearnley Executive Medical Director
Approved by:	Quality, Safety and Patient Experience Committee
Date approved:	January 2020
Date activated (live):	March 2020
Documents to be read alongside this document:	BCUHB Quality Improvement Strategy (2017-2020).
Date of next review:	March 2021
Date EqIA completed:	Jan 2020

First operational:					
Previously reviewed:					
Changes made yes/no:					

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

Table of Contents

1. Introduction / Overview:

1.2 Clinical Audit:

Clinical audit is a multi-professional, multidisciplinary activity.

"Audit is not concerned primarily with fault or discrepancy finding, but with the examination of working practice to improve effectiveness". Dickens (1994)

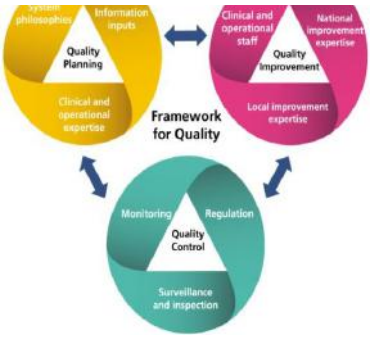
Figure 1 The Clinical Audit Cycle

"*Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.*"

New Principles of Best Practice in Clinical Audit (HQIP, January 2011).

Within the Health Board clinical audit is embedded within the future direction of improvement activity. Audit is a tool within the quality framework, identifying and prioritising improvement activities (Quality Planning) and providing assurance about service quality (Quality Control):

Figure 2: Quality Cycle: based on Juran and Godfrey (1999).



2. Policy Statement

This policy is applicable across all services participating in clinical audit within the Health Board. It sets out the expectations of the Health Board with respect to audit planning, multidisciplinary participation, and acting on the audit findings to maximize its effectiveness.

Clinical audit planning prioritises externally mandated requirements (as documented in the annual *National Clinical Audit and Outcome Review Plan* from Welsh Government), as well as local priorities in line with the Health Board's strategic objectives and risks.
Services should consider audits that provide information and/or assurance relating to key risks and strategies, such as the quality improvement strategy, and other service improvement activity relevant to the Health Board's priorities using the agreed tier structure (see section 8.1).

3. Aims / Purpose

This policy aims to support a culture of best practice in the management and delivery of clinical audit.
The purpose of this policy is to set out the rationale for clinical audit and provide a framework for such activity, including standards, guidance and procedures.

4. Objectives

This policy outlines processes in relation to clinical audit activity within BCUHB. It will reinforce its role within the quality framework in delivering quality improvement and quality control.

This includes:

- Topic selection based upon priorities (national and local).
- Local governance arrangements
- Clinical audit and effectiveness training
- Patient and carer involvement
- Roles and responsibilities
- Assurance about the effectiveness of services in relation to best practice

5. Scope

This policy relates to all BCUHB staff (including students and volunteers) and partner organisations participating in clinical audit activity within BCUHB; either by professional requirement, individual interest or relevance to a specific pathway / care group. This policy is also applicable when BCUHB is working in partnership with other health and social care partners. Where BCUHB commissions activity externally, quality assurance including participation in audit, is included within the contractual arrangements.

6. Roles and Responsibilities

6.1 Chief Executive Officer (CEO)

The Chief Executive Officer has overall responsibility in relation to the statutory duty for quality within the organisation and for participation in the mandatory requirements for clinical audit participation, as set out within the Welsh Government's *National Clinical Audit and Outcome Review Plan (NCAORP).*

6.2 Executive Medical Director

The Executive Medical Director is the Executive lead for clinical audit and effectiveness activity; ensuring that the BCUHB audit plan aligns with mandatory requirements, organisational priorities and is supported across all clinical services including primary, community and secondary care. The Clinical Audit and Effectiveness Department is located within the Office of the Medical Director.

6.3 Professional Leadership Roles

This group includes other clinical executives, medical directors, nursing directors and other clinical leaders, including clinical audit leads where they exist. Staff in these roles will support the implementation of this policy for services that fall within their remit and sphere of influence.

6.4 Lead Auditors

Lead auditors are responsible for individual audits. They will ensure the clinical audit cycle is completed in line with their service's clinical audit annual plan. This will include data collection, discussion of the findings and development and delivery of the action plan to improve care. It is their responsibility to escalate any delays or concerns through the service's governance framework.

6.6 Other Staff

All staff have a duty to ensure they are providing effective care to deliver best outcomes for patients. Participation in relevant clinical audit to enable benchmarking against key standards, supporting the development of subsequent action plans and undertaking quality improvement activity is expected.

6.7 Clinical Audit and Effectiveness Department

The department's role is managing the audit process. This includes working with services to develop the annual clinical audit plan, maintaining a central repository of audit activity, monitoring the timely implementation of the plan and delivering assurance reports to relevant governance groups culminating in an annual clinical audit report.

The department will provide proportionate support to BCUHB staff for all stages of the clinical audit cycle; priority is given to the mandatory audits (national or local).

The department delivers ad hoc audit and effectiveness training (see section 11).

7.0 Groups / Committees
The following Groups / Committees have a role in ensuring that clinical audit activity within their remit is optimised in terms of improvement potential and assurance. This will include approval, reporting and monitoring as relevant to each group's terms of reference. (See Appendix 1 – governance structure)

7.1 Audit Committee
The Audit Committee is the approving committee for the annual plan (national and locally prioritised audits). It will seek assurance on the overall plan, its fitness for purpose and its delivery. The role of the Audit Committee includes seeking assurance on:

- Does the organisation have a plan - and is it fit for purpose?
- Is it completed on time?
- Does it cover all relevant issues?
- Is it making a difference and leading to demonstrable change?
- Is change supported by recognised improvement methodologies?
- Does the organisation support clinical audit effectively?

7.2 Quality, Safety and Experience Committee (QSE)
The Quality, Safety and Experience Committee requires more detailed assurance that clinical audit is supporting the delivery of effective health care. It requires assurance that clinical audit is used to identify areas for improvement and subsequent actions deliver better outcomes for patients.

QSE will receive the clinical audit annual plan and recommend its adoption to the Audit Committee. It will be the approving committee for the Clinical Audit Policy and Procedure.

7.3 Joint Audit & Quality Committee
This committee meets annually. It includes all members of the Quality, Safety and Experience Committee and Audit Committee. Its purpose is to jointly review the effectiveness of clinical audit and receive the annual audit report.

7.4 Quality and Safety Groups
At each level of service e.g. Corporate/Divisional/ Site there are quality and safety groups. These groups ensure there is an effective audit function, supporting quality planning and assurance. Risks identified through the clinical audit process and outcome will be considered, mitigated and/or escalated from sites and divisions to the corporate group as appropriate.

7.5 Clinical Effectiveness ~~and Audit sub~~ Group (CE~~As~~G)
CE~~As~~G provides a forum where clinical audit and service evaluation is discussed as a standard agenda item. In relation to clinical audit, CE~~As~~G receives exception reporting from a number of effectiveness-related groups including the Clinical Improvement and Audit Groups or equivalent Quality and Safety Groups. This group will receive quarterly progress reports and the annual report; escalating risks in line with the governance framework.

8.0 Registration of audits:

All clinical audit activity within the Health Board should be prioritised to ensure it aligns with strategic or operational priorities as outlined in the service or corporate annual clinical audit plan.

All local clinical audit projects conducted within the Health Board must be approved prior to registration, either by the relevant Quality & Safety Group or Clinical Lead, in advance of registration with the CA&E department.

There is a clearly defined application procedure for registration, which involves the following steps:

8.1 Registration Tiers within BCUHB

Tier 1: National "must do" audits. These clinical audits are mandated by Welsh Government or other regulatory bodies such as *Medicines & Healthcare products Regulatory Agency* (MHRA). Local available resources are prioritized to support these audits. Nationally mandated audits require the completion of the assurance proforma to be returned to Welsh Government within 4 weeks. This documents the actions being taken to address the audit report findings.
NB: All National Clinical Audit and Outcome Review Plan (NCAORP) projects must be incorporated within relevant Divisional/Directorate annual clinical audit plans.

Tier 2: Local priority audits: These 'local must do' audits support delivery of the Quality Improvement Strategy goals and priorities, including accreditation requirements specific to the service, NICE guidance compliance, safety audits, audit related to high risk activity and corporately agreed service improvement priorities. These audits will take priority over completing tier 3 audits.
NB: All Corporate projects agreed at BCUHB Quality & Safety Group as priorities must be incorporated within relevant Division/Directorate annual clinical audit plans.

Tier 3: Local audits. This activity relates to those audits that have been agreed by the Division/Directorate to be included within their local, annual forward plan for clinical audit activity (see section 8.3 below). These should be risk based. All Tier 3 projects must:

- be approved by their Divisional/Directorate or Primary Care Lead.
  NB: These should not be approved unless there is local capacity and completion will not detract from completing Tier 1& 2 audits, including the associated improvement work.
- be registered with the Clinical Audit & Effectiveness Department (registration form accessed through intranet site via link:
  http://howis.wales.nhs.uk/sitesplus/861/page/45363
- ~~provide a blank copy of the data collection pro-forma / spreadsheet.~~
- ~~have a registration form signed by the clinical lead or their clinical supervisor and the Divisional/Directorate Clinical Audit Lead or Primary Care Lead.~~

A self-registration audit tool for registering Tier 3 has been developed. . To register your audit click on the link below:

Commented [JS1]: Remove this paragraph

Commented [JS2]: Add in this

http://7a1a1srvinforep/Tier3ClinicalAuditProjectSubmission

Commented [JS3]: Add in new self-registration link

NB: It is recognised that tier 3 audits may be undertaken as part of education and/or training, to learn the methodology. However, they should still be subject to completion of the audit cycle.

Quality improvement projects may use audit as a tool for measurement; however, they fall outside the scope of this policy. Quality improvement projects should be registered on the quality improvement hub (https://www.bcuqi.cymru)

8.2 Clinical Audit and Effectiveness Department Registration Database

All approved projects are allocated a unique ID number. A database is held within the Clinical Audit and Effectiveness Department, storing all Health Board registered clinical audits/ service evaluations. This facilitates audit activity reporting, identifies potential re-audits and provides evidence to support reviews and Health Board-wide comparison of findings. It enables quality planning and identification of quality improvement projects to support reliable care.

8.3 Annual Divisional / Directorate Clinical Audit Plan

An annual clinical audit plan will be agreed within each Division/Directorate including Primary Care and Community Services by the end of January. Early allocation of suitable lead auditors and the resources including clinicians' time required to complete the audit will optimise completion of the plan.

A systematic approach which enables the multidisciplinary team to prioritise and agree upon topics for inclusion is recommended with domains including:

- ***Frequency*** ('how often' or 'how many'?)
- ***Degree of risk*** (likelihood of something going wrong or not being done).
- ***Level of concern*** (how important is the question?)
- ***Outcome*** (what is the impact in relation to potential for improvement/harm?)

(Welsh Assembly Government, 2003)

8.4 Corporate Clinical Audit Annual Plan

The corporate clinical audit annual plan will be agreed by the end of February each year.
This will include all identified tier 1 and tier 2 audits.
Tier 1 audits will capture in-year data collection and/ or review of report and action planning.
Some audit reports will be an analysis of historic data, usually from the previous year.
Tier 2 audits will be based on audits identified by the Clinical Executive Leads as well as Divisional Management teams in line with section 8.1 above.

8.5 Clinical Audit and Effectiveness Department Support

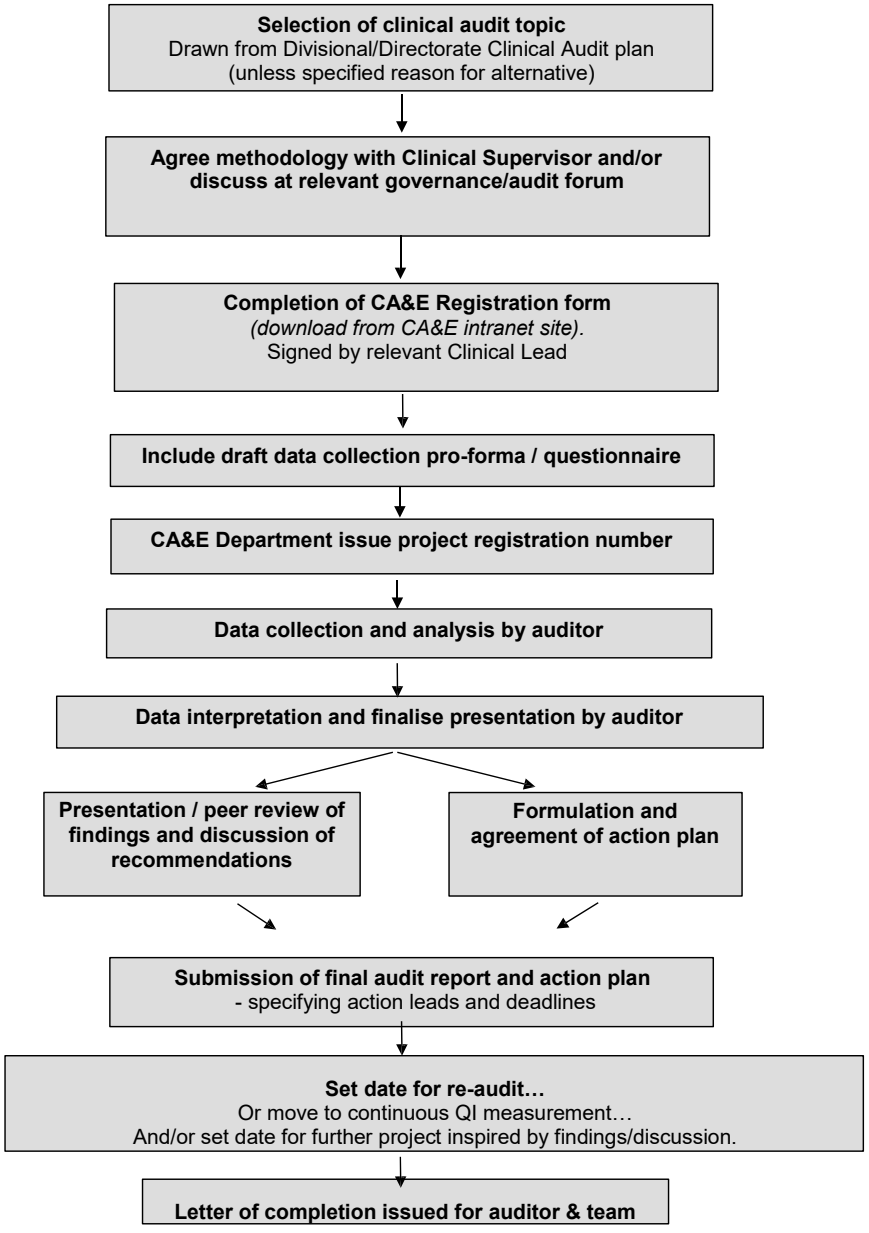
The Clinical Audit and Effectiveness Department is resourced to support Tier 1 and Tier 2 activity. Tier 1 activity will be prioritised.
Clinical Audit and Effectiveness (CA&E) staff will meet with lead auditor(s) to assess the level of support they require and to:

- Identify potential for patient participation/involvement.
- Identify potential for multidisciplinary participation/involvement.
- Agree the proposed methodology.
- Assist/advise with identification of evidence-base/critical appraisal.
- Assist with construction of clear and measurable audit standards.
- Agree data collection pro-forma/questionnaire format.
- Confirm local management support.
- Confirm the appropriate Divisional/Directorate clinical lead is aware of the project.
- Agree project timescales (including planned presentation date).
- Ensure Welsh Government assurance proformas are completed in a timely manner.

8.6 Assurance Reporting

The Clinical Audit and Effectiveness department will produce quarterly annual plan monitoring reports for the Clinical Effectiveness and Audit SubGroup. These reports will be cumulative, building to an annual report that will be received by the Joint Audit & Quality Committee in November each year. The report will document progress against the plan and highlight key service improvements related to clinical audit activity.

9. Procedure - Figure 1: Algorithm displaying clinical audit registration and progression



10. Developing a Clinical Audit Project

The process for clinical audit project development, registration and progression are displayed in algorithm format above.

10.1 Selection of topic

The Divisional / Directorate Annual Clinical Audit plan identifies the topics for Supervisors advising their trainees, juniors and other colleagues. Staff contacting Clinical Audit and Effectiveness department for advice will also be directed to these plans and the relevant Clinical Lead for their clinical area.

10.2 Multidisciplinary audit

Clinical Leads and lead auditors will assess all audits in relation to their potential for multidisciplinary and multi-professional involvement. Consultation with all relevant staff groups will occur. Where applicable, the lead auditor will be advised to invite participation from colleagues representing other professionals appropriate to the topic and also consider Managed Clinical Services colleagues such as Radiology and Pathology.

Multidisciplinary audit refers to a clinical audit team composed of representatives from at least two different disciplines (ideally those associated with the episode of care being audited).

10.3 Patient and Public Involvement

In planning each audit the potential for service user, carer and/or public involvement should be assessed and promoted. This may involve communication with appropriate forums relevant to the topic and/or the service to achieve this. This would range from gaining feedback regarding the proposed audit pro-forma/questionnaire to direct involvement where possible with other stages of the audit, guided by the relevant Information Governance considerations.

10.4 Presentation / dissemination / feedback

All lead auditors will feedback their findings to the relevant service forum, where peer review will confirm that the findings are clinically robust. In addition, findings will be shared as widely amongst the Health Board as appropriate to the topic.
Auditors will agree, in discussion with their Clinical Lead, the appropriate venue for PowerPoint style presentation (see Appendix 2 - template) and efficacy of utilising other media options (poster, circulation of brief written report, intranet, etc.).

10.5 Action planning

Where recommendations are made as a result of the audit, an action plan must be developed following consultation with the relevant staff (ideally at a service forum). Peer review will ensure that findings are disseminated and ascertain whether the recommendations are robust. The action plan must be specific, objective, set within measurable timescales and accountable in relation to who is responsible for each action. (See appendix 3 - action plan template). Tier 1 audits require the completion of the assurance proforma (Part A&B) within 4 weeks of the report release; this documents the actions being taken in response to the audit findings nationally and locally.

10.6 Submission of Clinical Audit Report
On completion of the audit, the lead auditor is required to provide the Clinical Audit and Effectiveness department with a copy of the final report and action plan (see Appendix 4 – report template).

10.7 Re-audit
Re-audit is not always necessary. For example, if no improvement needs have been identified or there is an alternative methodology to ensure improvement. In the latter case, it is important that all recommendations are tracked and monitored through the appropriate committee. Where assurance is required through audit, this needs to be included within a future clinical audit annual plan.

10.8 Letter of Completion for Project Lead
On receipt of the final report, the lead auditor/team (who demonstrate direct contribution) will be issued with a letter confirming their participation by the Clinical Audit and Effectiveness department. This letter will include additional bullet points as evidence is provided, such as:

- Presentation/dissemination/Peer Review of findings.
- Agreement of recommendations/action plan.
- Implementation of intervention.
- Re-audit (or clearly scheduled date and allocation of new lead).
- Clear link to another related project topic (audit, service evaluation, research).

10.9 Assurance
The Clinical Audit and Effectiveness department will be responsible for:

- Collating the annual corporate clinical audit plan each new financial year,
- Providing the Quality, Safety and Experience Committee with cumulative quarterly reports leading to an annual report that monitors progress against the plan.
- Providing JAQS with an annual report against plan.

11. Equality, including Welsh Language

Betsi Cadwaladr University Health Board is committed to advancing equality and protecting and promoting the rights of everybody to achieve better outcomes for all. The legislative framework requires us to promote equality in everything that we do.

Clinical audit activity should be undertaken with regard to equality and inclusion and opportunities to advance equality optimised. The process for determining choice of clinical audit projects, and identifying service user samples, must be inclusive and representative of the total population and where relevant consider protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity.

An Equality Impact Assessment (EqIA) for this polcy has been completed.

12. Training

All staff participating in clinical audit activity should have a good understanding of this methodology.
There is an 'e' learning '*Introduction to Clinical Audit'* training session which is accessible through the BCUHB intranet site:
http://howis.wales.nhs.uk/sitesplus/861/page/59825

In addition, the Clinical Audit & Effectiveness department will respond to requests to provide face to face sessions for teams where this can be delivered within capacity.

13. Review

The Clinical Audit Policy, as a new policy will be reviewed in one year's time and then on a three year cycle.

14. References

DICKENS, P. (1994). In: Welsh Assembly Government. (2003). *An introduction to clinical audit.* Wales

Healthcare Quality Improvement Partnership (HQIP). (2011). *New Principles of Best Practice in Clinical Audit.*

JURAN, J.M., GODFREY, A.B. (eds). (1999). *Juran's Quality Handbook.* 5th Edition. New York: McGraw Hill.

Welsh Assembly Government. (2003). *An Introduction to Clinical Audit*. Wales.

Appendix 1: Governance

NB: Quality governance structures are currently under review and this will be amended once agreed.

Appendix 2: Template for PowerPoint presentation slides.

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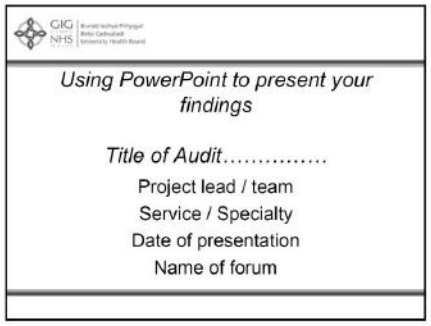
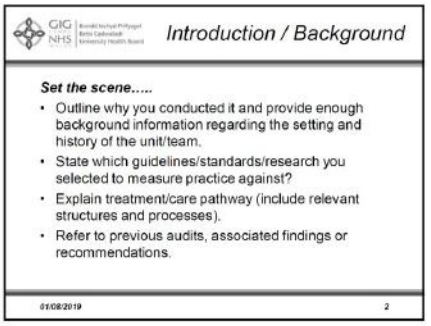
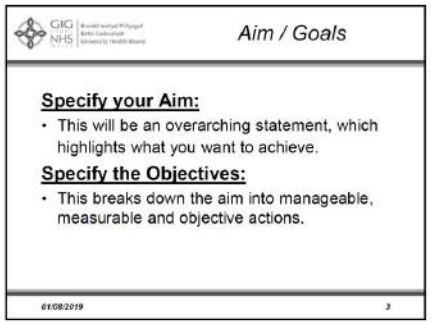
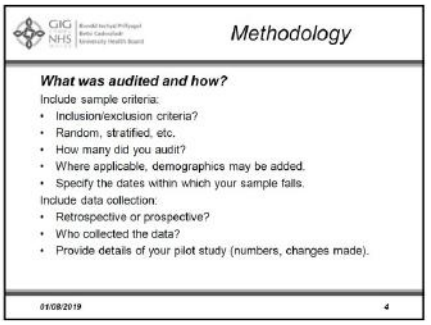
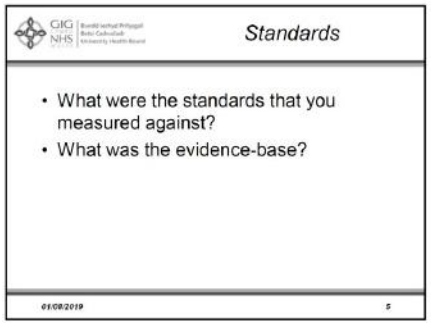
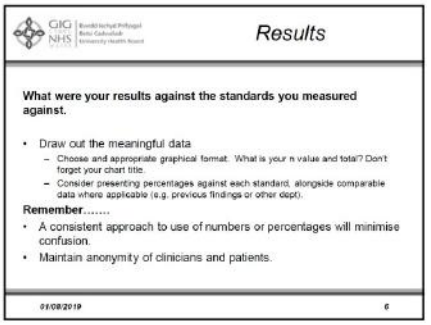


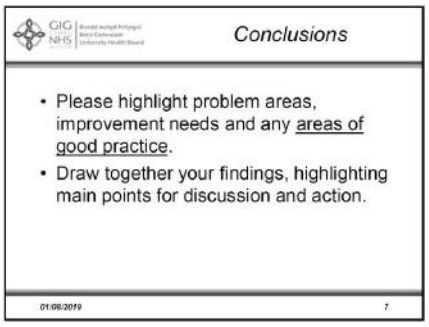


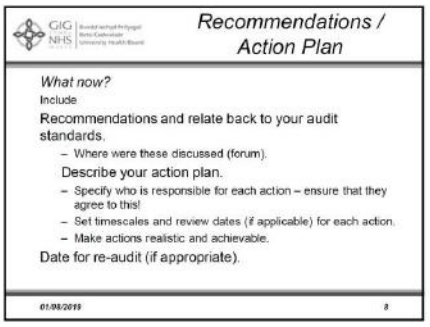


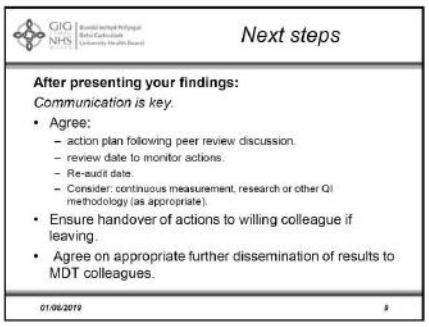







Conclusions
• Please highlight problem areas, improvement needs and any areas of good practice.
• Draw together your findings, highlighting main points for discussion and action.
01/08/2019
7


Recommendations / Action Plan
What now?
Include
Recommendations and relate back to your audit standards.
– Where were these discussed (forum).
Describe your action plan.
– Specify who is responsible for each action – ensure that they agree to this!
– Set timescales and review dates (if applicable) for each action.
– Make actions realistic and achievable.
Date for re-audit (if appropriate).
01/08/2019
8


Next steps
After presenting your findings:
Communication is key.
• Agree:
– action plan following peer review discussion.
– review date to monitor actions.
– Re-audit date.
– Consider: continuous measurement, research or other QI methodology (as appropriate).
• Ensure handover of actions to willing colleague if leaving.
• Agree on appropriate further dissemination of results to MDT colleagues.
01/08/2019
9

Appendix 3: Action planning template

Title			
Lead Auditor		**Author:**	
Contributors			
Approving Committee		**Date:**	
Is this on the risk register		**If yes, Score:**	

Action Plan:
(Please complete the action plan to specify how improvements will be made - i.e. what will be done, when and by whom?)

Issue Identified	**Improvement Action**	**By Who**	**By When**
Re-audit:	Date:	By Whom:	

Appendix 4: Template for final Clinical Audit report

Use attached guidance sheet: "Using Template Format for Clinical Audit Report".

Auditor (person conducting audit):	**Audit No:**	**Date:**
Audit Team members:	**Speciality / Service:**	

Full title of clinical audit project:
Include enough information to make the topic and location clear.

Introduction / background:
Set the scene for your audit. Outline why you conducted it and provide the reader with enough background information to understand the setting and history of the unit/team.

- What are the reasons for selecting this topic?
- Which guidelines/standards did you select to measure practice against?
- Refer to and summarise any relevant research or other forms of evidence.
- Outline topic-specific information and explain abbreviations or specialised terminology.
- Explain treatment/care pathway (including relevant structures and processes).
- Refer to previous audits and associated findings or recommendations.

Specify Aim:
This will be an overarching statement, which highlights what you want to achieve.
Specify Objectives:
This breaks down the aim into manageable, measurable and objective actions.

Standards:
What were the standards that you measured against – what was the evidence-base?

Methodology:
Explain the audit methodology you used, including sample criteria, time period and data sources used (i.e. what was audited and how?)

This section is important as it needs to make explicit the *'who, how, when and where'* elements of your project procedure. As in a scientific report, it is important that anyone wanting to replicate your project can do so by following your methodology.

The sample:

- Were there any inclusion/exclusion criteria?
- How was your sample selected? - random, stratified, etc.
- How did you identify participants? - Information Dept, admission book, etc.
- How many did you audit?
- If cases were missing - specify why (e.g. notes missing).
- Where applicable, demographics may be added (either here or in your results section)
- Specify the dates within which your sample falls.

The data collection:

- Was your data collection retrospective or prospective?
- Who collected the data?
- When were pro-forma/questionnaires completed/returned?

The pilot:

- Provide details of your pilot study (numbers, changes made).

Did you include your pilot data in your final analysis? If not, outline reason (e.g. data items changed significantly following pilot).

Results:
Provide the results of audit against the standards that you were measuring against and also any supporting or additional information. *Table format provided below*.

- Present only results that relate to the audit criteria.
- Don't be tempted to flood the reader with unnecessary data. The clarity of the point you are trying to communicate may be lost.
- Follow a logical order and grouping of results (such as the care pathway).
- Draw out the meaningful data and present in an accessible and graphical format (where applicable).
- Ensure all charts and tables are titled and state the 'n value' (total number 'out of').
- State how the data was stored and analysed (such as Excel or SPSS).
- It may be useful to use a table to present percentages against each standard, alongside comparable data where applicable (e.g. previous findings or other dept).
- A consistent approach to use of numbers or percentages will minimise confusion.
- Maintain anonymity of clinicians and patients.
- Use objective statements and avoid subjectivity.

No.	Standard	% Achieved	% Not Achieved
1.			
2.			
3.etc.			

Conclusions:
Please highlight problem areas, improvement needs and any areas of good practice.
Draw together your findings, highlighting main points for discussion and action.

Recommendations:
Clearly state your recommendations and relate back to your audit standards.

Action Plan:
Please complete the action plan to specify how improvements will be made - i.e. what will be done, when and by whom?
Complete the action plan to specify how improvements will be made (i.e. what will be done, when and by whom).
Following discussion of the recommendations at the appropriate forum, construct an action plan.

- Specify who is responsible for each action – ensure that they agree to this!
- Set timescales and review dates (if applicable) for each action.
- Make actions realistic and achievable.
- Set a date for re-audit (if appropriate).

Problem identified	Action	By Whom	By When
Re-audit:	Date:	By Whom:	

How has / will the clinical audit improve patient care? Please summarise the way in which your findings and implementation of recommendations will improve care.
References:
All full list of references should be provided using a recognised referencing system (such as Harvard).
Appendices:
Always include the clinical audit pro-forma within your appendices.
Ensure that a copy of the report is sent to the Clinical Audit and Effectiveness Department and the Specialty / Service clinical audit lead.

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

EQUALITY IMPACT ASSESSMENT FORMS
PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:
These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:
You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

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

Part A

Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Clinical Audit Policy and Procedure
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The aim of this document is to develop and sustain a culture of best practice in clinical audit. The objective is to outline the roles and responsibilities in relation to clinical audit activity, including the Trust's procedures and expectations for registering and approving clinical audit project proposals.
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Executive Medical Director is the nominated Executive Lead The Quality, Safety and Patient Experience Committee approves changes to the policy & procedure document
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	BCUHB Quality Improvement Strategy (2017).
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	Key stakeholders are: All clinical staff expected to contribute to clinical audit as a means of reviewing and improving patient care and their own practice and to any non-clinical staff involved in the audit process including volunteers and students. Patients' involvement is promoted (see section 9.3). For the Tier 1 (nationally mandated) audits patients and/or carer views are sought.
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	There needs to be: • Good communication and dissemination regarding the policy. This will be through: ➢ BCUHB Intranet. ➢ Relevant BCUHB groups and forums. ➢ Cascade through Clinical Audit / Governance / Quality leads. ➢ BCUHB Communication Department circulations. • Resources to support engagement in participation including time to complete clinical

		audits. • Clear understanding of processes related to the policy • Skills training for clinical audit and quality improvement availability – online audit training is available. Quality Improvement training is available to book through the online BCU QI Hub.

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:- Positive (+) Negative (-) Neutral (**N**) No Impact/Not applicable (**N/a**)	High Medium or Low	Please detail here, <u>for each characteristic listed on the left</u>:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact.
Age	**N**		This policy and procedure applies to all individuals regardless of their characteristics. Actions are based on the outcomes in relation to the measured standards.
Disability	**N**		*As above.*
Gender Reassignment	**N**		*As above.*
Marriage & Civil Partnership	**N**		*As above.*
Pregnancy & Maternity	**N**		*As above.*
Race / Ethnicity	**N**		*As above.*
Religion or Belief	**N**		*As above.*
Sex	**N**		*As above.*
Sexual Orientation	**N**		*As above.*
Welsh Language	**N**		*As above.*
Human Rights	**N**		*As above.*

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use your judgement to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the "General Duty". This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:- • Eliminate unlawful discrimination, harassment and victimisation; • Advance equality of opportunity; and • Foster good relations between different groups	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	The premise of clinical audit is to establish the extent to which evidence-based standards are evidenced in practice in a manner that reduces variance and optimises standardisation of excellent care and treatment for all. Clinical Audit & Effectiveness (CA&E) Department support is provided equally to all BCUHB staff and with respect for diversity. All CA&E Department team members have completed the Equality & Human Rights online training. This is a mandatory training requirement for staff within BCUHB.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	The premise of clinical audit is to establish the extent to which evidence-based standards are evidenced in practice in a manner that reduces variance and optimises standardisation of excellent care and treatment for all. There is opportunity to explore characteristics within audits (where that information is collected) to advance equality of opportunity. Clinical audit can be used to explore equality of opportunity, delivering improvement based on the results obtained.
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	The policy would: • Promote good practice as outlined above and encourages adherence to National guidance and standards.

	• Promote standardisation and equality of access to good practice. • Encourage patient and public involvement in clinical audit activity.

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed? (Copy from Form 1)	Clinical Audit Policy and Procedure

2. Brief Aims and Objectives: (Copy from Form 1)	The aim of this document is to develop and sustain a culture of best practice in clinical audit. The objective is to outline the roles and responsibilities in relation to clinical audit activity, including the Trust's procedures and expectations for registering and approving clinical audit project proposals.

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes	No √
3b. Could any of the protected groups be negatively affected?	Yes	No √
3c. Is your decision or policy of high significance?	Yes √	No

4. Did the decision scoring on Form 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No √
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic? The assessment above and within Part A demonstrate the positive impact that this policy will have upon the promotion and quantification of good practice. This will optimise equality of access to standardised care and treatment that is evidence-based and reduce unnecessary variation.	
5. If you answered 'no'	Yes	No √

above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Record Details:	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes √	No
	How is it being monitored?	Review date will be set. There will be quarterly reports monitoring progress against the annual audit plan (see section 8.6). An annual audit report will be produced.
	Who is responsible?	Head of Clinical Audit and Effectiveness, Office of the Medical Director.
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information? This will be based on nationally produced and benchmarked reports, locally produced reports and action plans and local monitoring within the Clinical Audit and Effectiveness Department.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	This will be reviewed alongside the scheduled review of the policy.

7. Where will your decision or policy be forwarded for approval?	BCUHB Quality, Safety and Patient Experience Committee

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	A bespoke workshop was held for clinical audit leads and audit staff across BCU. The resultant draft policy was then circulated to the Divisional Quality and Safety meetings for further input. Draft documentation was shared with the corporate Quality and Safety Group, Audit Committee and Joint Audit and Quality SubCommittee.

9. Names of all parties involved in undertaking	Name	Title/Role

this Equality Impact Assessment:	Trevor Smith	Head of Clinical Audit & Effectiveness
	Dr Melanie Maxwell	Senior Associate Medical Director
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan
This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	No potential negative impact identified	N/A	N/A
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?	None	N/A	N/A
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	No potential negative impact identified	N/A	N/A
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.	No potential negative impact identified	N/A	N/A
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Consider how to promote patient and carer engagement in clinical audit	Head of Clinical Audit & Effectiveness	Next review

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 3rd November 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Nurse Staffing Levels (Wales): Adult Acute Medical And Surgical Inpatient wards
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mrs Debra Hickman, Acting Executive Director of Nursing & Midwifery
Awdur yr Adroddiad **Report Author:**	Mrs Mandy Jones, Interim Secondary Care Director of Nursing
Craffu blaenorol: **Prior Scrutiny:**	None
Atodiadau **Appendices:**	Appendix 1 - Updated guidance regarding 25B status Appendix 2 - Letter from Professor Jean White, CNO Appendix 3 - Joint letter from Professor Jean White, CNO and Professional Bodies Appendix 4 - Acuity Data Appendix 5 - All Wales report template Appendix 5.1 – Summary of Nurse Staffing Levels for wards

Argymhelliad / Recommendation:

The Committee is asked to note the compliance with the prescribed requirements of the Nurse Staffing Levels (Wales) Act 2016 bi annual calculations for medical and surgical wards which meet 25B requirements and support the report.

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

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

Sefyllfa / Situation:

Formal presentation of the statutory requirement for a biannual calculation of the Nurse staffing levels as directed by the Nurse Staffing Levels (Wales) Act 2016 for 25B Acute Adult Medical and Surgical inpatient wards in line with the All Wales Nurse Staffing Act Group agreed reporting framework.

Cefndir / Background:

In September 2016 the Nurse Staffing Levels (Wales) Act became law, requiring organisations across NHS Wales to calculate and monitor the number of nurses required to care sensitively for patients on a phased implementation, taking full effect from April 2018 for Acute Adult Medical and Surgical wards.

The Act consists of 5 sections, 25A to E as specified below:

- 25A refers to the Health Board's overarching responsibility to have regard to providing sufficient nurses in all settings, allowing the nurses time to care for patients sensitively;
- 25B requires the Health Board's to calculate and take reasonable steps to maintain the nurse staffing level in all adult acute medical and surgical wards. The Health Board's are also required to inform patients of the nurse staffing level on those wards;
- 25C requires the Health Board to use a specific method to calculate the nurse staffing level in all adult acute medical and surgical wards;
- 25D relates to the statutory guidance released by the Welsh Government;
- 25E requires the Health Board to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward of which the Health Board is responsible for monitoring.

In the expectation that ward purpose would change at a rapid pace and become novel Covid wards the Chief Nursing Officer (CNO), Professor Jean White, provided clarity regarding compliance with section 25A and 25B of the Act, see appendix 1.

Section 25A of the Act requires Health Boards and Trusts to ensure they have robust workforce plans, recruitment strategies, structures and processes in place to ensure appropriate nurse staffing levels across their organisations. Section 25B of the Act lays down specific and very detailed requirements in relation to the calculation and maintenance of the nurse staffing levels. In determining which of the currently designated adult medical and surgical wards meet Section 25B of the Act and progress to a bi-annual triangulation as prescribed; consideration was given to the guidance from the CNO that lack of quality indicator information for the repurposed wards would make it impossible to undertake the triangulated calculation.

There was also a question whether the Welsh Levels of Care evidence based workforce planning tool could be applied in those wards given that they would be significantly different environments to the business as usual medical and surgical wards where the tool has been tested for two years.

To support the triangulation of repurposed wards which met the 25B requirements the best available information was used to undertake the triangulated calculations. In addition to the prescribed guidance further confirm and challenge meetings were held with peers to provide consistency and assurance regarding identified nurse staffing and compliance with the requirements.

In April 20202 24 medical wards and 13 surgical wards met the 25B requirements. Due to re purposing of wards to meet COVID 19 demands 24 medical and 12 surgical wards met the 25B requirements for the bi annual calculation and are included in the report.

BCUHB is aware of its duty to meet the requirements for section 25B and has actively been taking steps to maintain nurse staffing levels. Triangulation is applied to all acute medical and surgical wards. Reporting has been established from the outset of the Act for Secondary Care sites through a designated system (SafeCare). With monthly compliance reported to the Secondary Care Nurse Director. Quarterly reports are provided to the Executive Director of Nursing and Midwifery and in line with Nurse Staffing Act statutory guidance, an annual assurance report is presented to the BCUHB Board. Additionally a three yearly assurance report on compliance with nurse staffing levels (Wales Act) is due to Welsh Government in April 2021. See appendix 2 (letter from CNO – October 2020).

Our adult inpatient wards are also familiar with the Act requirements and are working towards compliance as the principles of the Act are clearly set out to maintain staffing levels. The proposed

extension of the Act to paediatric wards will be from an informed position as all our inpatient wards are familiar with the 25B Act requirements, the duty to inform patients of the nurse staffing levels and have been working towards compliance. Therefore, the proposed extension of 25B is a positive step forward which BCUHB actively encouraged during consultation feedback. The BUCHB Ward accreditation programme also introduced standards for monitoring the important activity of informing our patients of nurse staffing levels.

Nurse Staffing Levels

To deliver safe quality patient care it is essential wards have optimal nurse staffing levels. It has been acknowledged that one of the contributory factors linking failures in care and patient safety were inadequate staffing levels (Francis 2013). Appropriate staffing plays an important part in the delivery of safe and effective health and care. Safe staffing can be a complex area and has to take account of multiple factors. It must be considerate of patients' needs and is about skill-mix as well as numbers - Nursing Midwifery Council (NMC) (2016). The CNO guidance reinforces the complexities and multitude of factors associated with calculating Nurse Staffing levels, (Appendix 1).

The Nurse Safe Staffing Act (Wales) 2016, requires the Nurse staffing calculation to be undertaken bi-annually with documented evidence of a robust methodology. It also requires the Health Board to have due regard to providing sufficient nurses to allow time to sensitively care for patients and meet their health needs, ensuring that all reasonable steps have been taken to maintain safe planned nurse staffing levels and mitigate shortfalls.

BCUHB is fully compliant with 25B financial calculation requirements. All of the acute adult medical and surgical inpatient wards have a 26.9% uplift for Band 5 Registered Nurses and above, Health Care Support Workers (HCSW) have an uplift of 22% and Band 7 Ward Sisters are supernumerary and not included in the care delivery numbers for their respective ward areas. The electronic rostering system used within the Health Board captures when the Ward Manager was not assigned the supernumerary shift due to supporting clinical care delivery numbers.

Staffing Mitigation COVID-19

BCUHB is very aware of the natural shortage of registered nurses which has contributed to the high nursing and midwifery vacancy rates currently experienced by Welsh Health Board and English Trusts across the UK. In this challenging environment the BCUHB Workforce and Organisational Development department is working closely with senior nursing and midwifery colleagues to maximise recruitment and retention of nursing and midwifery staff. In support of this work a BCUHB wide nurse recruitment and retention group meets monthly and oversees a comprehensive work plan. Highlight of ongoing activities are as follows:

- Rolling ward / role specific adverts
- Recruitment diary planned throughout the year
- International recruitment with 40 Nurses in the pipeline, and planning further interviews to source 50 more
- Streamlining programme to appoint Student Nurses as seamlessly as possible
- Rolling adverts for bank registered Nurses and Health Care Support Workers to support substantive workforce with additional flexibility
- Recruitment clinics to support managers to progress vacancies
- Promotion of vacancies through social media.

BCUHB has been successful in sustaining numbers of registered nursing and midwifery staff. A proportion of the significant vacancies are due to investment in an additional 121 FTE posts which we are working hard to fill.

One of the most significant challenges of the Covid 19 pandemic was/is making sure there are enough nurses to deliver care sensitively. The joint statement issued by the CNO / Professional bodies outlined the expectations of meeting the Nurse Staffing Act (Wales) 2016 requirements within the reality of an abnormal emerging situation using clinical judgment, applying core principles to assess risk and maintain professional standards. (See appendix 3.)

Anticipating the nature of the COVID 19 outbreak a dynamic staff recruitment, up-skilling and deployment response was required. To support the existing recruitment campaign BCUHB worked with Bangor and Glyndwr University to encourage people who have been previously registered with the NMC to return to nursing.

Recognising that student placements would not have the required level of supervision the Nursing and Midwifery Council (NMC) and Health Education Improvement Wales (HEIW) agreed that student nurses in their 2nd and 3rd year of studies could opt in to return to clinical placements to support within non-supervisory band 3 and band 4 student Health Care Assistant roles for a three month period. BCUHB was supported by 213 band 3s and 180 band 4s.

It was aimed at mitigating the current registrant gap by providing a greater level of consistency, stability and wider skill mix than the traditional Health Care Support Worker role currently in the Health Board. It should be noted that this adjusts the overall available hours per patient and skill mix which is reflected positively throughout Health Boards in Wales when comparing the June 2019 to the July 2020 acuity data (appendix 4). However, availability of extra Health Care Assistants to mitigate registrant vacancies and gaps although favourable as short term mitigation is a false economy and not within BCUHB workforce strategy.

Internally BCUHB provided a range of upskilling opportunities for nursing teams, non-clinical staff, allied health professionals and public volunteers which further facilitated the Health Board's response to the first wave of unprecedented COVID 19 pandemic.

All decisions regarding deployment were made on a risk assessed basis.

Asesiad / Assessment & Analysis

Methodology

This report covers the period November 2019 to October 2020. Alongside the prescribed triangulation the following three-stage approach has been used as the underpinning methodology for the calculations:

1. **Acuity**
   Dependency & occupancy data is routinely collected three times a day and recorded in the Health Board's designated system. The information assists to support a dynamic assessment of staffing at coordinated intervals throughout each day and to inform the management of staffing levels. A record of mitigations taken is recorded to provide supporting evidence of staffing management. The dependency data is submitted to the All Wales Nurse Staffing group on a bi annual basis for analysis and national benchmarking. Our recent submissions took place in January and July 2020 of which analysis was used to inform the current revised calculations. It

should be noted that comparative could not be directly made due to the repurposing of wards during COVID 19 first wave.

2. **Quality and Professional Judgement (site level)**
   Nurse staffing review meetings with the Ward Sisters, Matron, Heads of Nursing, Site Directors of Nursing and Finance officers undertook a confirm and challenge approach reviewing the above evidence alongside:

   - capacity
   - current establishments - funded and actual
   - incidents
   - complaints / feedback
   - additional service demands
   - skills mix
   - COVID 19 first wave learning

3. **Quality and Professional Judgement (BCU Acute Site comparison)**
   The above information has been reviewed collectively with the Site Directors of Nursing, Interim Secondary Care Director of Nursing alongside external Peer support. The interim Executive Director of Nursing & Midwifery has verified the rationale for changes within establishments leading to final approval. Thus formulating a professional judgment of the staffing requirements for designated medical and surgical adult inpatient area who meet the 25B requirements.

Outcomes:
The reported acuity data, infection prevention requirements and increased enhanced observation needs of frail, elderly patients who may not be able to progress their care due to COVID 19 isolation guidance for care homes is reflected in the increased Welsh Levels of Care 3 and 4 reported and identified nurse staffing to meet their care needs sensitively. The significant number of vacancies across all three of the acute sites, the workforce implications of COVID 19 guidance and the challenges associated with this are reflected in the identified requirements. The workforce optimisation plans to support ongoing recruitment and retention initiatives, provide a level of stability and look to further strengthen clinical leadership, particularly in the more difficult to recruit to wards where there has been a conversion of a Band 5 to a Band 6 posts. A recruitment and retention initiative ‘grow your own’ HCSW development pathways to achieve National Vocational Qualification (NVQ) level 4 qualification and/or pursue further opportunity to become a registrant has been a proven success.

The focus on creating band 4 opportunities across the Health Board has provided the continued development opportunities for HCSWs and additional support to our existing registrant workforce.

Highlights from each of the site outcomes are given below.

<u>Ysbyty Wrexham Maelor (YWM)</u>

Glyndwr and AMU SSW ward have identified the requirements of additional HCSWs.

This is predominately to support diagnostic impact, staff rest periods to meet health and safety and wellbeing of continuously wearing Personal Protective Equipment (PPE), acuity/dependency of the patients and the patient turnover demands.

An additional registrant has been identified by the Acute Medical Unit on early and a late shift to support the acuity profile and provide comparative staffing to the respective sites.

A reduction in a registrant for early and late shift is identified for the Ear Nose & Throat (ENT) ward due to reduced capacity to meet the Covid 19 bed spacing guidance.

Ysbyty Glan Clywd (YGC)

YGC has identified the need to increase registrants for night duty for Ward 11, Ward 4, Ward 12, Ward 1, Ward 9, Ward 8 and Ward 7. An additional registrant has been identified for SAU for early, late and night duty.

These are predicated on the physical segregation of patients receiving aerosol-generating procedures; burden of person protective equipment use, change and rest requirements of staff supports the identified increase. Reported patient acuity, professional judgement and turnover, which the peer review supported.

Additional HCSW requirements have been identified for night duty for Ward 11, Ward 4, Ward 12, Ward 1, Ward 8, Ward 5, Ward 9 and Ward 2. The reported acuity, workload burden of infection prevention control measures and PPE requirements during the COVID-19 pandemic has identified the need for additional HCSW on the night duty specifically. High acuity due to cognitively impaired patients and frequently have a monthly cost pressure attributed to enhanced observation requirements of the patients as recognised in the Health Care Acquired COVID 19 learning.

Additional HCSW has been identified for Ward 14 and Ward 3 (Vascular). Ward 14 is the designated stroke ward providing 8 acute stroke beds and rehabilitation. The acute nature of the stroke admissions and care needs of the rehabilitation identified an additional HCSW for the late and night duty.

Day of Surgery Arrivals (DOSA) has been re purposed providing inpatient beds for escalation. Based on professional judgement and peer review the triangulation identified a reduction in registrants for early and late. As a re purposed ward there was no comparative quality data therefore it is anticipated that when the ward has established and at the discretion of the ward manager a further re calculation will be undertaken to ensure staffing meets the patient needs. The review identified an increase in HCSW for early, late and night duty to support the anticipated acuity needs of the patient cohort.

Recognising the number of wards with vacancies and where harms have been identified (not related to staffing) the following wards; 4, 9, 11, 12 and 14 have focused on strengthening the leadership model and continue to progress the movement of band 5 to band 6. In total 9.8 whole time equivalent Band 4s have been identified and work is ongoing to progress recruitment and training to ensure optimisation of the current workforce.

Ysbyty Gwynedd (YG)

YG has identified the need to increase registrants for Moelwyn, Glaslyn, Aran, Ogwen and Tudno. This is in the main due to the impact of COVID 19 and the repurposing of wards to support the complexity and demand associated. The layout and geography of the wards was noted to deliver care safely when segregating patients to reduce transmission from Aerosol generating procedures. Alongside the burden of personal protective equipment use, change and rest and the high

proportion of cognitively impaired patients and maintaining safety due to the need to socially distance.

Additional HCSW worker requirements have been identified across the inpatient acute medical and surgical areas including Moelwyn, Glyder, Hebog, Tryfan, Aran, Dulas, Ogwen and Tudno.

In the main to support the acuity and dependency of patients, ward layout to support segregation, PPE requirements and Infection prevention control measures further supports the request which is predominantly attributed to COVID 19 acuity, dependency and work burden.

Conclusion:

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

To meet the demand of the 1st COVID wave medical and surgical wards were repurposed. There was uncertainty initially as to whether 25B requirements applied to repurposed wards. The decision whether a ward met the 25B requirements factored predominantly on the primary purpose of the ward.

This has and will remain a dynamic situation depending on demand of winter pressures/Covid 19 2nd Wave, patient needs and Infection Prevention control measures. In light of the changing 'primary purpose' of the wards and 25B requirements the Health Board has/will proactively recalculate the nurse staffing if the wards primary purpose or speciality changes using the prescribed guidance and capture evidence of the triangulation methodology and calculation within the nationally agreed template.

Certainly the additional burden that Covid 19, vacancy rates and variable skill mix placed on nursing needs cannot be under estimated. The competency, skill and experience of the nurses providing care to patients was/is a crucial component that influenced the nurse staffing identified requirements within the bi annual triangulation. The appointment of new graduates via the streamlining process was a success but the skill mix on many wards identified the need for additional registrants to provide supervision and practice development and/or HCSW due to the higher acuity of patient cohort. As the skill mix improves it is anticipated that the bi annual calculation will reflect this.

Recruitment and retention remains a key feature with programmes looking to create stability in the current nursing workforce. A priority is increasing registrants, focused on international recruitment and BCUHB Health Care Assistants graduate schemes. Short /intermediate term mitigation will be through temporary staffing of bank and agency staff and deployment of staff internally (clinical and non-clinical).

The acuity audit supported the professional judgement of the Ward Mangers, Matrons and Heads of Nursing regarding a marked increase in the nursing needs of patients risk assessed as requiring enhanced observations. The acuity audit findings reported an increase in the number of patients who met the Welsh Levels of Care 3 and 4. The increase may be due to late presentation of a chronic illness, breakdown of support at home for cognitively impaired individuals or due to clinical instability. It is anticipated that the patient needs at Welsh Levels of Care 3 and 4 will continue to increase throughout the winter pressures period and Covid 19 2nd wave.

The impact on nursing care on a ward physical condition and layout is also evident in the nurse staffing calculations where the layout and physical features of a clinical area and need for infection prevention segregation impacted on workload burden and the efficient use of the nursing hours available.

Patients cared for in single rooms, in multiple closed bays or separated areas within same ward influences which patients can be observed and kept safe. Additional separation of storage, sluice etc influences the non productive time as staff have to walk long distances repeatedly.

Despite the challenges of the first wave of the Covid 19 pandemic the compliance with the Nurse Staffing Act 2016 requirements were maintained by the recruitment / up skilling, temporary staffing and redeployment of staff to mitigate shortfalls.

References:

NMC (2016) Appropriate staffing in health and care settings
https://www.nmc.org.uk/globalassets/sitedocuments/press/safe-staffing-position-statement.pdf.

Nurse staffing Levels (Wales) Act 2016: operational guidance
http://www.assembly.wales/laid%20documents/pri-ld10028%20-%20safe%20nurse%20staffing%20levels%20(wales)%20bill/pri-ld10028-e.pdf

National Institute for Health and Clinical Excellence (NICE) on safe staffing.
https://www.nice.org.uk/Guidance/SG1

Strategy Implications

Inability to provide appropriate nurse staffing levels to ensure time to care for patients sensitively can compromise the Health Board's ability to deliver Health Care effectively.

Financial Implications

The bi-annual calculation and review findings of the nurse staffing levels as directed by the Nurse Staffing Levels Wales (Act) 2016 identified changes to the nurse staffing establishments in line with the triangulated approach as required within the Act. (See reporting template Summary of Nurse Staffing Levels for wards where Section 25B applies, appendix 5).

Escalation capacity of which remains unfunded and therefore does not support the nurse staffing establishment.

Risk Analysis

The governance issues are:

- the current vacancy position and its impact on 25B wards
- the impact of the COVID 19 pandemic and the repurposing of wards to meet the clinical demand
- any instances whereby investigations identify staffing deficits
- quality indicator information for the wards may not be comparative year to year
- inconsistent interpretation of the Welsh Levels of Care workforce planning tool due to different environments as we are not currently business as usual

Legal and Compliance

Nurse staff Calculations are presented annually to the Health Board. Changes to ward establishments outside of the Biannual Calculation are approved by the Executive Director of Nursing.

Impact Assessment

Undertaken as part of the Biannual calculations

Health and Social Services Group
Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Prif Swyddog Nyrsio – Cyfarwyddwr Nyrs GIG Cymru
Chief Nursing Officer – Nurse Director NHS Wales

Llywodraeth Cymru
Welsh Government

To: NHS Executive Nurse Directors

24 March 2020

Dear Colleagues,

Clarity on COVID19 disruption to Nurse Staffing Levels (Wales) Act 2016

As COVID19 has become an established and significant epidemic across the UK, NHS Wales' staff and services are coming under increasingly extreme pressure. Welsh Government is fully aware that any sense of "*business-as-usual*" is becoming increasingly untenable.

I want to provide you with clarity and assurances around how I expect these additional pressures will disrupt the business-as-usual processes of - and work-streams associated with - the Nurse Staffing Levels (Wales) Act 2016 (*the Act*).

It will be helpful to consider the effects of the COVID19 pressures under two headings: firstly the ongoing work to extend the Act's second duty to paediatric inpatient wards; and secondly, compliance with and reporting against the existing duties under the Act.

Extending the second duty to Paediatrics

Thus far, the provisional schedule for this work has been as follows:

- June to August 2020: 3 month public consultation on the draft regulations and amended statutory guidance;
- November 2020: regulations laid before the Senedd;
- December 2020: Senedd debate and presumptive passing of regs;
- April 2021: Coming-into-force date of regulations on paediatric inpatient wards.

The timetable of those processes is now clearly compromised. In terms of the legislative steps, the capacity to undertake the drafting requirements is still available within Welsh Government. We intend to reschedule the plenary debate to February 2021, allowing the consultation to take place later in 2020, several months after the projected peak of COVID19 activity.

The remaining issue is the capacity within the health boards to take the necessary actions to prepare their wards and staff for the introduction of the new regulations. April 2021 now appears to be entirely unfeasible as a coming-into-force date. Given the current timescales, it is a fair assumption that health boards will require approximately 12 months of preparation time under normal circumstances before the regulations could come into force. In the context of this work stream, I consider *normal circumstances* to be suspended.

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However a final decision on a coming-into-force date won't need to be made until the regulations are laid before the Senedd in early 2021. We will of course be monitoring the COVID19 pressures intently in the coming weeks and months, and it is my intention that the 12 month countdown on necessary preparation time for health boards will not resume until pressures have subsided significantly enough to allow this work-stream to continue. For example, if by October 2020 we have returned to what could be considered more "normal circumstances", we would then target a coming-into-force date of October 2021.

This approach is of course based on the best currently available evidence and projection, and is subject to change if and when the situation evolves. Should our approach change in any way, I will of course update you immediately.

Also linked to the extension to paediatric inpatients, I am conscious that our second planned data capture around compliance with the interim paediatrics principles is due this coming May. For obvious reasons I have taken the decision to postpone this until November, pending any further developments.

Summary

- Welsh Government will proceed with the legislative steps that will allow extension of the Act's second duty within this government term as committed.
- This will be achieved through delaying the public consultation to late 2020 and the plenary debate to early 2021.
- The planned April 2021 coming-into-force date will be postponed based on at what point health boards have returned to normal enough circumstances to reasonably proceed with the necessary preparations for extension of the Act's second duty into paediatric inpatient wards.

Compliance with and reporting against the existing duties under the Act

Broadly, the duties on health boards currently under the Act are as follows:

- to calculate nurse staffing levels for adult medical and surgical wards using a prescribed triangulated methodology;
- to take all reasonable steps to maintain those calculated nurse staffing levels;
- to produce a three-yearly report to Welsh Ministers (May 2021) on the extent to which nurse staffing levels have been maintained and the impact not maintaining them has had on care.
- to have regard to providing sufficient nurses wherever nursing care is provided or commissioned;

Calculation

The wording of the statutory guidance is that health boards *should* undertake a recalculation every six months rather than *must*. There is an important legal distinction between the two. If "must" had been used, the biannual calculation schedule would be absolutely mandatory, and we would either need to consider suspending that guidance or accept that all health boards would be non-compliant with the Act. However, "should" allows for more discretion and flexibility in extraordinary circumstances. With the next biannual calculation due imminently, you will need to ask serious questions about whether the resource that goes in those calculations is better used elsewhere.

Further, there is a question around on which wards the health boards would actually be using that triangulated calculating methodology given that we expect ward purposes to change dramatically, and at a rapid pace. On the Executive Nurse Directors Skype meeting on Wednesday last week, you were united in your view that by the peak of the Covid19 pressures, it is likely that all of your currently designated adult medical and surgical wards

will have become "*Covid wards*". Those wards would technically be considered medical in nature, however given that they will be entirely novel, the lack of quality indicator information alone would make it impossible for you to perform the triangulated calculation as prescribed. There is also a fundamental question of whether the *Welsh Levels of Care* evidence-based workforce planning tool could be applied in those wards given that they will be significantly different environments to the business-as-usual medical and surgical wards where the tool was tested for 2 years.

Maintaining Nurse Staffing Levels

It is safe to say that during the additional Covid19 pressures, maintaining the nurse staffing levels that have been calculated on your adult medical and surgical wards will become an impossible challenge. Your workforces are likely to be reduced by sickness, and significant numbers of the available nursing staff will be redeployed to Covid19 response out of necessity.

However, we must bear in mind that varying from the nurse staffing level does not constitute a lack of compliance with the Act. As long as a ward remains designated as an adult medical or surgical ward, you will still be actively applying your professional judgement and taking all reasonable steps to mitigate the risk to patients on those wards. Indeed, closing those wards entirely is a reasonable step available to you if you deem it necessary. It is not a step we envisaged being commonly implemented when writing the legislation, but this public health crisis is in essence the most extreme test of the flexibility built into the Act.

Reporting

I am aware that you are due to take annual reports to your boards in May. I am also mindful that those annual reports are a voluntary step that you as a group of peers agreed to on an all-Wales basis rather than something that is mandated within the Act or its statutory guidance. In usual circumstances it is eminently sensible to provide annual assurances to your Boards that can then be aggregated to create the 3-yearly reports to Welsh Government. However in these extraordinary circumstances, you need to decide whether the time and resource necessary to produce those reports would not be more valuably redirected elsewhere.

In terms of the 3 year report (due in May 2021) which *is* a statutory requirement, the disruption caused by this pandemic will inevitably have a dramatic impact on the contents of those reports. Thanks to the work of the All Wales Adult work-stream of the Nurse Staffing Programme, we now have a consistent approach to meeting the reporting requirements of the Act. However, a key part of that approach involves enhancements to the HCMS system, which will be impacted by the additional Covid19 pressures. The timescale for delivery was initially 1 April, though I understand that has slipped by a week according to our last update. Whether the enhancements are delivered in April or not, it does not seem reasonable to ask frontline nurses to adopt a new process during what will be a national staffing emergency.

What will be important during these coming months, is that careful records are kept of the steps that you take to manage this developing situation. In April 2021, the first 3-year reports will look significantly different to how we would have envisaged at the start of this year. However, you will still be required to recount the story of what happened on your wards, for example, on what date you closed particular medical and surgical wards to repurpose them as Covid19 wards.

Overarching regard for providing sufficient nurses

Your duty under section 25A of the Act will remain an important factor in how you are deploying your nursing staff across the entirety of your health boards wherever nursing care is provided or commissioned. Even during a period where "providing sufficient nurses" will

seem like a foreign concept, your responsibility of minimising risk to patient safety through applying your professional judgement will remain.

Summary

Under these exceptional circumstances, it is the Welsh Government's position that:

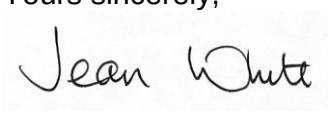
- it is within the health boards' respective discretion to proceed with or cease work on the imminently scheduled biannual re-calculation of adult medical and surgical wards;
- similarly it is within the health boards' respective discretion to indefinitely postpone the annual report to board, due May 2020;
- adult medical and surgical wards that have been repurposed as novel wards to deal with the Covid19 pandemic would be considered an exception under the definition of an adult medical ward, therefore would not be subject to the prescribed triangulated calculation methodology;
- as long as wards remain designated as adult medical and surgical wards, health boards will be expected to persist with taking all reasonable steps to maintain calculated nurse staffing levels and undertake the usual mitigating actions where possible;
- we acknowledge that those reasonable steps and mitigating actions are still likely to fall short of enabling health boards to maintain the Nurse Staffing Levels calculated during usual circumstances;
- health boards should ensure that they take whatever steps they deem necessary to record their actions taken over the coming months in order to adequately articulate within the first three-year report (due April 2021) the narrative of these extraordinary circumstances;
- health boards – through their executive nurse directors - ensure they are informed of actions being taken in other health boards, and that a consistent, collaborative approach is taken by all; and
- your professional judgement as designated persons will remain a key determinant in ensuring staffing in all areas where nursing care is either provided or commissioned is managed as appropriately as possible during an extraordinarily difficult time.

Finally, I feel I must stress the importance of remaining united as a peer group. Especially in such extraordinary times, there is clear value to a once-for-Wales approach to how health boards manage these immense pressures.

A hoffech gael yr wybodaeth hon yn Gymraeg, byddwch cystal â rhoi gwybod.

If you would like to receive this information in Welsh, please let me know.

Yours sincerely,



Professor Jean White CBE
Chief Nursing Officer
Nurse Director NHS Wales

Health and Social Services Group
Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Prif Swyddog Nyrsio – Cyfarwyddwr Nyrs GIG Cymru
Chief Nursing Officer – Nurse Director NHS Wales

Llywodraeth Cymru
Welsh Government

To: NHS Executive Nurse Directors

15 October 2020

Dear Colleagues,

Update on COVID19 disruption to Nurse Staffing Levels (Wales) Act 2016

You will recall that I wrote to you in March of this year as the NHS prepared for the predicted disruption of the Covid19 pandemic. In that letter I set out my expectations of how the pandemic might impact the various duties of the Nurse Staffing Levels (Wales) Act 2016, and stressed the importance of a unified approach across the country.

This included a rationale that wards *repurposed as novel Covid19 wards* would fall outside of the 25B ward definition, and therefore not be subject to the prescribed triangulated methodology. This was of course written early in the spread of the virus, where reasonable worst case scenario projections were describing a near-future where our NHS wards would be predominantly occupied by critically unwell Covid patients, and where field hospital care would be prevalent. Thankfully, those grim projections were not fully realised.

Following a meeting with the Chairs of the All-Wales Nurse Staffing Group and its Adult sub group, it is clear to me that the reality of how wards have been managed in the intervening months has been more nuanced and complex than we initially might have expected.

Understandably, different quarantining protocols and the repurposing of inpatient bed areas have been applied across NHS Wales. These range from: entirely Covid-free wards; wards with Covid-positive patients who are asymptomatic and being treated for other medical or surgical conditions; Covid-positive patients who are symptomatic but not acutely ill from the disease and being treated for other medical or surgical conditions; and wards where all patients are critically unwell with Covid requiring intensive care primarily for that reason.

With the benefit of hindsight of how the first phase of the Covid19 pandemic evolved, I feel that it would be timely to clarify how the lived experiences of the last six months relate to the dispensations outlined in my letter of 24 March. Questions have been raised from an operational perspective whether – for example – a ward with asymptomatic Covid-positive patients not being treated for Covid-related illness would be exempt from the 25B definition. The most concise way to answer this is to refer back to the Statutory Guidance of the Act where the definitions of adult acute medical and surgical wards apply "*according to the primary purpose of the ward*".

If the primary purpose of a ward remains the treatment of patients for medical or surgical conditions, and the Welsh Levels of Care tool is still applicable to that setting, then in my view those wards would remain under the auspices of 25B of the Act.
Conversely, if a ward was legitimately repurposed to treat those critically unwell Covid19 patients - as we expected in March to be a more common occurrence – my view would

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remain that those wards would be considered exclusions with an expectation you would follow national advice on staffing critical care areas.

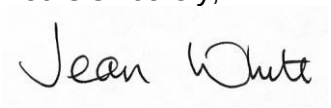
On 1 July 2020, an updated version of the Healthcare Monitoring System (HCMS) went live for use. Informed by the All-Wales Adult work-stream, the enhancements were designed to support health boards in recording data that the Act lists as being necessary under section 25E (reporting). With this in mind, I would expect to see the beginnings of a more detailed reporting picture from 1 July 2020 than had previously been possible. I do appreciate that the disruption caused by Covid19 will not have created the optimum conditions for the roll-out of this updated system, but I hope that you have instructed your senior staff on the importance of ensuring that the data are being captured as accurately as possible as this will inform the first public 3-year report due in May next year.

Finally I want to thank you for your focus and hard work over the last six months. With the winter approaching and a second peak of Covid infections coming with it, you will be required to display the same resolute character and professionalism in the face of potentially greater adversity than the NHS has endured so far this year. I hope this letter provides the clarity and support you will need to be able to capture the nurse staffing story in a consistent way to inform next year's reports. I would also like to remind you of the portions of my 24 March letter that highlighted the various areas of work where the Act gives health boards the discretion to make decisions on whether or not to undertake certain processes. As we approach another period that may well bring unprecedented pressures, I want to be clear that those discretionary provisions are still relevant. All I would ask – once again – is that you make those decisions together as a peer group, and take a unified approach where possible and appropriate.

A hoffech gael yr wybodaeth hon yn Gymraeg, byddwch cystal â rhoi gwybod.

If you would like to receive this information in Welsh, please let me know.

Yours sincerely,



Professor Jean White CBE
Chief Nursing Officer
Nurse Director NHS Wales

12 March 2020

Dear colleagues

Supporting Nurses and Midwives across the UK and Nursing Associates (England only) in the event of a COVID-19 epidemic in the UK

Let us start by thanking you, we know that you and your colleagues have been working exceptionally hard, and you should know that the work you are doing is having a real impact.

If COVID-19 becomes an established significant epidemic in the UK, NHS services across the health and care sectors will be put under extreme pressure. This pressure will inevitably be exacerbated by staff shortages due to sickness or caring responsibilities. It will be a challenge, but we are confident that nursing and midwifery professionals will respond rapidly and professionally. We want to assure colleagues that we recognise this will require temporary changes to practice, and that regulators and others will take this into account.

A significant epidemic will require health and care professionals to be flexible in what they do. It may entail working in unfamiliar circumstances or surroundings or working in clinical areas outside of their usual practice for the benefit of patients, individuals and the population as a whole. This can be stressful, and we recognise that you may have concerns about both the professional practicalities and implications of working in such circumstances.

We need to stick to the core principles of nursing and midwifery practice. As registered professionals you are expected to practice in line with the NMC code and use judgement in applying the principles to situations that you may face. However, these also take account of the realities of a very abnormal emergency situation. We want nursing and midwifery professionals in partnership with patients and those individuals that we care for, to use their professional judgement to assess risk and to make sure people receive safe care, informed by the values and principles set out in their professional standards. A rational approach to varying practice in an emergency is part of that professional response.

It is the responsibility of the organisations in which you work to ensure that you are supported to do this. They must bear in mind that clinicians may need to depart, possibly significantly, from established procedures in order to care for patients in the unique and highly challenging but time-bound circumstances of the peak of an epidemic.

We expect employers, educationalists, professional bodies and national NHS organisations to be flexible in terms of their approach and the expectations of routine requirements. Health and care professional regulators, including the NMC have already committed to take into account factors relevant to the environment in which the professional is working.

Due consideration should and will be given to health and care professionals and other staff who are using their skills under difficult circumstances due to lack of personnel and overwhelming demand in a major epidemic. This may include working outside their usual scope of practice. The health and care regulators have already released a joint statement to explain this: https://www.nmc.org.uk/news/news-and-updates/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus/

We are now working with the NMC to enable people to come back to work and to invite our final year student nurses and midwives to come into clinical practice to support us over the next few months.

Finally, we would like to thank you all for all the efforts you are already making. Many nursing and midwifery professionals across the NHS, public health and care services have already made major contributions to the response to COVID-19. We are very proud of the response of the professions in all areas of practice in their response to this challenge. It has been exemplary. We are confident of the commitment, dedication and hard work that nursing and midwifery professionals have and will continue to have in the very testing event of a significant epidemic in the UK.

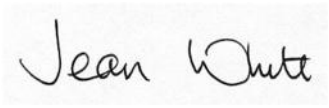
Your professionalism and work has never been more vital or more valued.

Yours sincerely

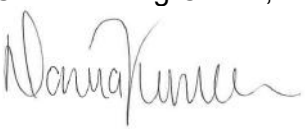
Ruth May
Chief Nursing Officer, England

Fiona McQueen
Chief Nursing Officer, Scotland

Charlotte McArdle
Chief Nursing Officer, Northern Ireland

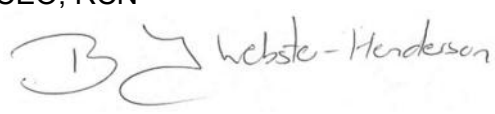


Jean White
Chief Nursing Officer, Wales



Dame Donna Kinnair
CEO, RCN

Andrea Sutcliffe
Chief Executive and Registrar, NMC



Professor Brian Webster-Henderson
Chair, Council of Deans of Health

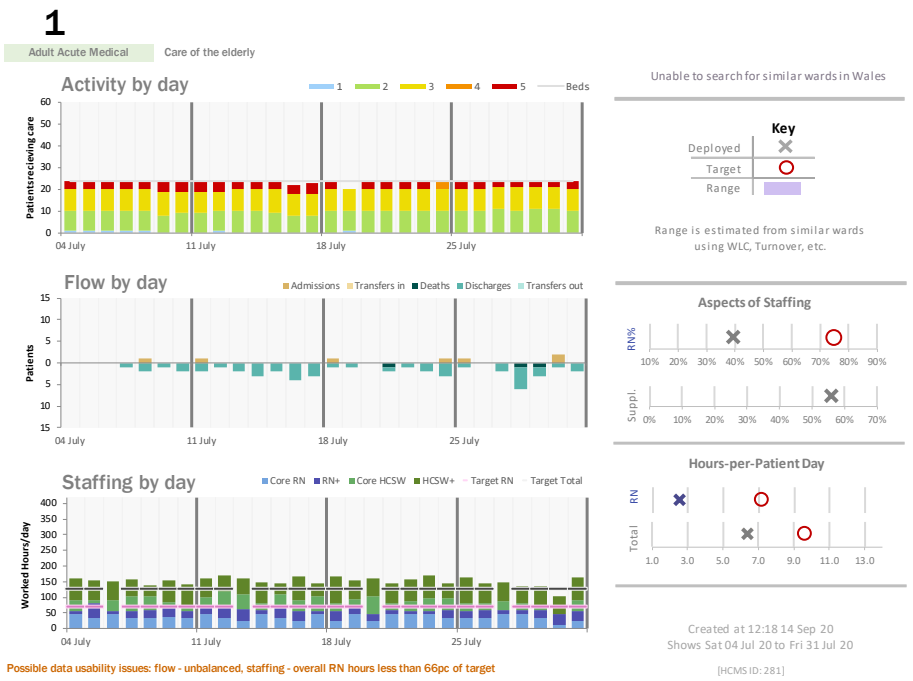
Gill Walton
Chief Executive, RCM

Appendix 4

Acuity Data

July 2020

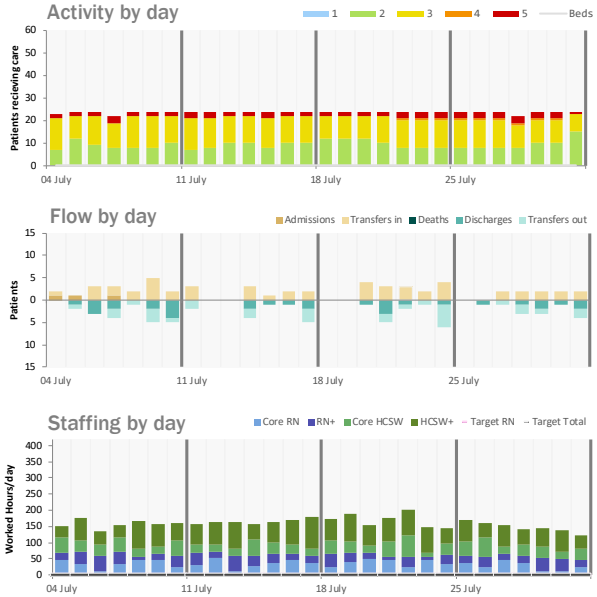
Ysbyty Glan Clwyd



June 2019

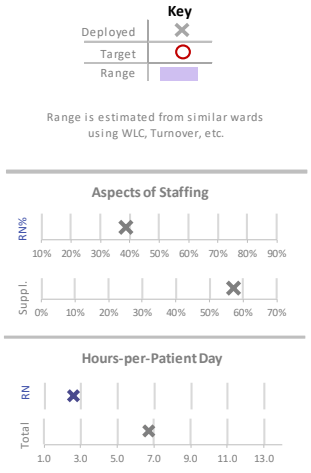
2a

Non-§25B Unknown



Possible data usability issues: manage - missing beds, manage - missing specialty, staffing - daily RN hours greater than

Unable to search for similar wards in Wales



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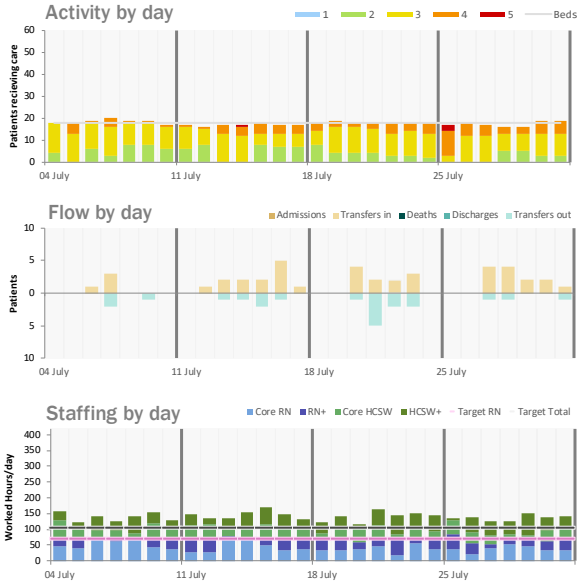
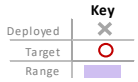
2b

3

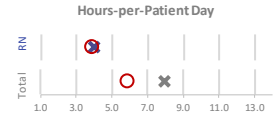
Non-§25B Medical Surgical : Acute Vascular



Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.

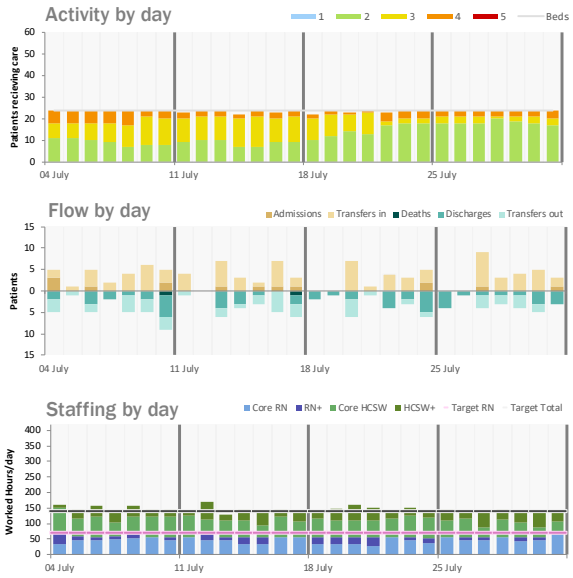


Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

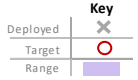
[HCMS ID: 294]

4

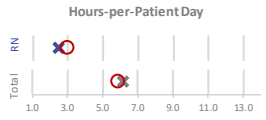
Adult Acute Medical | CardiologyGENERL MEDICAL PATIENTS



Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.

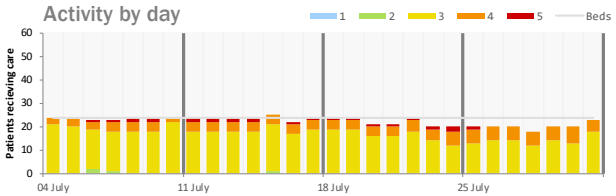


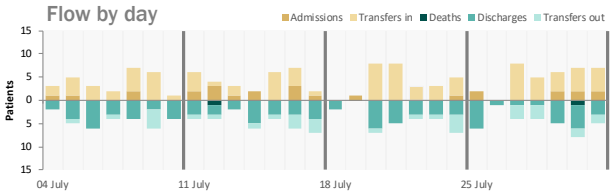
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

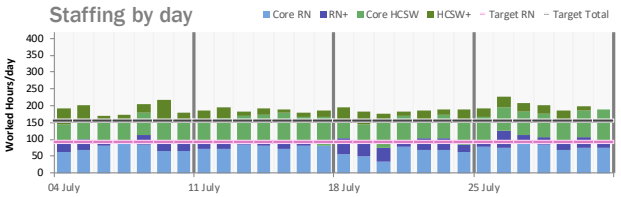
[HCMS ID: 1261]

5

Adult Acute Unknown | Acute surgical ward : ENT / Maxillo facial / Urology

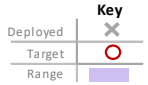




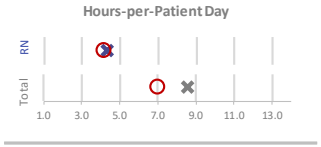


Possible data usability issues: manage - missing specialty

Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.

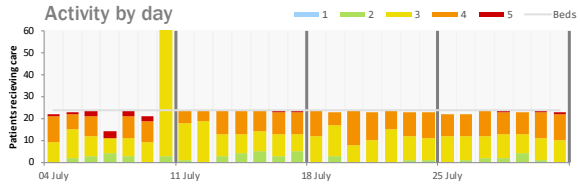


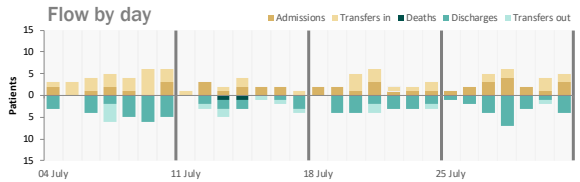
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

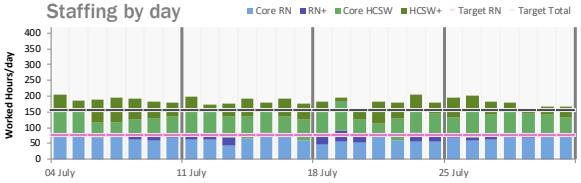
[HCMS ID: 299]

7

Adult Acute Unknown | Surgical Ward :Trauma and orthopoedics

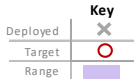




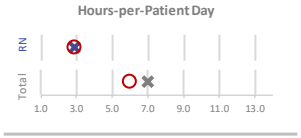


Possible data usability issues: acuity - daily occupancy greater than 175pc, acuity - jump in patient numbers, manage -

Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.

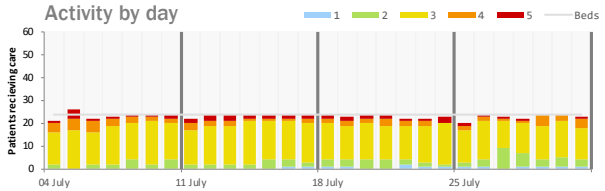


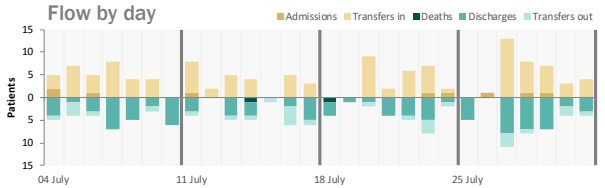
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

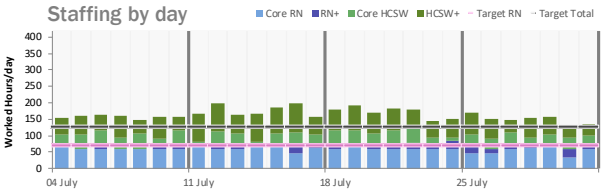
[HCMS ID: 293]

8

Adult Acute Unknown | Acute Surgical ward, Colo Rectal

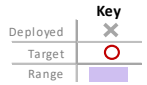




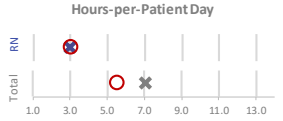


Possible data usability issues: manage - missing specialty

Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.



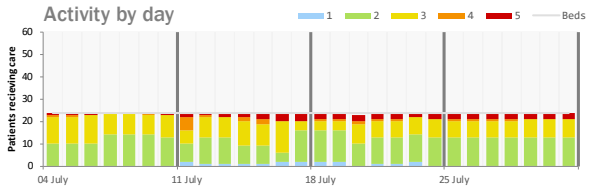
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

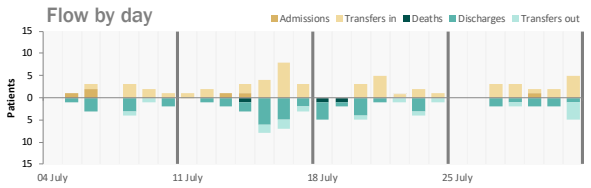
[HCMS ID: 295]

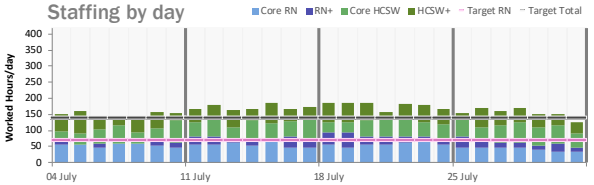
9

Adult Acute Medical

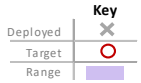
Medical ward with Gastro specialtyescalation bed open most days taking bed nyu...



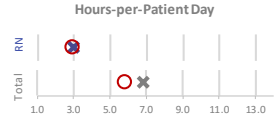




Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.

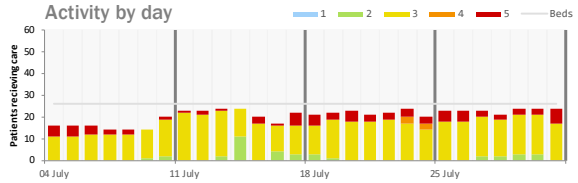


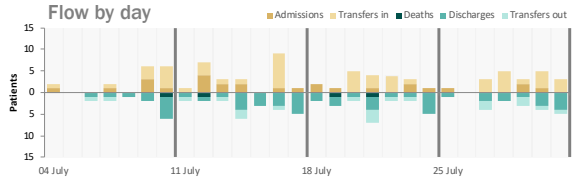
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

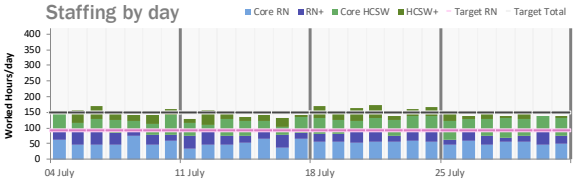
[HCMS ID: 285]

11

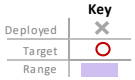
Adult Acute Medical | Acute and Chronic Respiratory patientsAlso funded for 3 x Level 2 beds to acco...



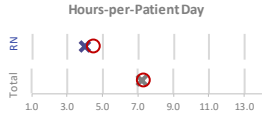




Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.



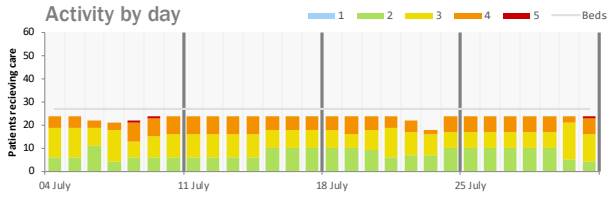
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

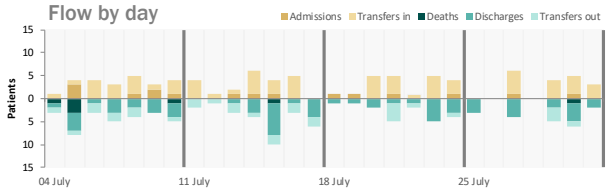
[HCMS ID: 286]

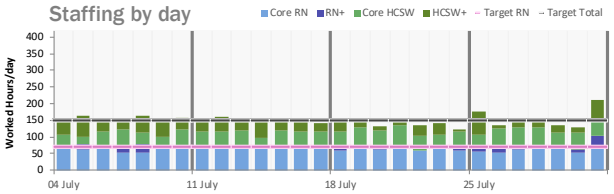
12

Adult Acute Medical

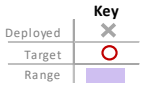
Acute medical ward.Specialty: Renal and diabetes - on ward dialysis and CAPD...



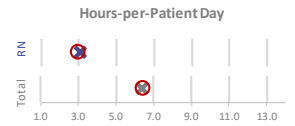




Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.

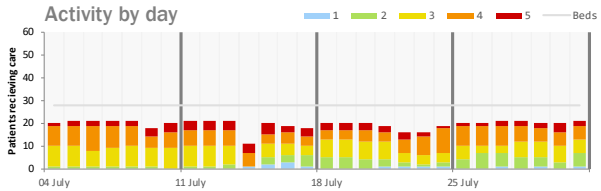


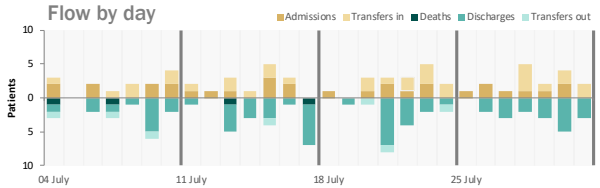
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

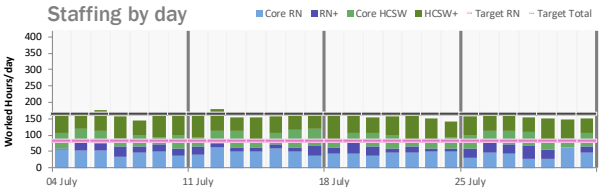
[HCMS ID: 1260]

14

Adult Acute Medical | medical inpatientStroke speciality - can have hight acuity level 4/5 patients ...

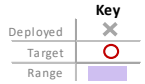




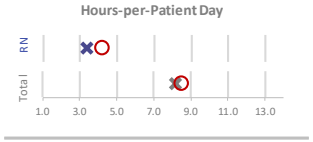


Possible data usability issues: acuity - jump in patient numbers

Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.

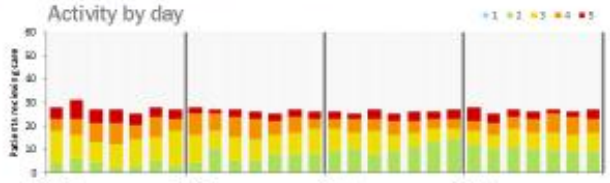


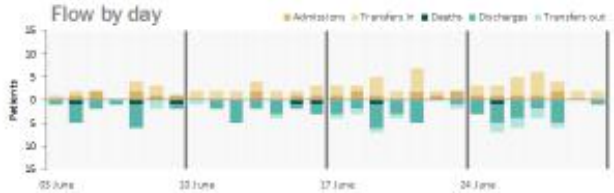
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

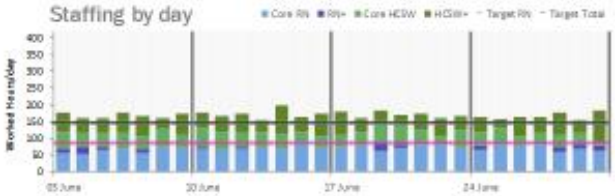
[HCMS ID: 287]

14

Adult Acute Medical | medical inpatient Stroke speciality







3 similar wards found in Wales

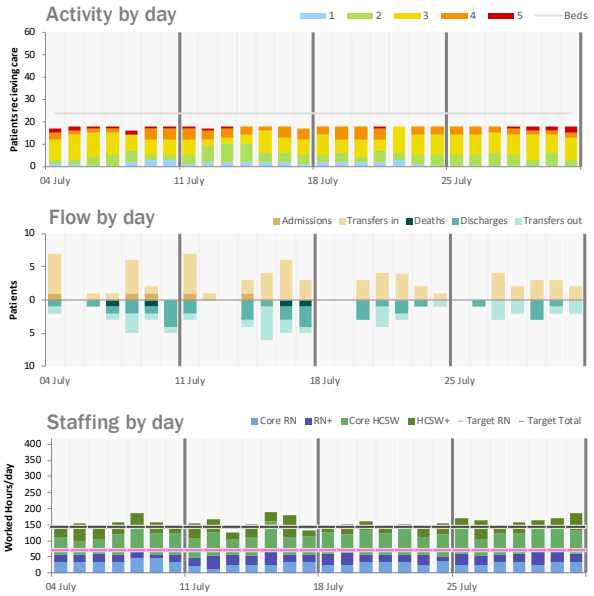
Range is estimated from similar wards using WLC, Turnover, etc.

Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19

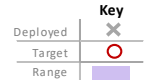
Ysbyty Glan Clwyd ℓ7

19

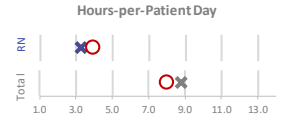
Adult Acute Medical | Care of the elderly



Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.

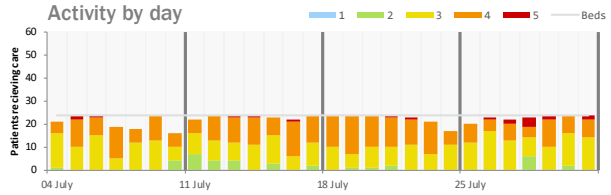


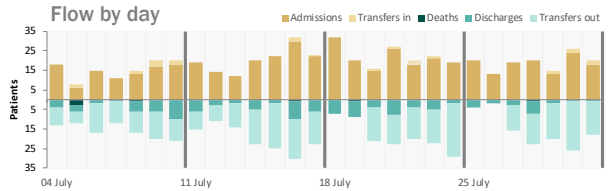
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

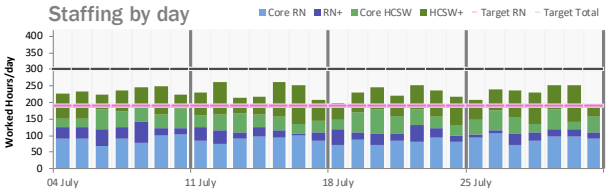
[HCMS ID: 282]

Acute Medical Unit

Non-§25B Medical acute medical admission unit

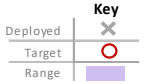




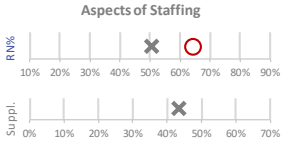


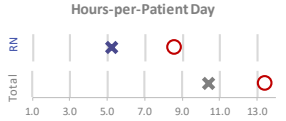
Possible data usability issues: flow - daily turnover greater than 120pc, staffing - overall RN hours less than 66pc of

Unable to search for similar wards in Wales



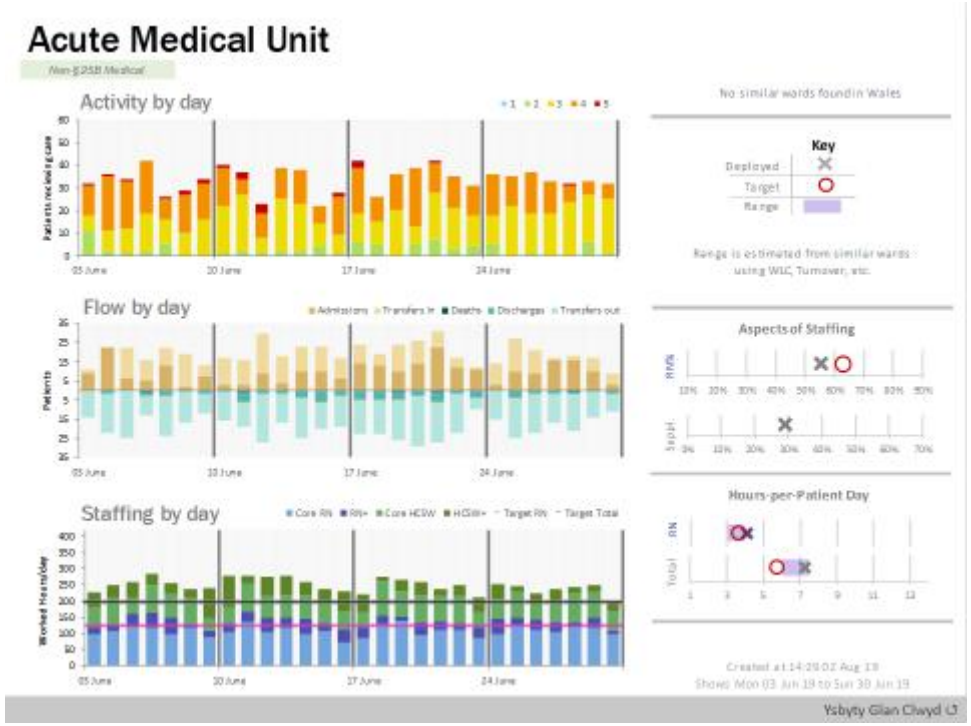
Range is estimated from similar wards using WLC, Turnover, etc.





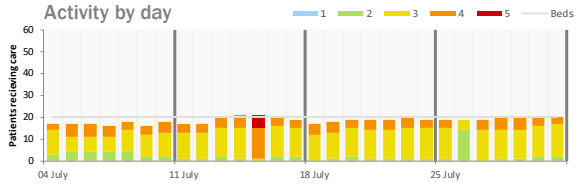
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

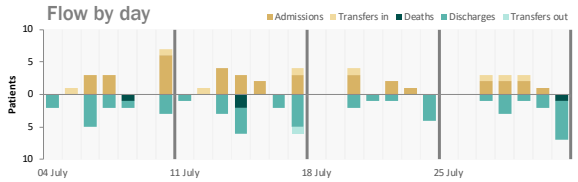
[HCMS ID: 280]

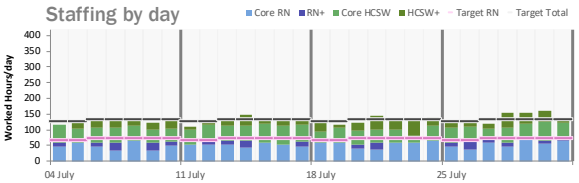


Enfys

Non-§25B Medical Oncology

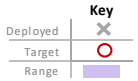




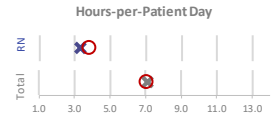


Possible data usability issues: acuity - jump in acuity

Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.

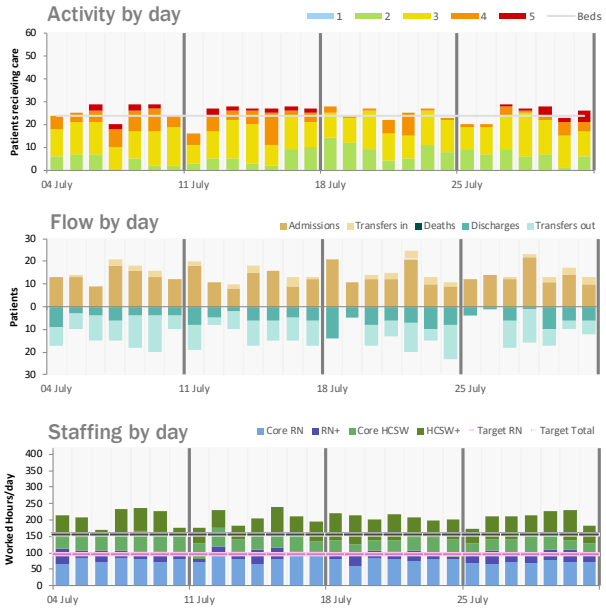


Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

[HCMS ID: 308]

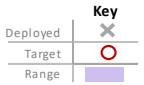
Surgical Assessment Unit

Non-§25B Surgical Admissions unit for unscheduled surgical admisions, adult

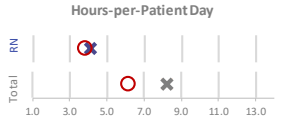


Possible data usability issues: flow - daily turnover greater than 120pc

Unable to search for similar wards in Wales

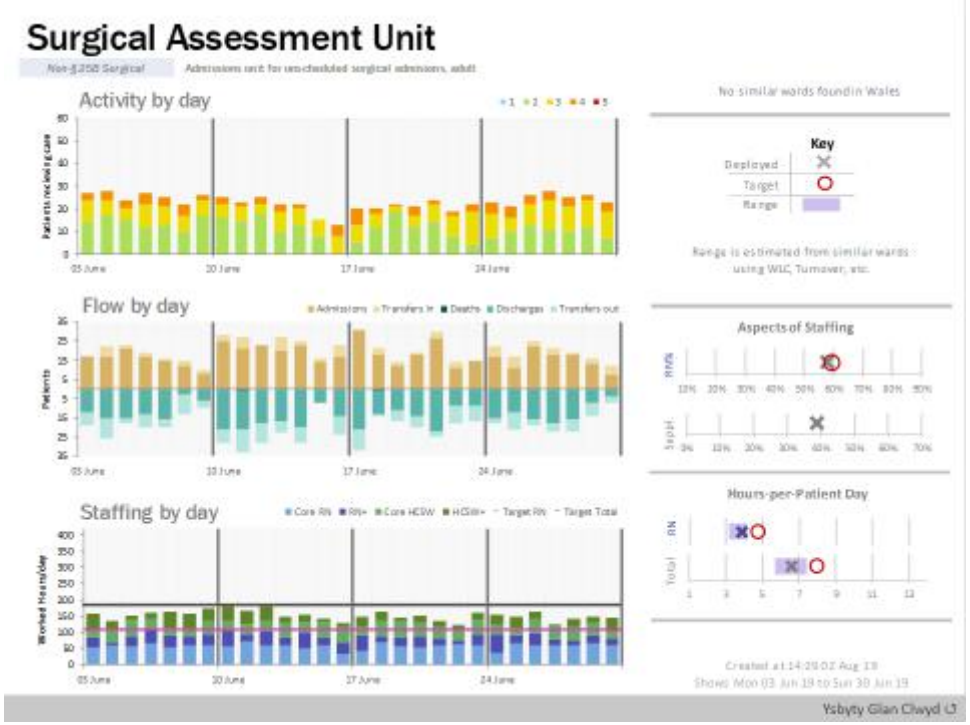


Range is estimated from similar wards using WLC, Turnover, etc.

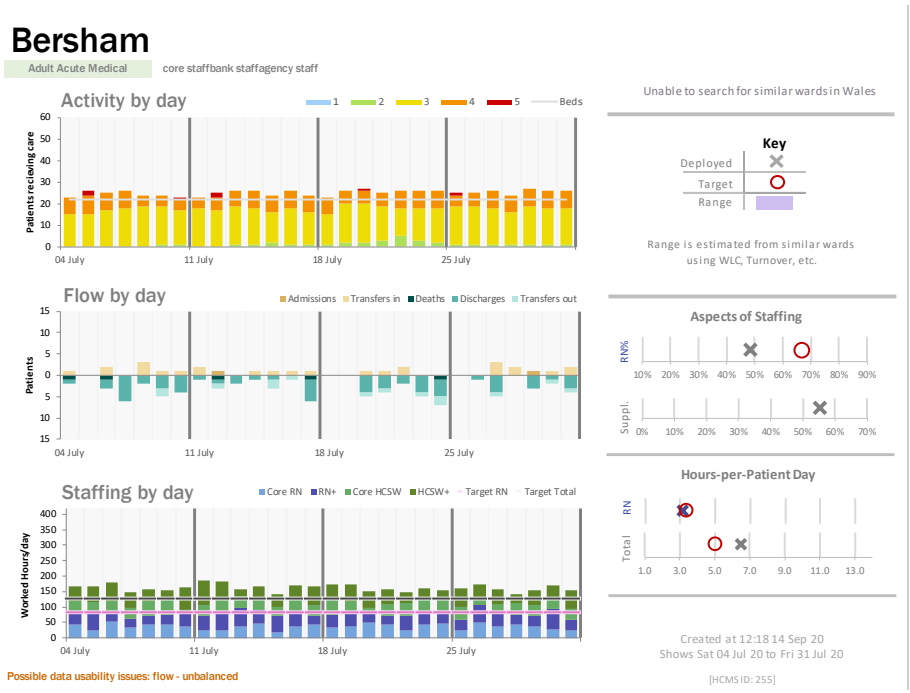


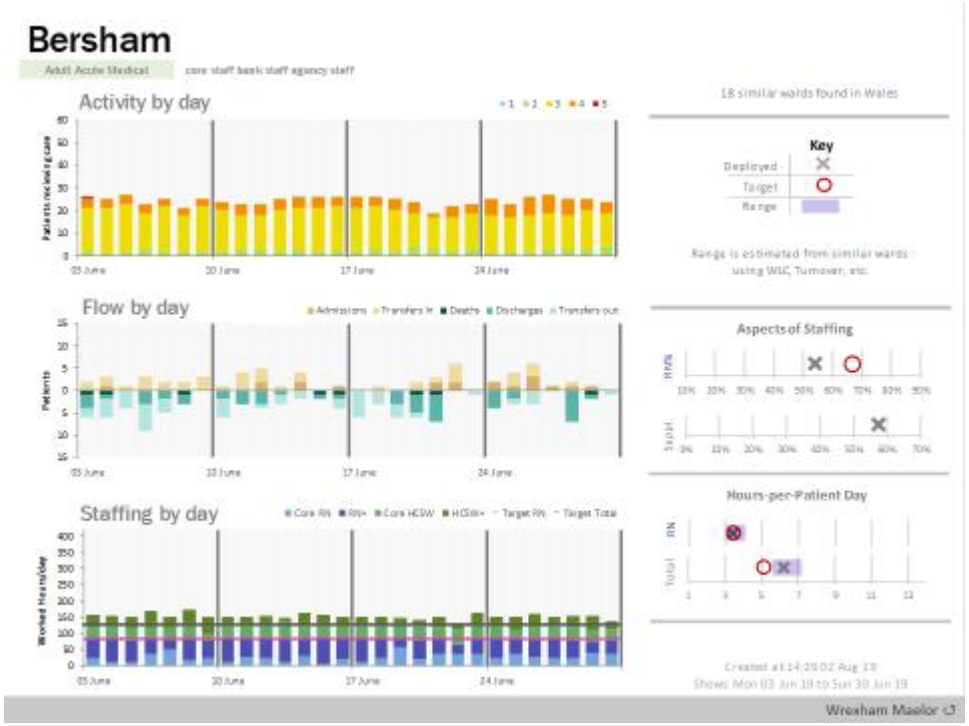
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

[HCMS ID: 296]



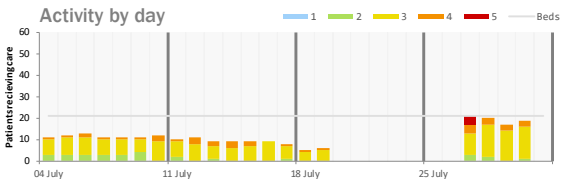
Ysbyty Wrexham Maelor

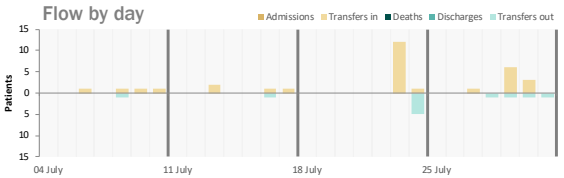


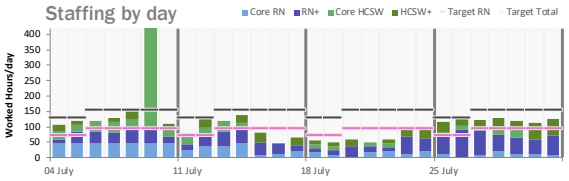


Bromfield Womens

Adult Acute Surgical | All female ward where patients with Gynaecology and breast conditions are cared ...

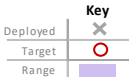




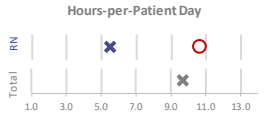


Possible data usability issues: acuity - jump in patient numbers, acuity - zeroed, flow - unbalanced, staffing - daily total

Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.

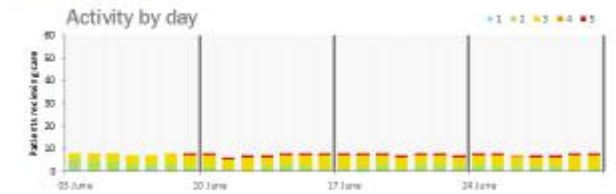


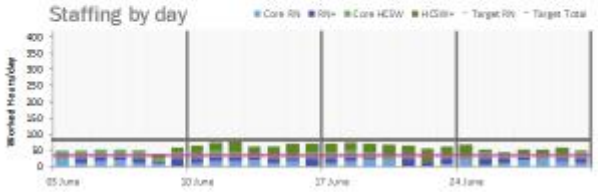
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

[HCMS ID: 251]

Bromfield

Non-ESAS Medical | Currently used as CDiff cohort ward





No similar wards found in Wales

Range is estimated from similar wards using WLC, Turnover, etc.

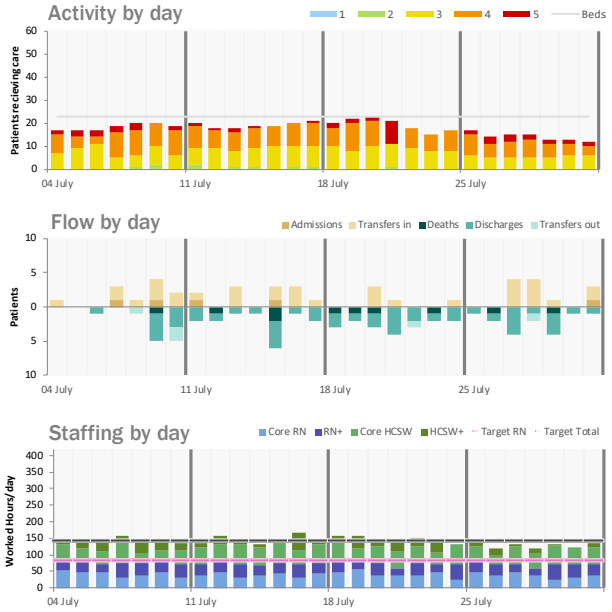
Created at 14:21 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19

Wrexham Maelor

Cunliffe

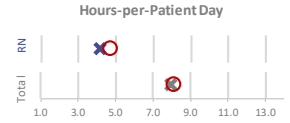
Adult Acute Medical

Cunliffe ward is a 23 bedded medical ward with Nephrology as its main specialty ...



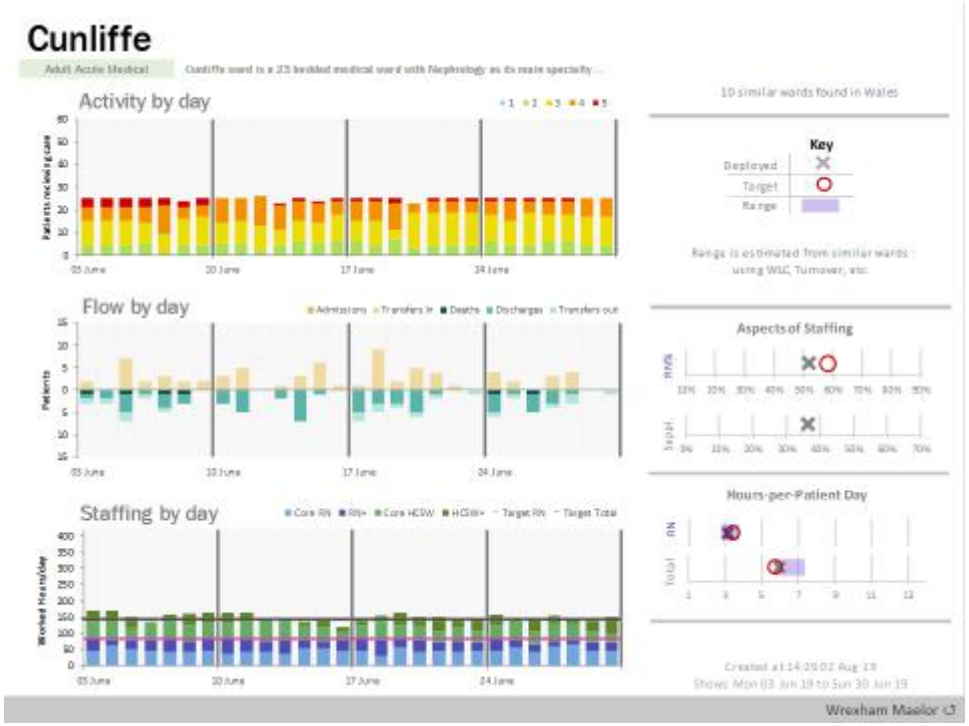
Unable to search for similar wards in Wales

Range is estimated from similar wards using WLC, Turnover, etc.



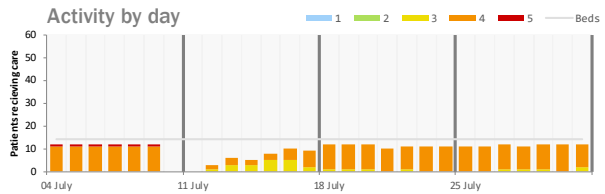
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

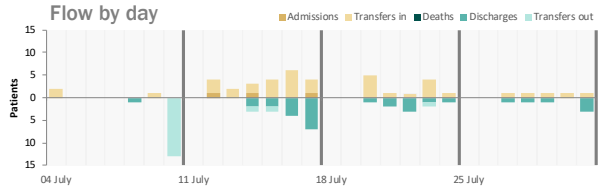
[HCMS ID: 258]

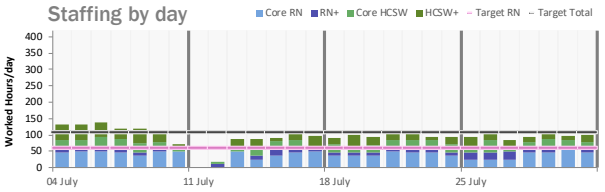


Ear, Nose & Throat

Adult Acute Unknown | ENT, medical, surigcal, eye and orth patients

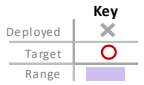




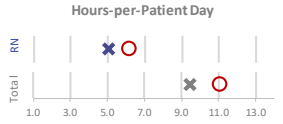


Possible data usability issues: acuity - zeroed, manage - missing specialty, staffing - RN hours less than 24, staffing - RN

Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.

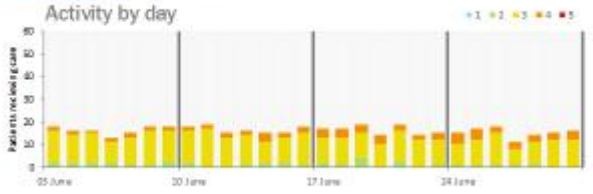


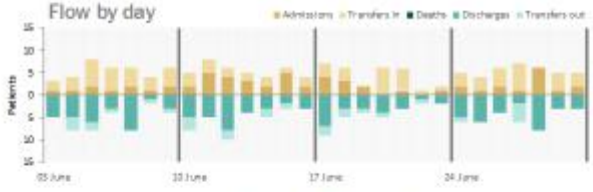
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

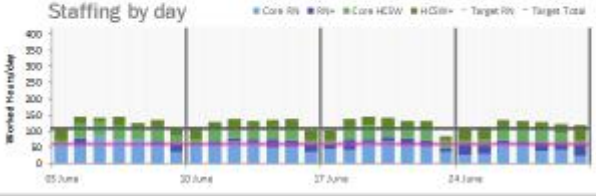
[HCMS ID: 247]

Ear, Nose & Throat

Adult Acute Unknown | ENT, medical, surigcal, eye and orth patients

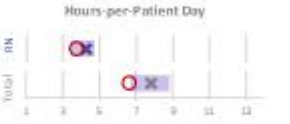






No similar wards found in Wales

Range is estimated from similar wards using WLC, Turnover, etc.

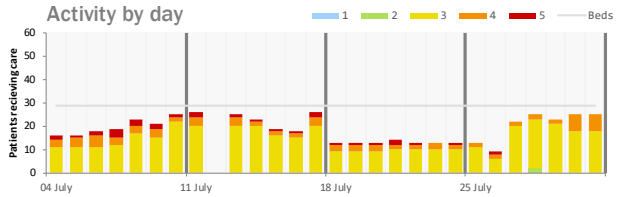


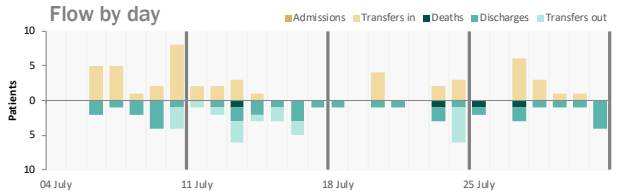
Created at 14:20 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19

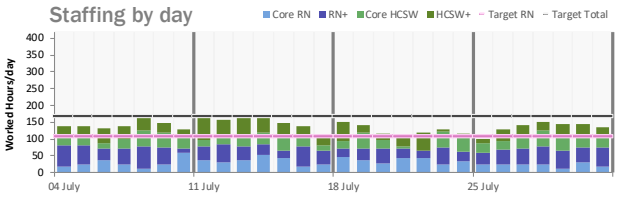
Wrexham Maelor

Erddig

Adult Acute Medical | Respiratory

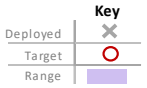




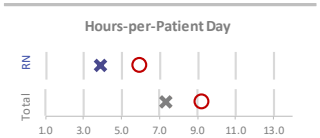


Possible data usability issues: acuity - jump in patient numbers, acuity - zeroed

Unable to search for similar wards in Wales

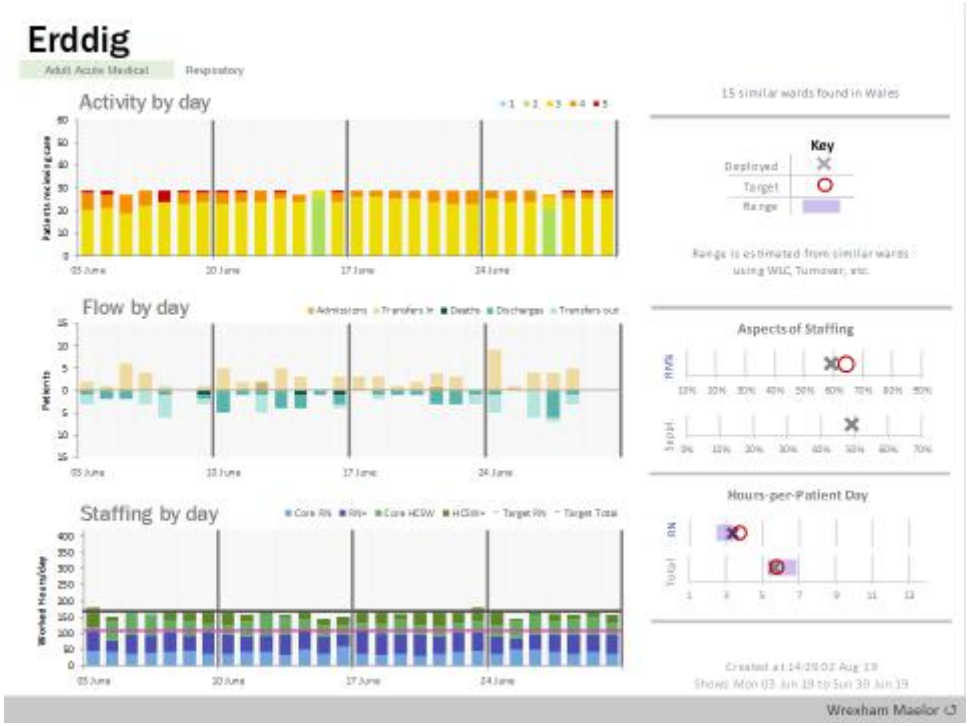


Range is estimated from similar wards using WLC, Turnover, etc.



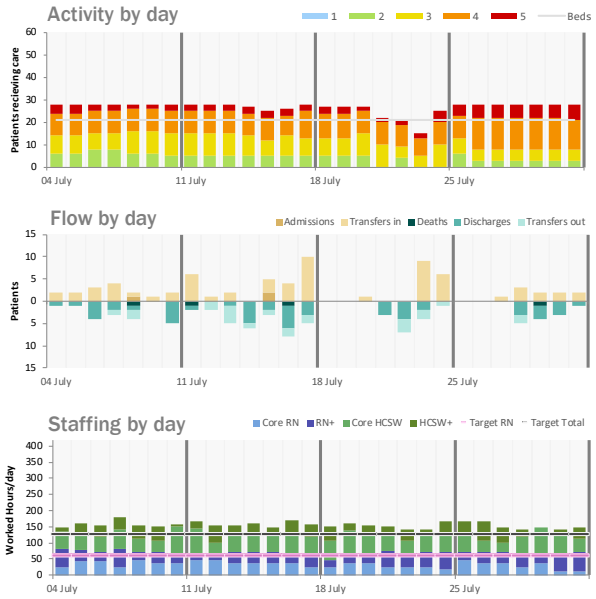
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

[HCMS ID: 260]

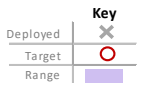


Evington COTE

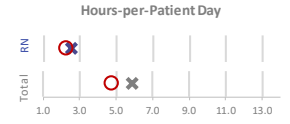
Adult Acute Medical | Gastroenterology Ward and acute medical.



Unable to search for similar wards in Wales

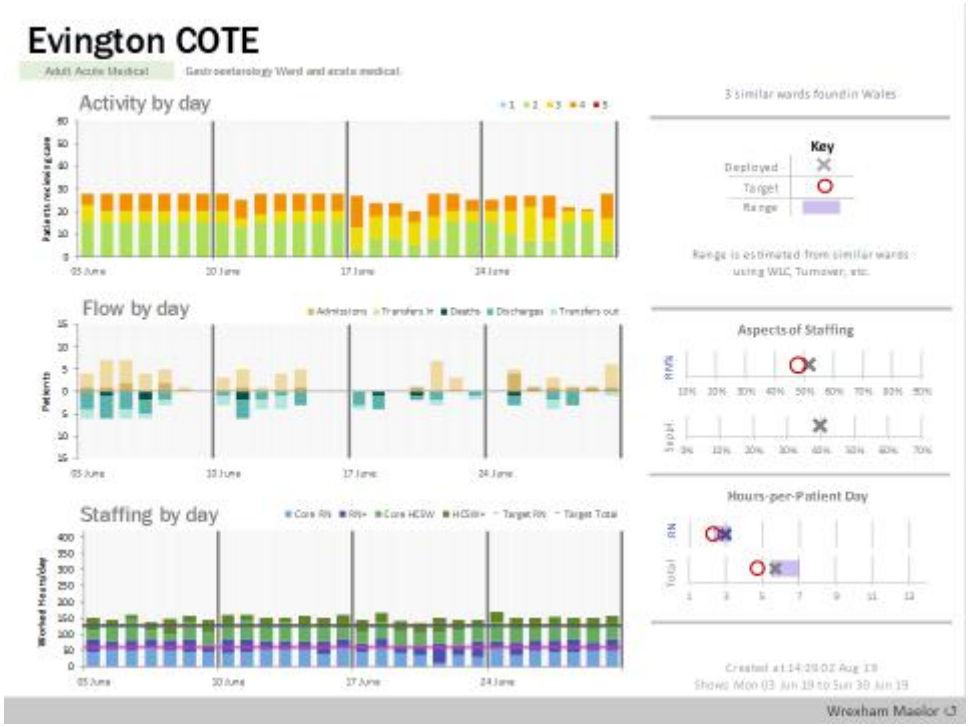


Range is estimated from similar wards using WLC, Turnover, etc.



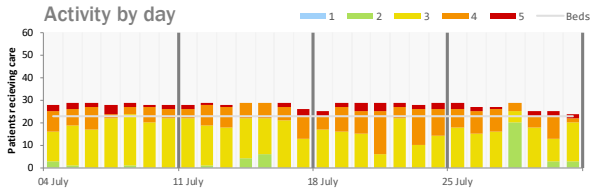
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

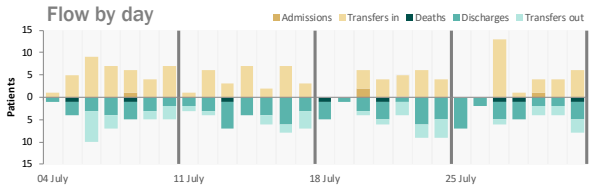
[HCMS ID: 253]

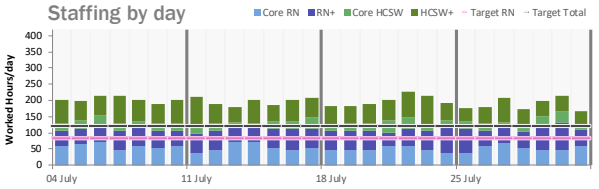


Fleming

Adult Acute Unknown Surgical ward. Colorectal, UGI, vascular, urology, emergency surgery from admis...

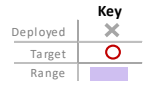




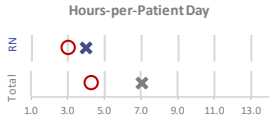


Possible data usability issues: acuity - jump in acuity, manage - missing specialty, staffing - daily total hours greater than

Unable to search for similar wards in Wales

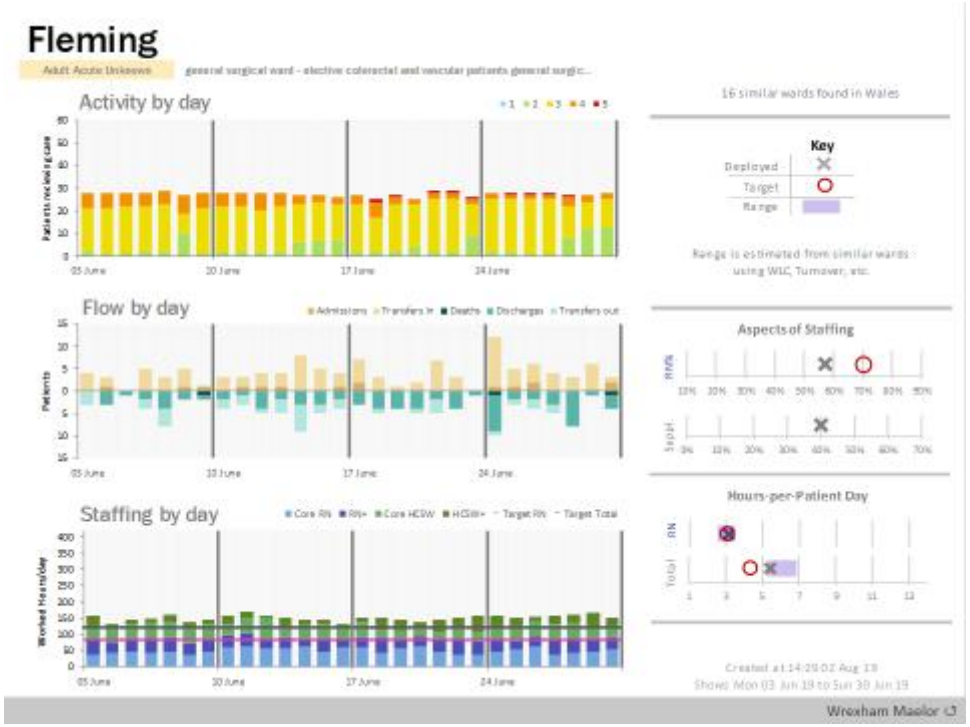


Range is estimated from similar wards using WLC, Turnover, etc.



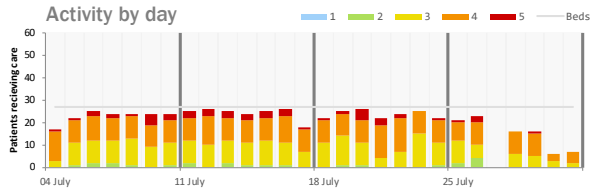
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

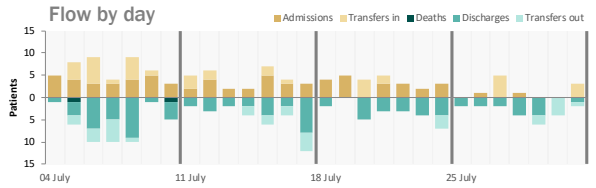
[HCMS ID: 242]

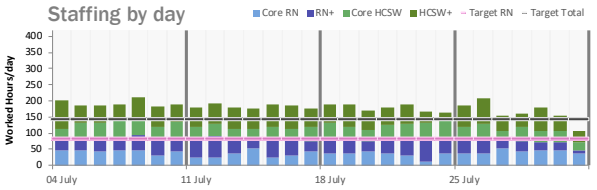


Mason

Adult Acute Medical | Orthopaedic Trauma admissions ward

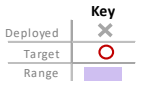




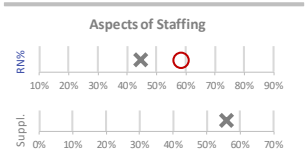


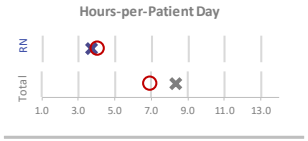
Possible data usability issues: acuity - jump in patient numbers, acuity - zeroed

Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.



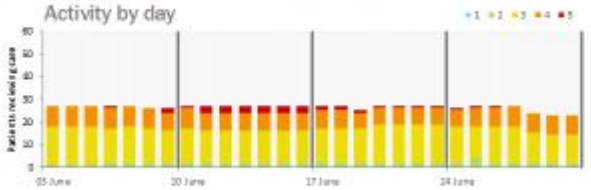


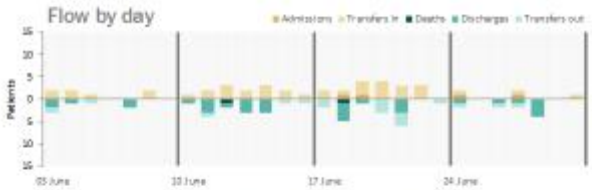
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

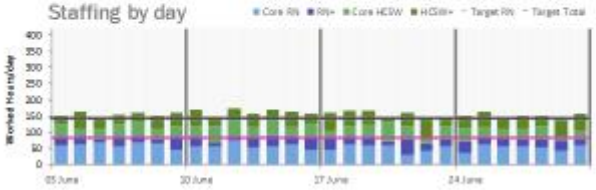
[HCMS ID: 257]

Mason

Adult Acute Medical | Acute Endocrinology, Rheumatology, Dermatology, Haematology, adult nursing - var...







9 similar wards found in Wales

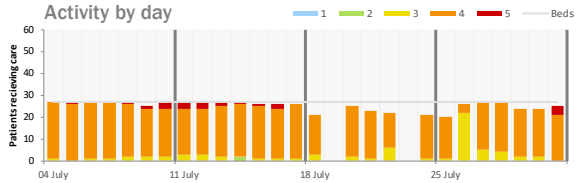
Range is estimated from similar wards using WLC, Turnover, etc.

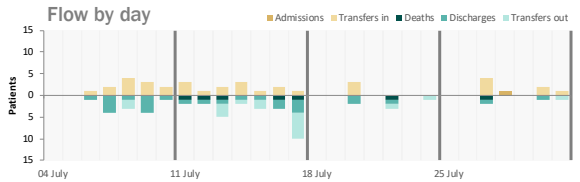
Created at 14:28:02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19

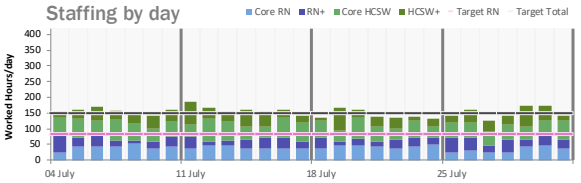
Wrexham Maelor

Morris

Adult Acute Medical | Care of the Elderly Ward. Patients with dementia, complex discharges

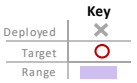




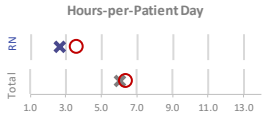


Possible data usability issues: acuity - jump in patient numbers, acuity - zeroed

Unable to search for similar wards in Wales

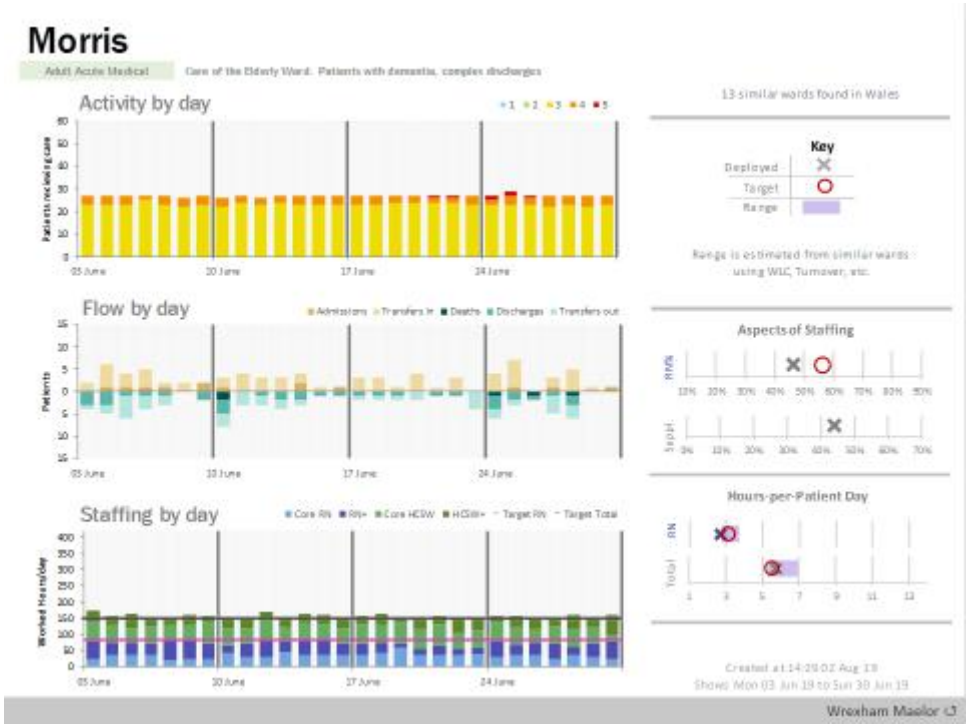


Range is estimated from similar wards using WLC, Turnover, etc.



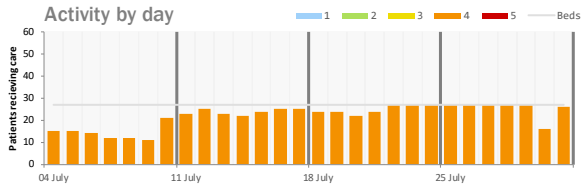
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

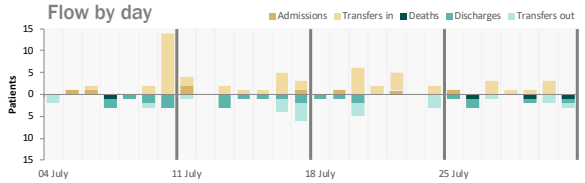
[HCMS ID: 254]

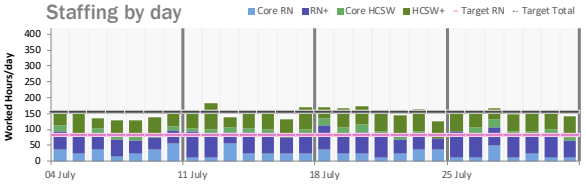


Pantomime

Adult Acute Unknown | Orthopaedic trauma admissions

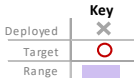




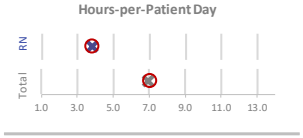


Possible data usability issues: manage - missing specialty

Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.

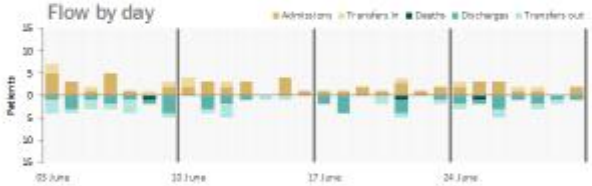


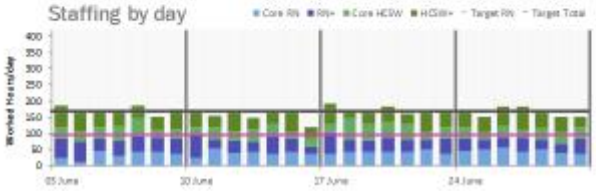
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

[HCMS ID: 244]

Pantomime

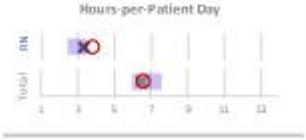
Adult Acute Unknown





2 similar wards found in Wales

Range is estimated from similar wards using WLC, Turnover, etc.

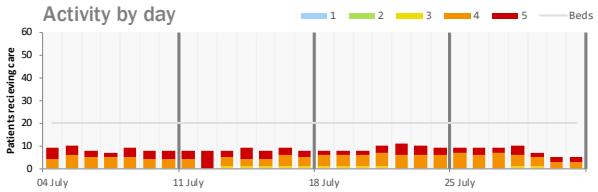


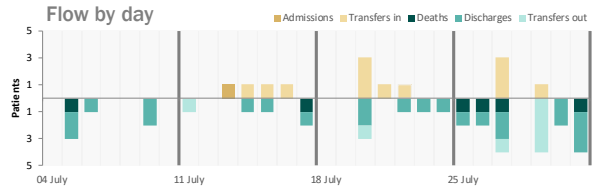
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19

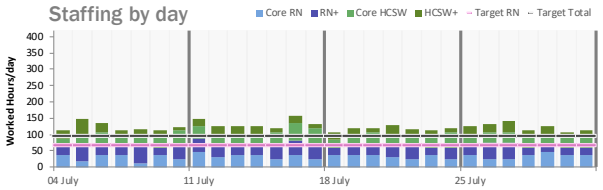
Wrexham Maelor

Prince of Wales

Adult Acute Unknown | Prince of Wales WardOrthopaedic elective

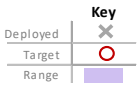




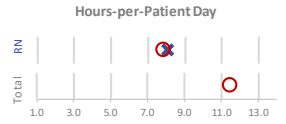


Possible data usability issues: flow - unbalanced, manage - missing specialty

Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.

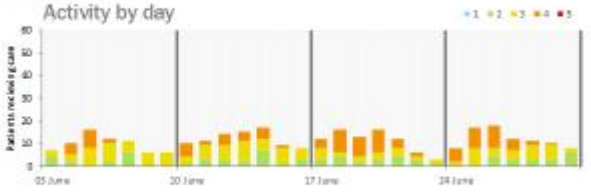


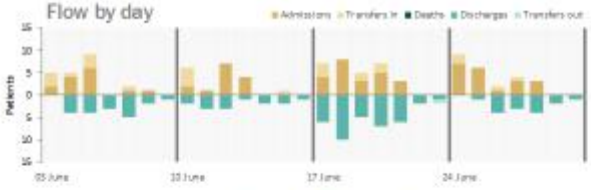
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

[HCMS ID: 245]

Prince of Wales

Adult Acute Unknown





One similar ward found in Wales

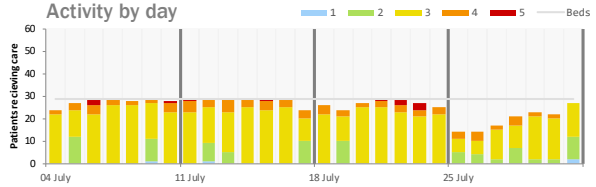
Range is estimated from similar wards using WLC, Turnover, etc.

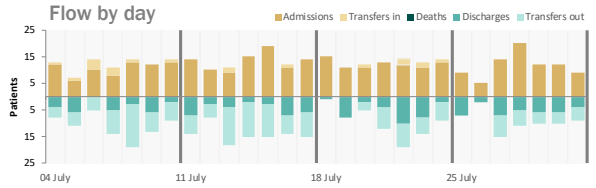
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19

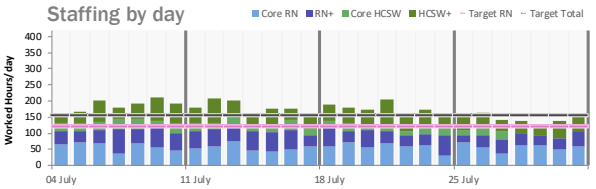
Wrexham Maelor

Surgical Admission

Non-§25B Unknown 16 urology beds13 surical admission beds direct admissions from GP and EDmed...

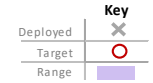




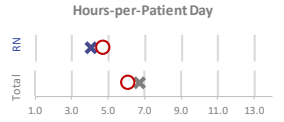


Possible data usability issues: manage - missing specialty

Unable to search for similar wards in Wales

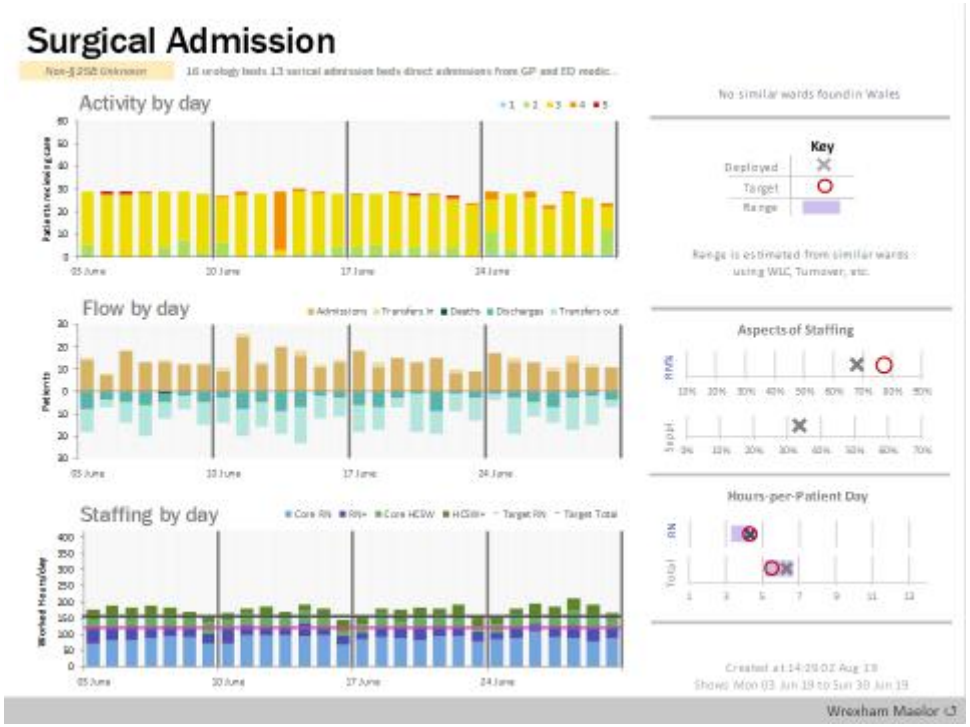


Range is estimated from similar wards using WLC, Turnover, etc.

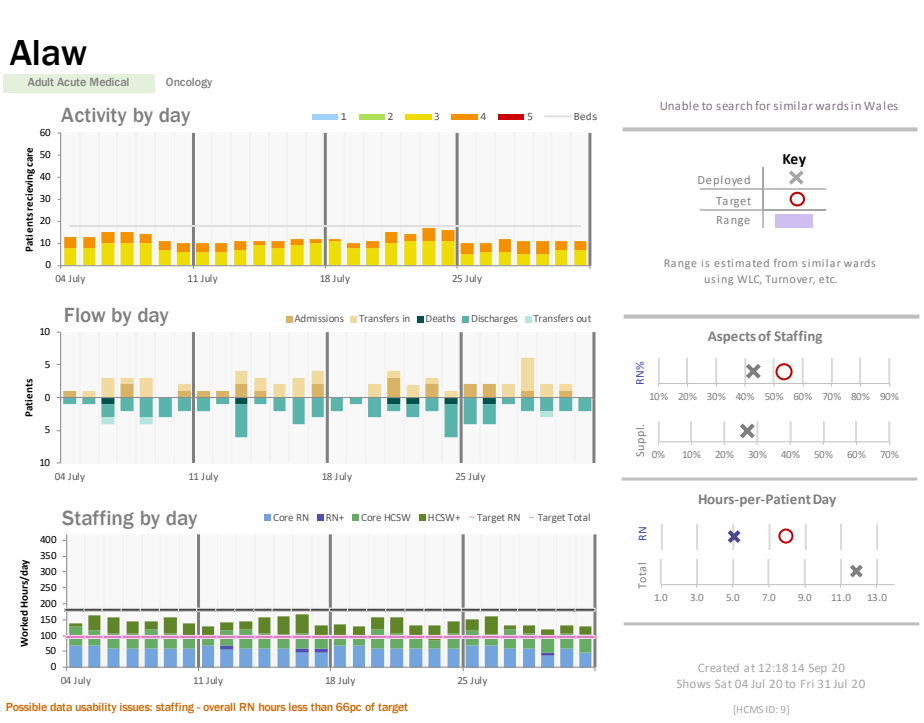


Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

[HCMS ID: 240]

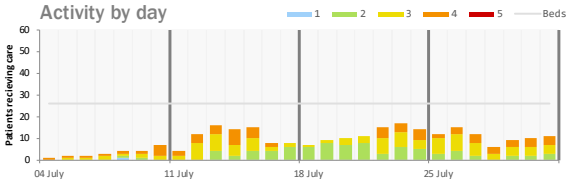


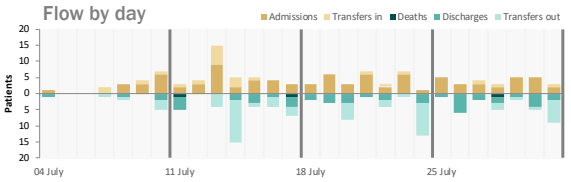
Ysbyty Gwynedd

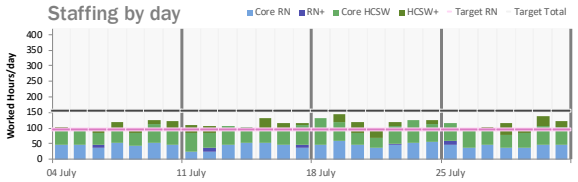


Aran

Adult Acute Unknown | Medical COVID ward. 14 x positive COVID beds and 12 x suspicious COVID beds ...

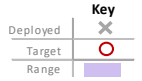




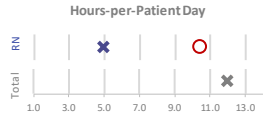


Possible data usability issues: acuity - NHPPD greater than 30, manage - missing specialty, staffing - overall RN hours

Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.

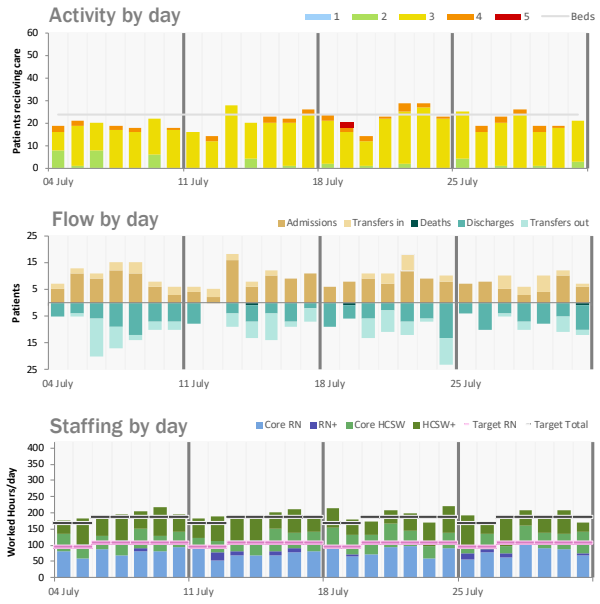


Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

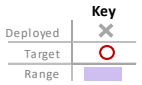
[HCMS ID: 1202]

Conwy (SAU)

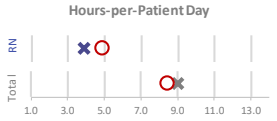
Non-§25B Surgical Surical with Medical Short Stay beds - changes made during COVID pandemic ther...



Unable to search for similar wards in Wales



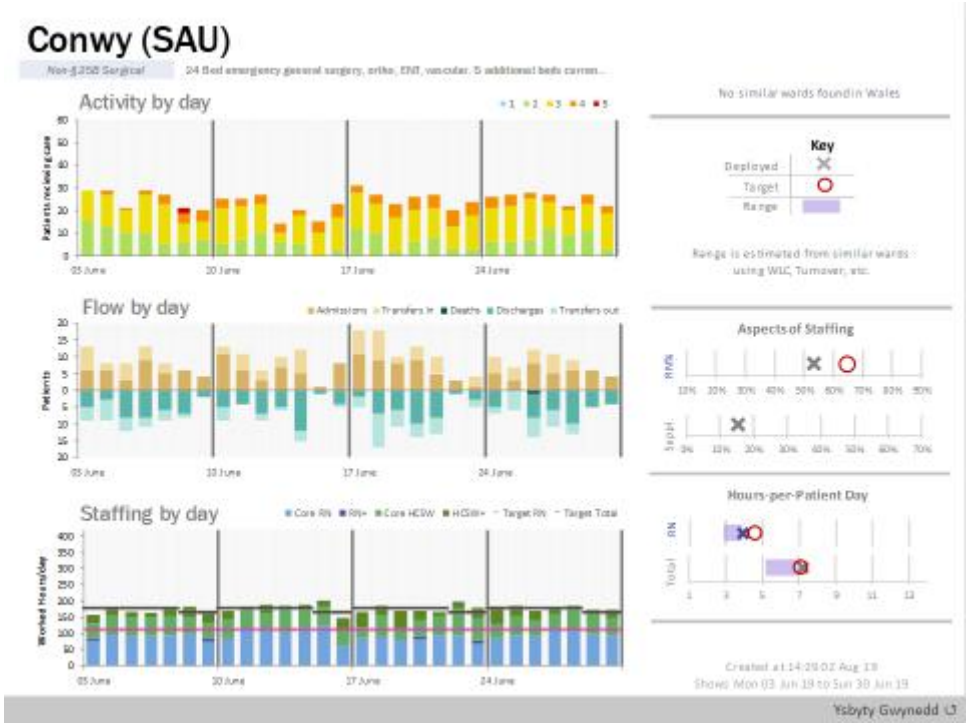
Range is estimated from similar wards using WLC, Turnover, etc.



Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

[HCMS ID: 279]

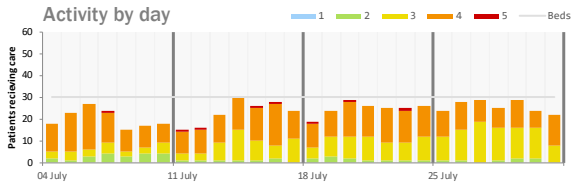
Conwy (SAU)

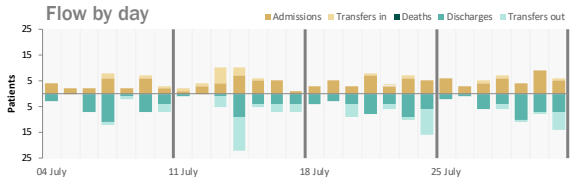


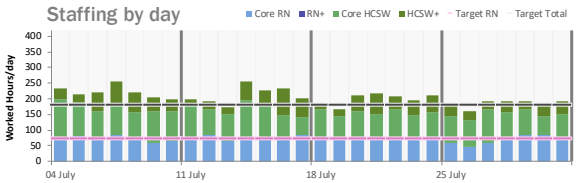
Dulas

Adult Acute Surgical

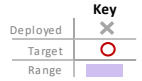
During COVID pandemic- Dulas became the Orth Ward with some ENT beds.



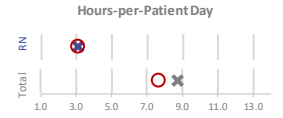




Unable to search for similar wards in Wales



Range is estimated from similar wards using WLC, Turnover, etc.



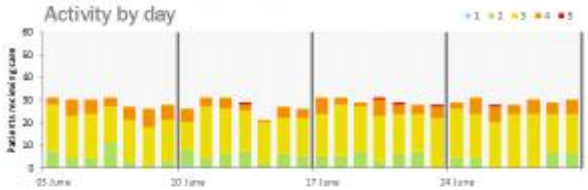
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

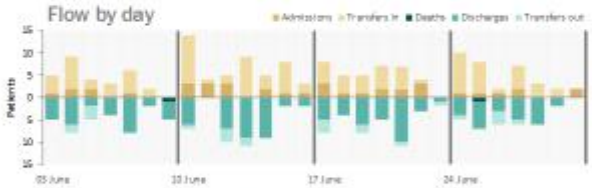
[HCMS ID: 22]

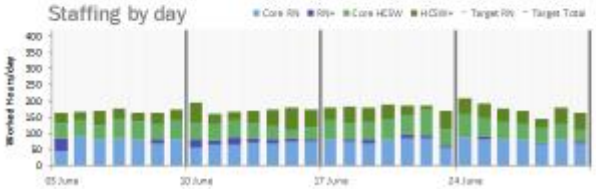
Dulas

Adult Acute Surgical

Vascular & ENT & outlying capacity from other wards. When the escalation capac...

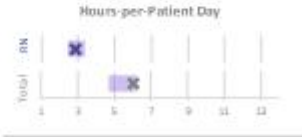






4 similar wards found in Wales

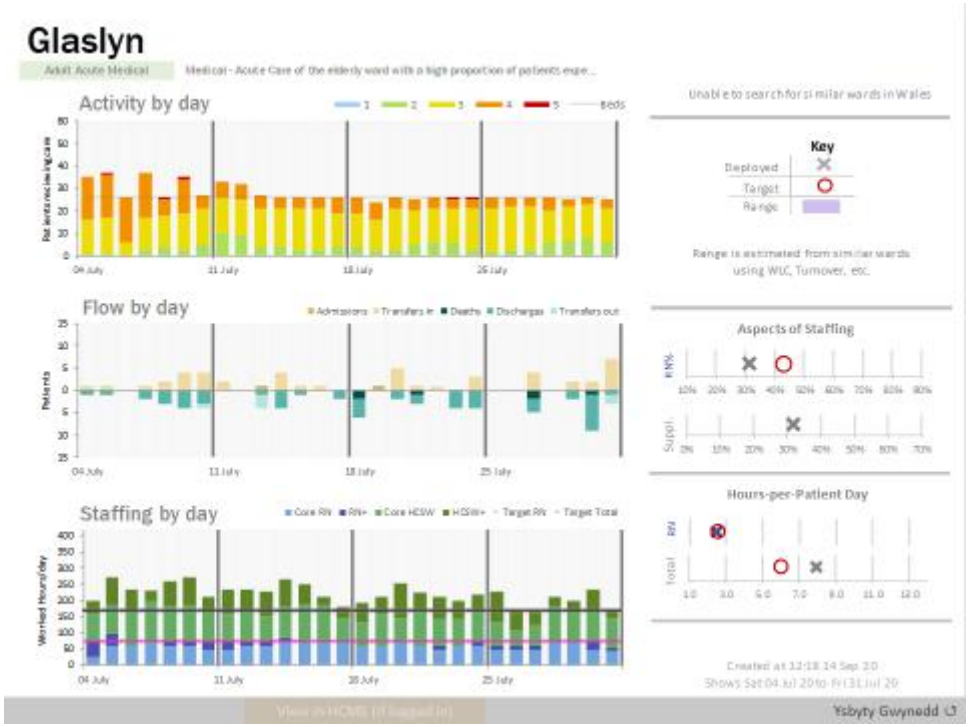
Range is estimated from similar wards using WLC, Turnover, etc.

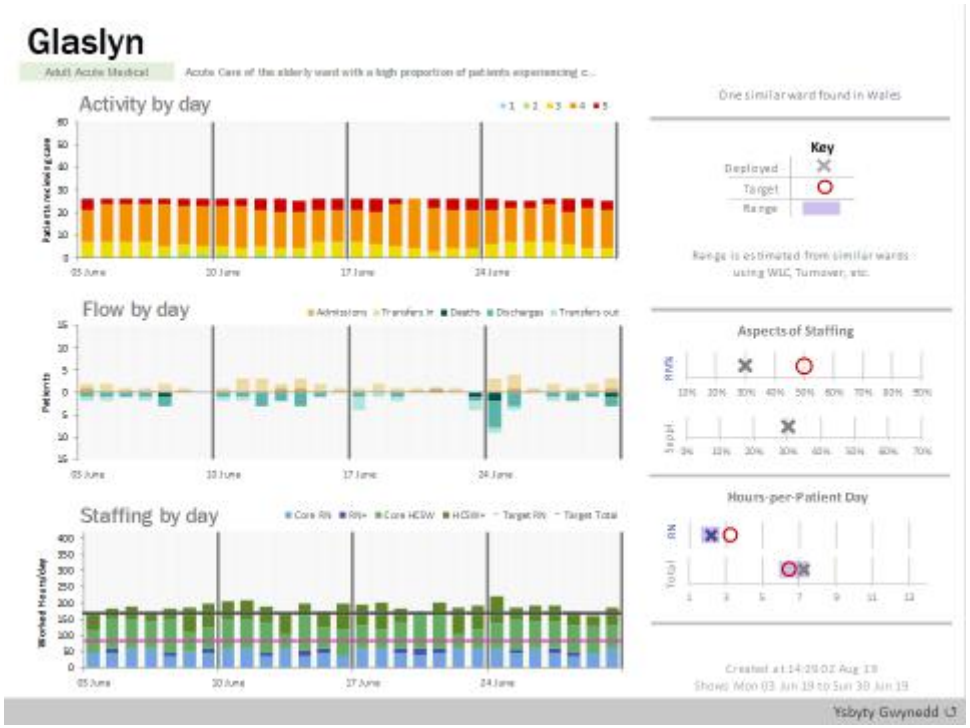


Created at 14:29:02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19

Ysbyty Gwynedd


Enlli
Adult Acute Surgical
elective orthopaedic ward
Activity by day
Flow by day
Staffing by day
One similar ward found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
RN%
Total
Hours-per-Patient Day
RN
Total
Created at 14:29:02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Gwynedd


Glaslyn
Adult Acute Medical
Medical - Acute Care of the elderly ward with a high proportion of patients expe...
Activity by day
1
2
3
4
5
Beds
Patients receiving care
04 July
11 July
18 July
25 July
Flow by day
Admissions
Transfers in
Deaths
Discharges
Transfers out
Patients
Staffing by day
Core RN
RN+
Core HCSW
HCSW+
Target RN
Target Total
Worked Hours/day
Unable to search for similar wards in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
RN%
Suppl.
Hours-per-Patient Day
RN
Total
Created at 12:18:14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20
Ysbyty Gwynedd


Glaslyn
Adult Acute Medical
Acute Care of the elderly ward with a high proportion of patients experiencing c...
Activity by day
1
2
3
4
5
Patients receiving care
05 June
10 June
17 June
24 June
Flow by day
Admissions
Transfers in
Deaths
Discharges
Transfers out
Patients
Staffing by day
Core RN
RN+
Core HCSW
HCSW+
Target RN
Target Total
Worked Hours/day
One similar ward found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
RN%
Suppl.
Hours-per-Patient Day
RN
Total
Created at 14:29:02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Gwynedd


Glyder
Adult Acute Medical
Medical - cardiology ward
Activity by day
Flow by day
Staffing by day
Unable to search for similar wards in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20
Ysbyty Gwynedd

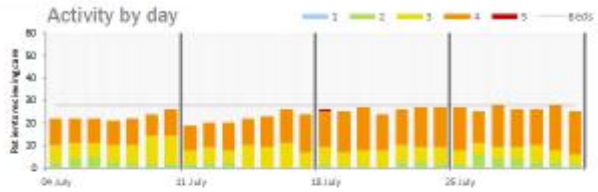

Glyder
Adult Acute Medical
cardiology ward
Activity by day
Flow by day
Staffing by day
One similar ward found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Gwynedd

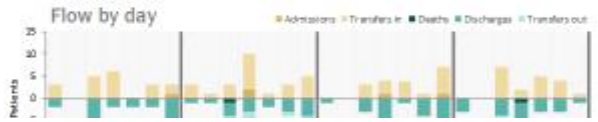

Hebog
Adult Acute Medical
Medical - renal ward with 4 x bed acute renal unit for acute dialysis
Activity by day
Flow by day
Staffing by day
Unable to search for similar wards in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20
Ysbyty Gwynedd


Hebog
Adult Acute Medical
renal ward with 4 x bed acute renal unit for acute dialysis
Activity by day
Flow by day
Staffing by day
3 similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Gwynedd

Moelwyn

Adult Acute Medical | Medical - Respiratory ward with acute NIV bay (4 x beds) during periods of h...



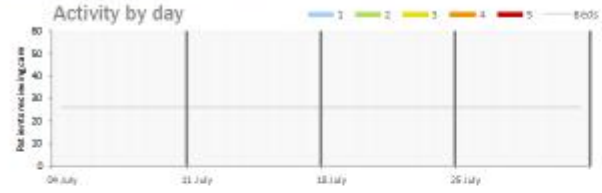


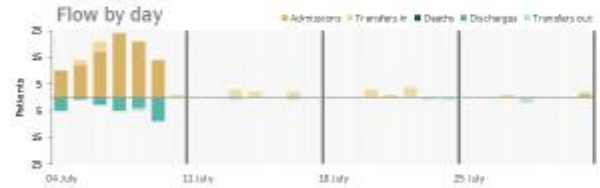
Unable to search for similar wards in Wales

Range is estimated from similar wards using WLC, Turnover, etc.

Ogwen

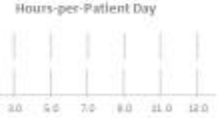
Adult Acute Surgical | Surgical - orthopaedic acute ward- predominantly care of the elderly





Unable to search for similar wards in Wales

Range is estimated from similar wards using WLC, Turnover, etc.



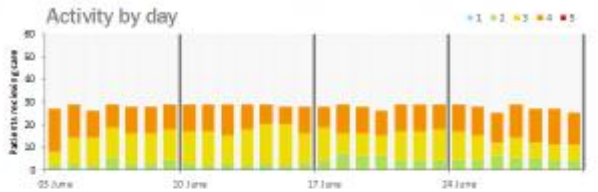
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20

View in HOMS (if logged in)

Ysbyty Gwynedd

Moelwyn

Adult Acute Medical | Respiratory ward with acute NIV bay (4 x beds) during periods of high escalat...

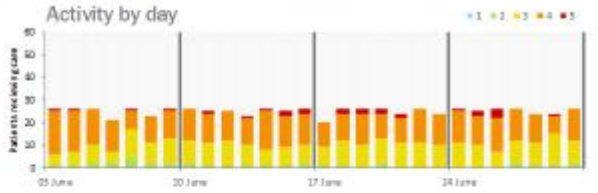


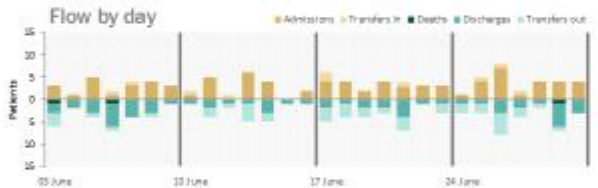
8 similar wards found in Wales

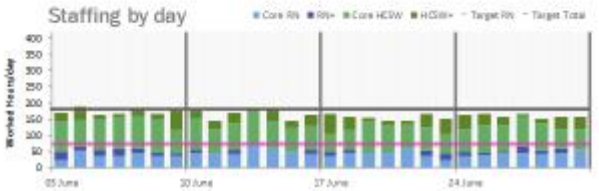
Range is estimated from similar wards using WLC, Turnover, etc.

Ogwen

Adult Acute Medical | orthopaedic acute ward- predominantly care of the elderly







5 similar wards found in Wales

Range is estimated from similar wards using WLC, Turnover, etc.

Created at 14:29:02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19

Ysbyty Gwynedd


Prysor
Adult Acute Medical
Medical - Acute Stroke Unit - 1x acute stroke bed for thrombolysis
Activity by day
Flow by day
Staffing by day
Unable to search for similar wards in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20
Ysbyty Gwynedd


Prysor
Adult Acute Medical
Acute Stroke Unit - 1x acute stroke bed for thrombolysis
Activity by day
Flow by day
Staffing by day
2 similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Created at 14:26 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Gwynedd


Tegid
Adult Acute Surgical
acute colo rectal surgical ward with some urology patients
Activity by day
Beds
Flow by day
Admissions
Transfers in
Deaths
Discharges
Transfers out
Patients
Staffing by day
Core RN
RN+
Core HCSW
HCSW+
Target RN
Target Total
Worked Hours/day
04 July
11 July
18 July
25 July
Unable to search for similar wards in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
RN%
Suppl
Hours-per-Patient Day
RN
Total
Created at 12:18 14 Sep 20
Shows Sat 04 Jul 20 to Fri 31 Jul 20
Ysbyty Gwynedd


Tegid
Adult Acute Surgical
acute colo rectal surgical ward with some urology patients
Activity by day
Flow by day
Admissions
Transfers in
Deaths
Discharges
Transfers out
Patients
Staffing by day
Core RN
RN+
Core HCSW
HCSW+
Target RN
Target Total
Worked Hours/day
05 June
10 June
17 June
24 June
4 similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
RN%
Suppl
Hours-per-Patient Day
RN
Total
Created at 14:29 02 Aug 19
Shows Mon 03 Jun 19 to Sun 30 Jun 19
Ysbyty Gwynedd


Tryfan
Adult Acute Medical
Activity by day
Flow by day
Staffing by day
Unable to search for similar wards in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Ysbyty Gwynedd


Tryfan
Adult Acute Medical
Activity by day
Flow by day
Staffing by day
7 similar wards found in Wales
Key
Deployed
Target
Range
Range is estimated from similar wards using WLC, Turnover, etc.
Aspects of Staffing
Hours-per-Patient Day
Ysbyty Gwynedd

	Annual Presentation of Nurse Staffing Levels to the Board
Health board	**Betsi Cadwaladr University Health Board (BCUHB)**
Date of annual presentation of Nurse Staffing Levels to Board	**3rd November 2020**
Period covered	**November 2019 to October 2020**
Number and identity of section 25B wards during the reporting period. • **Adult acute medical inpatient wards** • **Adult acute surgical inpatient wards** (Ref: paragraph 26-30)	**Please see appendix 5.1, Summary of Nurse Staffing Levels for wards where Section 25B applies**
Using the triangulated approach to calculate the nurse staffing level on section 25B wards (Ref: paragraph 31-45)	**Triangulation Methodology** The following approach has been used as the underpinning methodology for the calculations **Acuity** Quality and Professional Judgement (site level) Nurse staffing review meetings with the Ward Sisters, Matron, Heads of Nursing, Site Directors of Nursing and Finance officers undertook a confirm and challenge approach reviewing the above evidence documented in appendix 5.1 of the Nurse Staffing Act guidance alongside: • capacity • current establishments - funded and actual • incidents • complaints / feedback • additional service demands • skills mix • COVID 19 first wave learning **1. Quality and Professional Judgement (BCU Acute Site comparison)** The above information has been reviewed collectively with the Site Directors of Nursing, Interim Secondary Care Director of Nursing alongside external Peer support. The Interim Executive Director of

Nursing & Midwifery has verified the rationale for changes within establishments leading to final approval. Thus formulating a professional judgment of the staffing requirements for designated medical and surgical adult inpatient area who meet the 25B requirements.

Evidence of uplift at 26.9% Finance
Nurse staffing is calculated using the nationally agreed template.
All of the acute adult medical and surgical inpatient wards have a 26.9% uplift for Band 5 Registered Nurses and above, Health Care Support Workers have an uplift of 22%.

Evidence of supernumerary/leadership (both funded and the extent on which this is achieved).

As detailed BCUHB is fully compliant with 25B financial calculation requirements.
Band 7 Ward Sisters are not included in the care delivery numbers for their respective ward areas
The electronic system used within the Health Board captures when the Ward Manager was not assigned the supernumerary shift due to supporting clinical care delivery numbers.

Evidence of engagement with the nursing management structure

The above information has been reviewed collectively with the Site Directors of Nursing, Interim Secondary Care Director of Nursing alongside external Peer support. The Interim Executive Director of Nursing & Midwifery has verified the rationale for changes within establishments leading to final approval. Thus formulating a professional judgment of the staffing requirements for designated medical and surgical adult inpatient area who meet the 25B requirements.

Title of meeting	Date	In attendance
Bi-annual nurse staffing triangulation meetings	August – September 2020	Ward Manager Matron

			Head of Nursing Site Director of Nursing
	Internal Peer Review of bi-annual nurse staffing triangulation outcomes	October 2020	Interim Executive Director of Nursing and Midwifery Site Director of Nursing YWM, YGC and YG Interim Secondary Care Nurse Director
	External Peer review of bi-annual nurse staffing triangulation outcomes	October 2020	Site Director of Nursing YWM, YGC and YG Interim Secondary Care Nurse Director Associate Chief Nurse, The Royal Wolverhampton, NHS Trust
Finance and workforce implications	In light of the dynamic and rapidly changing pace attributed to winter pressures, COVID 19 2nd wave, surge capacity and staffing shortfalls due to shielding, self isolation etc BCUHB has proactively looked at ways of maintaining sufficient nurses to allow time to sensitively care for patients and meet their health needs, ensuring that all reasonable steps have been taken to maintain safe planned nurse staffing levels. Anticipating the nature of the winter pressures and COVID 19 pandemic a dynamic staff recruitment, up skilling and deployment response was/is required. BUCHB, Workforce and Organisational Development departments is working closely with senior nursing and midwifery colleagues to maximise recruitment and retention of nursing and midwifery staff. In support of		

	this work a BCUHB wide Nurse recruitment and retention group meets monthly and oversees a comprehensive work plan. Highlight of ongoing activities are as follows: - Rolling ward / role specific adverts - Recruitment diary planned throughout the year - International recruitment with 40 Nurses in the pipeline, and planning further interviews to source 50 more - Streamlining programme to appoint Student Nurses as seamlessly as possible - Rolling adverts for bank registered Nurses and Health Care Support Workers to support substantive workforce with additional flexibility - Recruitment clinics to support managers to progress vacancies - Promotion of vacancies through social media. To support the existing recruitment campaign BCUHB worked with Bangor and Glyndwr University to encourage people who have been previously registered with the NMC to return to nursing. Alongside this there was/is an active recruitment of public volunteers to support substantive workforce Internally BCUHB provides a range of up skilling opportunities for nursing teams, non-clinical staff, allied health professionals and public volunteers which further facilitated the Health Boards response to the 2nd wave To support deployment decisions each registrant staff member on the electronic staff record have been assigned a competency level to support appropriate deployment. The workforce team developed a high level dashboard capturing detail from the electronic staff rosters for all areas across the Health Board to support decision making. Designated Electronic system (Safe Care) used by nurse in charge of all ward to capture staffing, acuity and professional judgement 3 times a day. Detail supports continuous decision making regarding staffing and deployment

	All decisions regarding deployment were made on a risk assessed basis.

Conclusion & Recommendations	
	• BCUHB are fully compliant with the bi annual calculation for 25B wards • The dynamic and moving nature of repurposed wards due to Covid-19 makes it difficult to determine which wards met the 25B criteria and progress to annual triangulation as required • The activity, acuity and quality data for repurposed wards cannot be compared to support a comprehensive triangulation • There is a lack of confidence regarding the data for triangulation of repurposed wards that meet the 25B requirements however the professional judgement internal and external peer review undertaken provide assurance regarding the identified nursing staffing • There remains uncertainty whether the Welsh Level of Care workforce planning tool can be applied to wards given that they would be significantly different environments. • The NMC and HEIW decision to allow student nurses to opt in to support clinical areas is reflected positively in the nurse staffing per day and this is reflected throughout the Health Board. • The nurse staffing bi-annual reviews identified an increase in the reported level 3 and 4 of the Welsh Level of Care. This is reflected throughout the Health Boards in Wales and attributed to the increased enhanced observation needs of frail, elderly patients who may not be able to progress their care due to COVID 19 isolation guidance for care homes. • The workforce optimisation plans to support ongoing recruitment and retention initiatives, provide a level of stability and look to further strengthen clinical leadership, particularly in the more difficult to recruit to wards where there has been a conversion of a Band 5 to a Band 6 post. • A recruitment and retention initiative of grow your own HCSW development pathways to achieve level 4 qualification and/or pursue further opportunity to become a registrant has been a proven success. • The focus on creating band 4 opportunities across the Health Board has provided the continued development opportunities for the HCSW and additional support to our existing registrant workforce.

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

Health Board/Trust:	Name: Betsi Cadwalader UHB	
Period being reported on :	Start date: 1st April 2020	End Date: Sept 30th 2020
Number of wards where section 25B has applied during the period:	**Medical:**	**Surgical:**
	YWM 9	**YWM 4**

To be completed for EVERY wards where section 25B has applied

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

Ward	Planned Roster			Required Establishment at the start of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the end of the reporting period (Sept 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Morris	E	4	4	17.29	17.8	Yes	E	4	4	17.29	17.8	Yes	Yes	No		No	No	
	L	4	3				L	4	3									
	LD						LD											
	TW						TW											
	N	2	3				N	2	3									
Mason (in Erddig ward template)	E	4	3	20.01	16.39	Yes	E	4	3	20.01	16.39	Yes	Yes	No		No	No	
	L	4	3				L	4	3									
	LD						LD											
	TW						TW											
	N	3	3				N	3	3									
Evington	E	4	4	15.81	15.20	Yes	E	4	4	15.81	15.20	Yes	Yes	No		Yes	Yes	October 20 post biannual review – increase in patient safety incidents noted, additional
	L	3	3				L	3	3									
	LD						LD											
	TW						TW											
	N	2	2				N	2	2									

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

																		HCSW support requested
Erddig (on PoW template)	**E**	**5**	**4**	**25.70**	**17.80**	**Yes**	**E**	**5**	**4**	**25.70**	**17.80**	**Yes**	**Yes**	**No**	Establishment reviewed for COVID-19 high care CPAP area - Based on PoW template currently. No adjustment needed due to acuity of patients – CPAP/NIV	**No**	**No**	
	L	**5**	**3**				**L**	**5**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**4**	**3**				**N**	**4**	**3**									
Cunliffe	**E**	**4**	**3**	**20.01**	**13.77**	**Yes**	**E**	**4**	**3**	**20.01**	**13.77**	**Yes**	**Yes**	**No**		**No**	**No**	
	L	**4**	**3**				**L**	**4**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**3**	**2**				**N**	**3**	**2**									
Bromfield	**E**	**2**	**1**	**11.37**	**5.46**	**Yes**	**E**	**2**	**1**	**11.37**	**5.46**	**Yes**	**Yes**	**No**	N.B. Currently Bromfield not in use as Act Ward due to COVID-19. Staff supporting COVID-19 areas and service re-provided on Bonney	**NA**	**NA**	
	L	**2**	**1**				**L**	**2**	**1**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**1**				**N**	**2**	**1**									
Bersham	**E**	**5**	**3**	**25.70**	**13.77**	**Yes**	**E**	**5**	**3**	**25.70**	**13.77**	**Yes**	**Yes**	**No**		**No**	**No**	
	L	**5**	**3**				**L**	**5**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**4**	**2**				**N**	**4**	**2**									
ACU	**E**	**6**	**3**	**31.38**	**13.77**	**Yes**	**E**	**6**	**3**	**31.38**	**13.77**	**Yes**	**Yes**	**No**	4 beds allocated for CCU	**No**	**No**	
	L	**6**	**3**				**L**	**6**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**5**	**2**				**N**	**5**	**2**									
Bonney COVID-19	**E**	**4**	**4**	**22.70**	**21.86**	**Yes**	**E**	**4**	**4**	**22.70**	**21.86**	**Yes**	**Yes**	**No**	Repurposed gynae ward as COVID-19 cohort ward. Staffing allocated accordingly from Arrivals/Bromfield staff but not fully funded complement for inpatient area 24/7. Supplemented from staffing from other areas.	**No**	**No**	
	L	**4**	**4**				**L**	**4**	**4**									
	LD						**LD**											
	TW						**TW**											
	N	**4**	**4**				**N**	**4**	**4**									

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

														Currently reported within Bromfield within outcome of nurse staffing bi-annual calculations			
Fleming	**E**	**6**	**3**	**28.66**	**16.39**	**Yes**	**E**	**6**	**3**	**28.66**	**16.39**	**Yes**	**Yes**	**No**		**No**	**No**	
	L	**6**	**3**				**L**	**6**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**4**	**3**				**N**	**4**	**3**									
ENT	**E**	**3**	**2**	**14.33**	**10.09**	**Yes**	**E**	**2**	**2**	**11.37**	**10.09**	**Yes**	**Yes**	**Yes**	Reduction in beds due to social distancing	**No**	**No**	
	L	**3**	**2**				**L**	**2**	**2**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**2**				**N**	**2**	**2**									
Pantomime trauma (currently on Mason template)	**E**	**4**	**6**	**20.01**	**23.51**	**Yes**	**E**	**4**	**6**	**20.01**	**23.51**	**Yes**	**Yes**	**No**		**No**	**No**	
	L	**4**	**5**				**L**	**4**	**5**									
	LD						**LD**											
	TW						**TW**											
	N	**3**	**3**				**N**	**3**	**3**									
Prince of Wales ward 21 funded	**E**			**15.21**	**11.93**	**Yes**	**E**			**15.21**	**11.93**	**Yes**	**No**	**No**	Ward not operational in usual capacity due to step down of activity for COVID-19 response.	**No**	**No**	
	L						**L**											
	LD						**LD**											
	TW						**TW**											
	N						**N**											
2nd ward template for COVID-19	**E**	**4**	**4**	**22.70**	**21.86**	**Yes**	**E**	**4**	**4**	**22.70**	**21.86**	**Yes**	**Yes**	**No**	Staffing assessment for 2nd surge COVID-19 ward completed	**No**	**No**	
	L	**4**	**4**				**L**	**4**	**4**									
	LD						**LD**											
	TW						**TW**											
	N	**4**	**4**				**N**	**4**	**4**									

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

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

Health Board/Trust:	Name: Betsi Cadwalader UHB	
Period being reported on :	Start date: 01.04.2020	End Date: 30.09.2020
Number of wards where section 25B has applied during the period:	**Medical: 8**	**Surgical: 4**

To be completed for EVERY wards where section 25B has applied

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

Ward	Planned Roster			Required Establishment at the start of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the end of the reporting period (September 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 3	E	3	2	18.06	8.2	Yes	E	3	3	17.34	13.10	Yes	Yes	No	Uplift in HCSW following 2020 establishment review. High acuity , high dependency ward with this patient client group. Review impact in relation to quality improvement, patient experience and staff retention in 6 months.	No	No	
	L	3	2				L	3	3									
	LD						LD											
	TW						TW											
	N	3	1				N	3	2									
Ward 5	E	5	4	24.33	15.49	Yes	E	5	4	22.79	17.19	Yes	Yes	No	Uplift in HCA at night following 2020 establishment review.	No	No	
	L	5	3				L	5	3									
	LD						LD											
	TW						TW											
	N	3	2				N	3	3									

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Ward 7	**E**	**5**	**4**	**20.07**	**19.59**	**Yes**	**E**	**5**	**4**	**21.61**	**18.33**	**Yes**	**Yes**	**No**	High acuity and dependency. Uplift in RN at night time following 2020 establishment review.	**No**	**No**	
	L	**4**	**4**				**L**	**4**	**4**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**3**				**N**	**3**	**3**									
Ward 8	**E**	**4**	**3**	**18.53**	**14.01**	**Yes**	**E**	**4**	**3**	**20.07**	**15.71**	**Yes**	**Yes**	**No**	Post operative acuity. Uplift establishment to 3 RN's at night. Ward has 2 RN vacancies pre up lift. Extra HCA to support night shift whist recruitment initiatives proceed	**No**	**No**	
	L	**4**	**3**				**L**	**4**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**2**				**N**	**3**	**3**									
Ward 6 ABH						**Yes**						**Yes**	**No**	**No**	Pre covid adult acute ward where section 25B applied. Elective orthopaedic inpatient services not yet resumed and therefore will not form part of this review.	**No**	**No**	
Ward 1	**E**	**4**	**3**	**18.53**	**14.01**	**Yes**	**E**	**4**	**3**	**20.07**	**15.71**	**Yes**	**Yes**	**No**	Acuity, KPI triangulation. September 2020 Calculation	**No**	**No**	
	L	**4**	**3**				**L**	**4**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**2**				**N**	**3**	**3**									
Ward 2	**E**	**4**	**3**	**18.53**	**14.01**	**Yes**	**E**	**4**	**3**	**17.34**	**15.71**	**Yes**	**Yes**	**No**	Acuity, KPI triangulation. September 2020 Calculation	**No**	**No**	
	L	**4**	**3**				**L**	**4**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**2**				**N**	**2**	**3**									
Ward 4	**E**	**4**	**3**	**18.53**	**14.01**	**Yes**	**E**	**4**	**3**	**20.07**	**15.71**	**Yes**	**Yes**	**No**	Acuity, KPI triangulation. September 2020 Calculation Acute medical cardiology. Telemetry monitoring, high acuity area.	**No**	**No**	
	L	**4**	**3**				**L**	**4**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**2**				**N**	**3**	**3**									
Ward 9	**E**	**4**	**3**	**18.53**	**14.01**	**Yes**	**E**	**4**	**3**	**20.07**	**15.71**	**Yes**	**Yes**	**No**	Acuity, KPI triangulation. September 2020 Calculation Acute Gastroenterology – high patient acuity	**No**	**No**	
	L	**4**	**3**				**L**	**4**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**2**				**N**	**3**	**3**									
Ward 11	**E**	**5**	**3**	**18.53**	**12.64**	**Yes**	**E**	**5**	**3**	**25.52**	**15.71**	**Yes**	**Yes**	**No**	Acuity, KPI triangulation. September 2020 Calculation Acute respiratory Non Invasive ventilation – 1:2 ratio for NIV patients – high acuity area.	**No**	**No**	
	L	**5**	**3**				**L**	**5**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**3**	**2**				**N**	**4**	**3**									
Ward 12	**E**	**4**	**3**	**18.53**	**14.01**	**Yes**	**E**	**4**	**3**	**20.07**	**15.71**	**Yes**	**Yes**	**No**	Acuity, KPI triangulation. September 2020 Calculation	**No**	**No**	
	L	**4**	**3**				**L**	**4**	**3**									
	LD						**LD**											

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

	TW						**TW**											
	N	**2**	**2**				**N**	**3**	**3**						In Patient renal ward, peritoneal dialysis, high acuity area.			
Ward 14	**E**	**5**	**3**	**18.53**	**10.91**	**Yes**	**E**	**5**	**3**	**22.79**	**13.09**	**Yes**	**Yes**	**No**	Acuity, KPI triangulation. September 2020 Calculation Acute stroke unit and stroke rehab – high acuity care area. 1:2 ratio in HASU post stroke.	**No**	**No**	
	L	**5**	**2**				**L**	**5**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**3**	**1**				**N**	**3**	**2**									
DOSA escalation – formerly ward 2	**E**	**4**	**3**	**18.53**	**14.01**	**Yes**	**E**	**3**	**4**	**16.57**	**19.61**	**Yes**	**Yes**	**No**	Acuity, KPI triangulation. September 2020 Calculation Variable acuity – layout of ward varies from other areas requiring additional support.	**No**	**No**	
	L	**4**	**3**				**L**	**3**	**4**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**2**				**N**	**2**	**3**									

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

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

Health Board/Trust:	Name: Betsi Cadwalader UHB	
Period being reported on :	Start date: April 1st 2020	End Date: 30th September 2020
Number of wards where section 25B has applied during the period:	**Medical:**	**Surgical:**
	YG 7	**YG 4**

To be completed for EVERY wards where section 25B has applied

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

Ward	Planned Roster April 2020			Required Establishment at the start of the reporting period CURRENT FUNDED WTE		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the end of the reporting period (Sept 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
ARAN	E	5	3	24.07	14.48	Yes	E	5	4	25.58	19.13	Yes	Yes	No	Establishment for Covid 19. Roster amendments due to covid + ward configuration	No	No	
	L	5	3				L	5	4									
	LD						LD											
	TW						TW											
	N	3	2				N	4	3									
GLYDER	E	3	2	14.45	7.44	Yes	E	3	2	12.80	8.19	Yes	Yes	No	Reduction in trained nurse on late shift after NSA meeting and triangulation review of data	No	No	
	L	3	2				L	2	2									
	LD						LD											
	TW						TW											
	N	2	1				N	2	1									
HEBOG	E	6	3	26.56	11.73	Yes	E	6	3	24.77	13.66	Yes	Yes	No	Increase in HCA on nights following of harm data and acuity review	No	No	
	L	6	3				L	6	3									
	LD						LD											
	TW						TW											
	N	3	1				N	3	2									

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															WEEKEND Trained nurse reduction to 5 trained at weekends E/L due to no acute dialysis			
GLASLYN	**E**	**4**	**5**	**17.91**	**23.16**	**Yes**	**E**	**4**	**5**	**19.90**	**21.86**	**Yes**	**Yes**	**No**	Increase of HCA on nights following NSA review of harm data and acuity	**No**	**No**	
	L	**4**	**5**				**L**	**4**	**5**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**3**				**N**	**3**	**3**									
TRYFAN	**E**	**4**	**2**	**20.98**	**8.75**	**Yes**	**E**	**4**	**4**	**19.90**	**15.03**	**Yes**	**Yes**	**No**	HCA increase across 3 shifts due to challenge of gastro patients and acuity of patients	**No**	**No**	
	L	**4**	**2**				**L**	**4**	**3**									
	LD						**LD**											
	TW						**TW**											
	N	**3**	**1**				**N**	**3**	**2**									
PRYSOR	**E**	**3**	**2**	**13.67**	**8.61**	**Yes**	**E**	**3**	**2**	**12.80**	**8.19**	**Yes**	**Yes**	**No**		**No**	**No**	
	L	**2**	**2**				**L**	**2**	**2**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**1**				**N**	**2**	**1**									
DULAS	**E**	**5**	**4**	**22.74**	**16.40**	**Yes**	**E**	**5**	**4**	**22.74**	**19.13**	**Yes**	**Yes**	**No**	Establishment for Covid 19. Increase HCA night shift due to AGP bay- covid related change	**No**	**No**	
	L	**5**	**4**				**L**	**5**	**4**									
	LD						**LD**											
	TW						**TW**											
	N	**3**	**2**				**N**	**3**	**3**									
TEGID	**E**	**6**	**4**	**28.44**	**19.14**	**Yes**	**E**	**5**	**4**	**22.74**	**16.40**	**Yes**	**Yes**	**No**	Establishment for Covid 19. Reduction in trained and HCA (due to staff supporting Tudno elective- covid related change) and introduction of PACU on site	**No**	**No**	
	L	**6**	**4**				**L**	**5**	**4**									
	LD						**LD**											
	TW						**TW**											
	N	**4**	**3**				**N**	**3**	**2**									
OGWEN	**E**	**4**	**5**	**17.36**	**21.86**	**Yes**	**E**	**4**	**5**	**19.90**	**21.86**	**Yes**	**Yes**	**No**	Increase in HCA on nights due to acuity, bay nursing, however discussion regarding 3rd trained on nights rather than increase in HCA's	**No**	**No**	
	L	**4**	**5**				**L**	**4**	**5**									
	LD						**LD**											
	TW						**TW**											
	N	**2**	**3**				**N**	**3**	**3**									
Moelwyn	**E**	**5**	**3**	**24.07**	**13.11**	**Yes**	**E**	**6**	**4**	**31.27**	**16.40**	**Yes**	**Yes**	**No**	Establishment for Covid 19.	**Yes**	**Yes**	Increase of RN due to COVID
	L	**5**	**2**				**L**	**6**	**4**									

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	LD						LD											and reconfiguration of ward / AGP area
	TW						TW											
	N	3	2				N	5	3									
Tudno	E	6	3	**11.90**	**6.09**	**Yes**	E	7	6	**18.68**	**20.69**	**Yes**	**Yes**	**No**	Repurposed ward to provide ring fenced elective surgical beds for screened patients. Changes made following NSA meeting during July NSA meeting	**No**	**No**	
	L	6	3				L	7	6									
	LD						LD											
	TW						TW											
	N						N	3	3									
Enlli	E	3	2	**13.26**	**7.42**	**Yes**	E	3	2	**1.00**	**0.00**	**Yes**	**Yes**	**No**	Currently not in used as Act ward due to Covid-19. Staff deployed to support Critical Care	**No**	**No**	
	L	3	2				L	3	2									
	LD						LD											
	TW						TW											
	N	2	1				N	2	1									

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

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 3rd November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quality Awards
Cyfarwyddwr Cyfrifol: Responsible Director:	Debra Hickman, Acting Executive Director of Nursing & Midwifery
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 Director and Executive Director
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Committee is asked to note this report.

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

Sefyllfa / Situation:

The Committee has requested a briefing paper on quality awards.

The Associate Director of Quality Assurance took on this action in September 2020 and has prepared this paper to respond to the Committee's request with the support of the Assistant Director of Communications and Engagement.

Cefndir / Background:

As with many aspects of the Health Board's activity, the COVID-19 pandemic has impacted upon the formal recognition of excellence and outstanding practice within the organisation and its workforce. During the year 2020, a number staff and services have received recognition, a summary of which is below:

- Staff took part in a UK first online pan-Wales Health Hack event, arranged by Menai Science Park (M-Sparc), The Bevan Commission, MediWales, the Life Sciences Hub and the Health Board that saw staff pitch COVID-19 related projects to an audience of businesses and industry experts. A team led by Ysbyty Gwynedd Anaesthetist, Dr Simon Burnell, won first place and received £5,000 from North Wales' NHS Charity, Awyr Las, and £3,000 from Santander for their project to develop a short-range communication aid for use whilst wearing Personal Protective Equipment (PPE). The project from the MASK-COMMS team is in response to one of many

challenges faced during the pandemic after identifying that face masks in hospital prevented them from communicating effectively.

- The Health Board was once again named as the best ranked Welsh health employer by lesbian, gay, bi and trans equality charity Stonewall in its Top 100 Employers list for 2020. The Health Board has been placed 39th in this year's top 100, and is the second highest ranked of all the NHS organisations in the UK that took part.
- The Dermatology Team at Ysbyty Gwynedd, who have transformed their service over the last two years, are in the running for a prestigious national award. The service, led by Consultant Dermatologist Professor Alex Anstey, is nominated for The British Medical Journal's Dermatology Team of the Year award. In January 2019, an Integrated Dermatology service was created to build a stronger relationship between specialists and GPs in the area, and in turn improve patient care.
- A senior nurse who leads Abergele's District Nurses has been shortlisted for a UK-wide award. Team Leader Amanda Hughes is in the running to win the Nurse Manager of the Year award at the Nursing Times Workforce Awards. The awards are in December 2020.
- A surgeon at Ysbyty Gwynedd has been recognised for providing excellent learning opportunities and improving the surgical skills of his trainees. Consultant Orthopaedic and Trauma Surgeon, Mr Muthu Ganapathi, is nominated for the annual 'Trainer of the Year' award, which is chosen by trainees across Wales. Mr Ganapathi, who has been nominated for the award by one of his former registrars, is the Orthopaedic Education Lead at Ysbyty Gwynedd, and oversees the teaching and training programme for the surgical trainees within the Trauma & Orthopaedic Department.
- A doctor from Ysbyty Gwynedd has been appointed to a prestigious new role within Health Education and Improvement Wales (HEIW), to oversee the delivery of simulation training amongst healthcare workers. Alongside his clinical role, Dr Suman Mitra will take up the new post of Associate Dean for Clinical Skills and Simulation, to establish a faculty network across Wales, and help shape best practice in the delivery of education and training amongst NHS staff. Simulation is a way of delivering education where a real life event or experience is recreated with the aim of providing a safe learning environment, thereby improving safety in patient care.
- A critical care nurse from Wrexham Maelor Hospital who has been described by her colleagues as an 'inspiration' received an award. Senior Sister Jayne Galante was nominated for a Seren Betsi Star award by her colleagues Sister Natasha Corcoran and Sister Joanne Richards. Over the last 18 months Jayne has been fundraising in order to create an outside garden area for her Critical Care patients and their families, and has so far raised almost £15,000. The garden would provide patients with an opportunity to experience leaving the Critical Care Unit for a short period of time and provide a peaceful and private area for them and their families.
- A quick-thinking switchboard operator who helped a caller access care and support in their hour of need was commended with an award. Cheryl Jones, who works at Glan Clwyd Hospital, has won a Seren Betsi Star award after she offered kindness and compassion to a caller experiencing a mental health crisis. Cheryl, who has worked at Glan Clwyd for more than 25 years, kept her caller on the phone for almost 20 minutes while specialist support and advice was secured to help. After accessing mental health services, the caller then got back in touch with the switchboard team to thank Cheryl for her kindness, prompting her line manager Karl Roberts to put her name forward for the award.
- A Speech and Language Therapist who went above and beyond for one of her patients at HMP Berwyn has received an award. Jacqui Learoyd was nominated for a Seren Betsi Star award by Organisational Development Officer Katie Williams, who says she was 'blown away' by the therapist's enthusiasm for her role. Jacqui has been praised for providing support for one of her patients at the Wrexham prison who after listening to the man's story and through assessment,

came to understand that he had a learning difficulty. This was potentially blocking his ability to convey to the parole board why he should be considered for release and no longer deemed a risk to the public.

- Lorraine Gardner, Matron for Maternity Services, Glan Clwyd Hospital, won the Wales and South West England Maternity and Midwifery Festival Midwife Achievement Award.
- Staff were recognised in the Queen's Birthday Honours List. Senior Nurse Anne Thomas who works at Dolgellau Hospital was awarded a British Empire Medal (BEM). Fiona Giraud, Director of Midwifery, was awarded Member of the British Empire (MBE).

Asesiad / Assessment & Analysis

Strategy Implication – Not applicable.

Financial Implications – Not applicable.

Risk Analysis – Not applicable.

Legal and Compliance – Not applicable.

Impact Assessment – Not applicable.

Cyfarfod a dyddiad: Meeting and date:	Quality Safety and Experience (QSE) Committee 3rd November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Health and Safety Quarter 2 Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Green, Executive Director of Workforce and Organisational Development
Awdur yr Adroddiad Report Author:	Pete Bohan, Associate Director of Health, Safety and Equality Sue Morgan, Head of Health and Safety
Craffu blaenorol: Prior Scrutiny:	Strategic Occupational Health and Safety Group 21st October 2020
Atodiadau Appendices:	1. Security and V&A incidents

Argymhelliad / Recommendation:

The Committee is asked to note the position outlined in the Quarter 2 Report and support the actions being taken to delivery against the recommendations agreed by Strategic Occupational Health and Safety Group

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 Quarter 2 report provides an update on the work undertaken by the Corporate Health and Safety (H&S) Team during the period between the 1st of June 2020 and 30th of September 2020. The 2019/20 annual report identified that the BCUHB Health and Safety (H&S) Strategic approach still required considerable work. With the onset of the COVID-19 pandemic in March 2020 the proactive work being undertaken to progress the 3-year strategy was refocused to support staff and patients during this challenging period.

Cefndir / Background:

The gap analysis undertaken in September 2019 identified significant areas of concern in the management of Occupational Health & Safety (OHS) within BCUHB. The OHS Team developed a comprehensive action plan to identify and mitigate the risks identified. This action plan included key areas of risk such as, contractor management and control, work at height, vibration and noise, asbestos, legionella water safety, driver safety, security, violence and aggression (V&A), fire, electrical safety, manual handling and incident reporting procedures to ensure when things do go wrong we learn lessons. These actions will still need to be completed to ensure BCUHB compliance with legislation.

Asesiad / Assessment & Analysis

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 Health & Safety Executive (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 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. The changes outlined in this report due to the COVID-19 pandemic will impact on achieving the OHS 3-year Strategy

Options considered

There are limited alternative options than compliance with legislation. These are the minimum criteria and recommendations identified within the gap analysis and business case provided to the Executive Team that require implementation.

Financial implications

There are significant budgetary implications, which are currently not funded. A business case has been produced and submitted to the Business case review group. This has been built into the financial planning assumptions for quarter 3/4. 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 particularly in Bangor Hospital 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. These risks were initially added onto the risk register under the Corporate Health and Safety Team and will need to be allocated to the functions who hold the responsibility for the management of these risks.

Legal and compliance

Failure to comply with Health and Safety legislation can lead to the increased risk of accidents and incidents occurring and the risk of enforcement action, prosecution, fines and compensation claims.

Impact Assessment

The impact of non-compliance with Health and safety legislation described will have a detrimental effect on staff health, safety and wellbeing at work this includes both physical and mental health.

1. Health and Safety Gap Analysis Action Plan

The full gap analysis action plan was put on hold at the start of the COVID-19 pandemic. In Q2 a Health and Safety workshop was held to recommence the work required to ensure compliance with H&S legislation. Due to the increased workload at this time for the Corporate H&S team the action plan has been reviewed and priorities reallocated. Those areas that sit with Estates including fire safety, asbestos, and control of contractors, working at height, electricity and water management will remain under review by the Estates team supported by the H&S team. The reviewed action plan now has specific subheadings including Security, COVID-19 related H&S work, Manual Handling, RIDDOR and COSHH (with the primary focus on Fit Testing). These actions now form the H&S team objectives for the next 6 – 12 months and will be regularly reviewed and updated with key performance indicators evidenced.

2. Corporate Health and Safety Team Site Visits

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. With the change in the Welsh Government advice in June to 'stay local', this allowed the Corporate H&S team to start undertaking further site visits to support with the 'social distancing and staying safe' program. In Q1, the H&S team undertook 56 site visits and these were either at the request of departments to provide managers with support or to assist with Health and Safety investigations. In Q2 a further 128 site / department visits have been completed. The offer of these site visits was extended to support any manager to undertake a risk assessment for a staff member returning from shielding.

3. Health and Safety frequently asked questions (FAQs) and supporting guidance documents

A full review of guidance documents and supporting risk assessment templates was undertaken towards the end of Q2. These are now being uploaded to the intranet so that the FAQs can be updated and recirculated.

4. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

Information from the HSE, on when an incident is reportable under RIDDOR, has changed since the start of the pandemic and, in Q2 the guidance was amended further. This now gives clearer information on the factors to consider when deciding if an incident is reportable and will support the decision making process of a reportable incident going forward. A link to this is below:
https://www.hse.gov.uk/coronavirus/riddor/riddor-reporting-further-guidance.htm#reasonable

To date the total number of RIDDOR's reported for Q1 and Q2 are 591. This is a significant increase on previous years, which has affected the team's workload.

Quarter 2 reported incidents:

Area	COVID-19 RIDDOR's	Non COVID-19 RIDDOR's	Total Q2 2020	Comparison total Q2 2019
Central	51	9	60	9
West	83	9	92	8
East	144	2	146	10
Totals	278	20	298	27

5. Covid-19 Specific Investigations undertaken in Q2

5.1 Wrexham and Ysbyty Glan Clwyd (YGC) COVID-19 Outbreaks

The Corporate H&S team have supported the Outbreak Control teams during the COVID-19 outbreaks in both Wrexham and YGC. This has included supporting the progression of the Datix reports, 72-hour reviews and Make It Safe reviews, giving advice on elements to be investigated. Also the tracking of case progression for staff investigations and recording of significant events and information. From the information received, a detailed analysis of each staff related incident was undertaken to identify if they were reportable under RIDDOR and where required these reports were sent to the HSE.

The team have provided daily data validation and provision of data for the Workforce Sitrep Slides, along with thematic reporting to the Outbreak Control Teams, to inform the lessons learned and the ongoing work of the Delivery Group. This work has also contributed to the development of the Workforce Standard Operating Procedure.

5.2 HSE Improvement Notice

A RIDDOR report of a Dangerous Occurrence was sent to the HSE on the 28th of May 2020 relating to the partial failure of an FFP3 mask. This report has led to an HSE investigation and subsequently BCUHB received an Improvement Notice on the 24th of August 2020. This Improvement Notice was issued to the Ysbyty Glan Clwyd site, although the accompanying letter confirmed the requirements were BCUHB – wide. The notice refers to three specific sections.

1. Every employee working in higher risk acute care areas with possible or confirmed case(s) of COVID-19 and/or aerosol generating procedures (AGPs) should be face fit tested by a competent face fit tester.
2. Demonstrate that your face fit tests achieve the following minimum requirement defined in the British and European Standard entitled; Respiratory Protective Devices. Selection Use and Maintenance Part 3 Fit Testing Procedures: BS ISO 16975-3:2017, and which are summarised in HSE Guidance on RPE fit testing INDG 479.
3. Demonstrate that your arrangements allow sufficient time to conduct an adequate face fit test procedure

Work had commenced prior to the issuing of the notice and an RPE Task and Finish Group was established reporting directly to the PPE Steering Group. This group is chaired by Corporate H&S and working to recommendations agreed by the Executive Director of Workforce and Organisational Development. BCUHB have purchased 9 new portacount machines to move solely to quantitative testing which is the preferred method as advised by the IP&C team. Fit testers are being retrained to use this method and a program for refitting staff in high risk areas has commenced. Further updates will be provided in the Q3 report.

It is important to note that BCUHB have appealed the issuing of this Improvement Notice. The appeal is based on a number of reasons including the steps already taken and the ongoing progress being made. It is not the intention of this appeal to delay or stop any of the actions that have already been agreed.

6. Datix incidents (Personal Injury)

A total of 2,626 incidents were reported in Q2 under the datix category 'Accident that may result in personal injury incidents'. This is an increase from Q1 where 2,122 incidents were reported and Q4 where there were 1,873 incidents reported in this category**.** These are broken down below into staff, patients and 'other' (which could include contractors, visitors or the public)

	01.01.20-31.03.20 (Q4)	01.04.20 – 30.06.20 (Q1)	01.07.20 – 30.09.20 (Q2)
Total	1,873	2,122	1,872
Staff	353	770 (513 C19 related)	431 (130 C19 related)
Patients	1,484	1,328	1,407
Other	36	24	34

7. Security

The current review of Security & VA Case Management is ongoing with a focus on integration of the two areas looking to achieve a holistic approach and improved service.

7.1 Security related policies and procedures

The following policies are under review:

Policy	Status
V&A Policy	To be presented to SOH&S group Oct 2020
Security policy	To be presented to SOH&S group Oct 2020
CCTV Policy	To be presented to SOH&S group Oct 2020
Lone Working	Draft to be completed 31/01/21
Lockdown	Draft to be completed 31/03/21

7.2 Datix Incidents (Security)

Security Incidents reported in Quarter 2 on the Datix system are largely comparable to those over the previous 2 years. (See attached appendix for more information). In addition to Datix reports, on site security have received the following urgent calls for assistance in the District General Hospitals, (as supplied by Samson security)

Security Bleeps	YG	YGC	WRX M
Q1	354	360	280
Q2	433	478	459

7.3 Security Training
Violence & Aggression training managed by the H&S department is under review, with a focus to integrate Violence & Aggression themes within a more inclusive Security training package. The review is exploring both the content as well as trainer credentials and delivery methods. The current break away training requires a 'hands on' approach which has been suspended during the COVID-19 pandemic, however the E-Learning remains available. Draft findings of Review will be completed by the 31st of December 2020.

7.4 Security Staffing Resources
1 x 0.8WTE V&A Case Manager/Security Manager fully supported by the Head of Health & Safety currently manages security services. To effectively manage the security requirements in BCUHB a business case has been submitted to explore the possibility of 3 full time Security Advisors. 1x Security advisor has been approved for employment on a "bank" basis (awaiting start date)

7.5 Security Management Provision
The provision of security differs across BCUHB with some elements undertaken by Estates and Facilities staff and some provided by an external contractor, Samson Security. This has led to different security management models and some confusion between the role of the Estates security guards and the Patient, Staff and Visitors (PSV) security guards. A meeting has been held with representatives from the Hospital Management Teams to identify a proposed model going forward. The proposed model would see an increase in the security provision to two guards 24/7 on the 3 District General Hospital sites, which would require additional funding. This role would cover both the Estates and PSV provision and having two guards would reduce the risk of lone working. The security provision required for the Community Hospitals will also need to be agreed and the current suggested proposal is for a mobile security team in each area; this does need to be explored and discussed further.

8. Manual Handling

8.1 Training
In addition to the short competency observations reintroduced in Q1, the Level 2 Foundation training course and refresher courses were also restarted in Q2. Risk assessments and Standard Operating Procedures were completed prior to the start of these 'face to face' classroom sessions and modifications made to the training including smaller classrooms and the completion of a workbook prior to attendance. These classes are for both employees and Health Science Students from Universities. Videos for all manual-handling techniques required under the All Wales Manual Handling Passport have been created to provide a blended learning approach. These are now due to be uploaded to the intranet.

The manual handling team remain under resourced from a combination of reduced working hour requests and maternity leave. This has contributed to the delay in the ability to reintroduce Level 1 training via other means than e-learning, which will not be suitable for all staff. The department has not been able to recommence the two-day Champion courses, where staff are upskilled to ensure gold standard manual handling occurs in their workplace, or to provide regular support and group meetings for the existing Champions.

During this quarter, the team were able to provide 76 competency assessments classes, 35 Foundation classes and 130 Refresher classes, offering a total 1,446 places. Although this has been a good start to return to training, this has left a shortfall of 138 places for Level 2 this quarter. These shortfalls will accumulate and potentially leave BCUHB at further risk of untrained staff.

8.2 Datix (Manual Handling)

Datix incidents for manual handling all answered within 7 days, advice is offered and those with any training issues have direct input from the department with further training given and followed up to ensure targeted intervention is effective. All Datix received this quarter have a 75% rate where training issues can be pointed as the cause for reporting.

8.3 Assessments

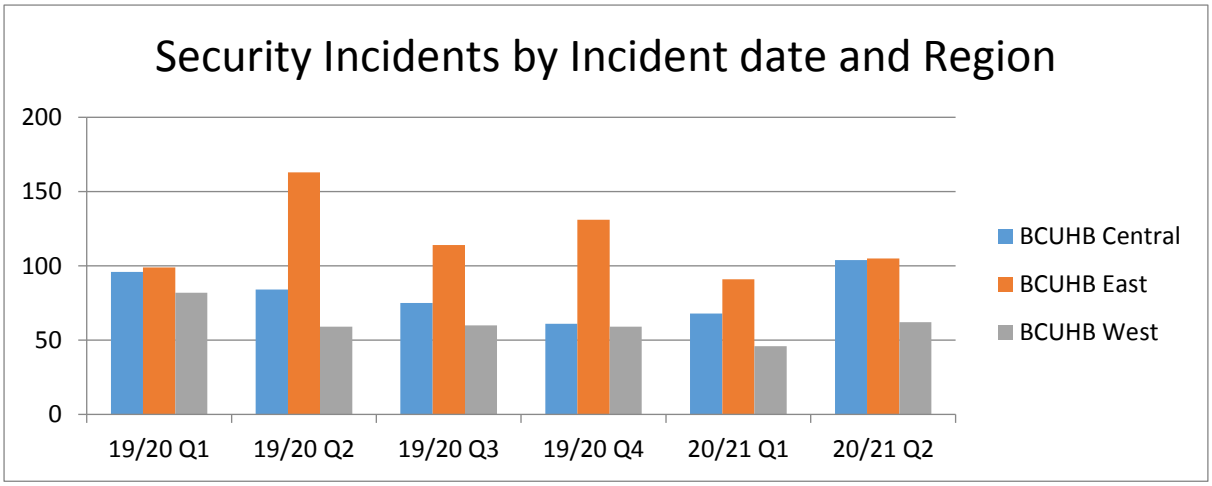
All emails received requesting an assessment are answered within 7 days and the person is seen for an assessment within 4 weeks, with the exception of staff returning to work (seen within 7 days). During this quarter, assessments were conducted again in person, with the exception of areas with local outbreaks or known Covid-19; these were conducted through Skype. Two thirds of assessments conducted have been relating to DSE and it has been noted that there is a slight increase in the requests for assistance for equipment due to agile working**.**

9. Recommendations agreed by the Strategic Occupational Health and Safety Group

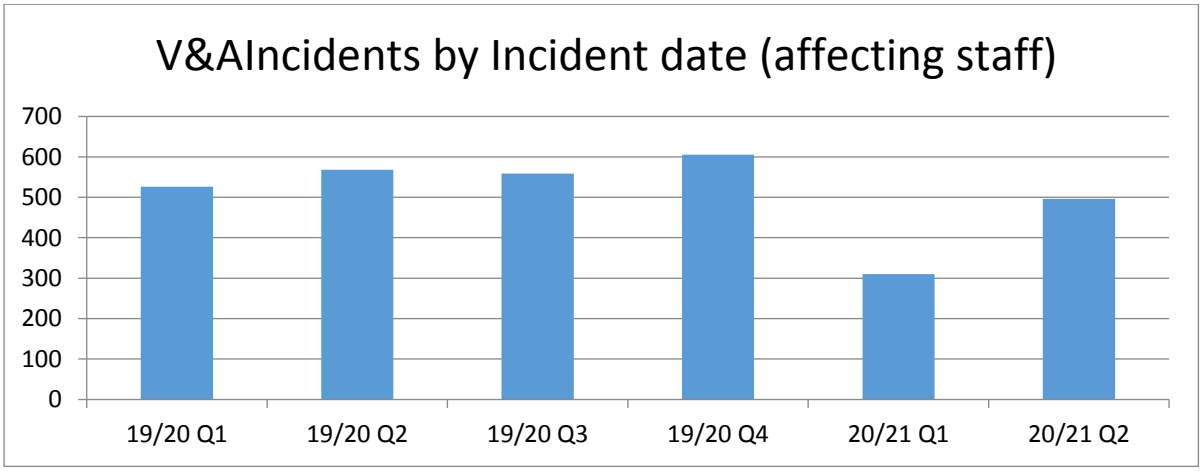
- Ensure adequate staffing is available to provide an appropriate Health and Safety, Security and Manual Handling function to BCUHB
- Establish objectives for the next 6 – 12 months, which are aligned to COVID-19 requirements monitoring systems to measure performance including clear KPIs.
- Learn lessons from incidents and re-introduce RIDDOR training November 2020.
- Implement Policies for Security and review structure and contract.

Appendix 1: Security and V&A figures

Security Incidents			
Financial quarter 19/20	Total	**Financial Quarter 20/21**	Total
19/20 Q1	277	**20/21 Q1**	205
19/20 Q2	306	**20/21 Q2**	271
19/20 Q3	249		
19/20 Q4	251		



Violence and Aggression Incidents			
Financial quarter 19/20	Total	**Financial Quarter 20/21**	Total
19/20 Q1	981	**20/21 Q1**	604
19/20 Q2	953	**20/21 Q2**	989
19/20 Q3	992		
19/20 Q4	1057		



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 3rd November 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Prison Health Update : HMP Berwyn Annual Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Chris Stockport – Executive Director Primary Care & Community Services
Awdur yr Adroddiad Report Author:	Simon Newman, Head of Healthcare. HMP Berwyn
Craffu blaenorol: Prior Scrutiny:	Content shared and scrutinised monthly at HMP Berwyn Quality, safety and Performance meetings in accordance with approved (and included) governance structure. Report also provided to East Area Director.
Atodiadau Appendices:	1. HMP Berwyn Annual Report

Argymhelliad / Recommendation:

The Committee are asked to receive the report for information, noting the ongoing particular areas for attention in the following areas:

1. High level of planned appointments not attended which was highlighted by the Independent Monitoring Board (IMB) report in their annual report which was published in September 2020 – Page 5
2. Increasing waiting list / access to routine dental services at HMP Berwyn – Page 6
3. Upcoming Her Majesty's Inspectorate of Prisons (HMIP) Scrutiny Visit planned for November 2020 – Page 9
4. HMP Berwyn Risk Register – Page 13
5. The Health & Wellbeing Service COVID delivery plan, staged approach in line with Her Majesty's Prison & Probation Service (HMPPS) model – Page 14

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 purpose of this paper is for the QSE committee to be sighted on quality, safety and performance issues in the delivery of our health and wellbeing services at HMP Berwyn

Cefndir / Background:

This is an annual report for QSE committee outlining all aspects of quality, safety and performance in relation to our health and wellbeing services at HMP Berwyn.

Asesiad / Assessment & Analysis

Strategy Implications

Nil to note

Options considered

Nil to note

Financial Implications

There are no financial implications to note. The health and wellbeing services at HMP Berwyn continue to be fully funded by the Ministry of Justice through HMPPS (Her Majestys Prison and Probation Service)

Risk Analysis

Risks related to HMP Berwyn are incorporated in the East Area risk register with the exception of dental service risks which are incorporated in the Central Area register. The risk register is detailed on page 13 of the report.

Legal and Compliance

Nil to note

Impact Assessment

Nil to note

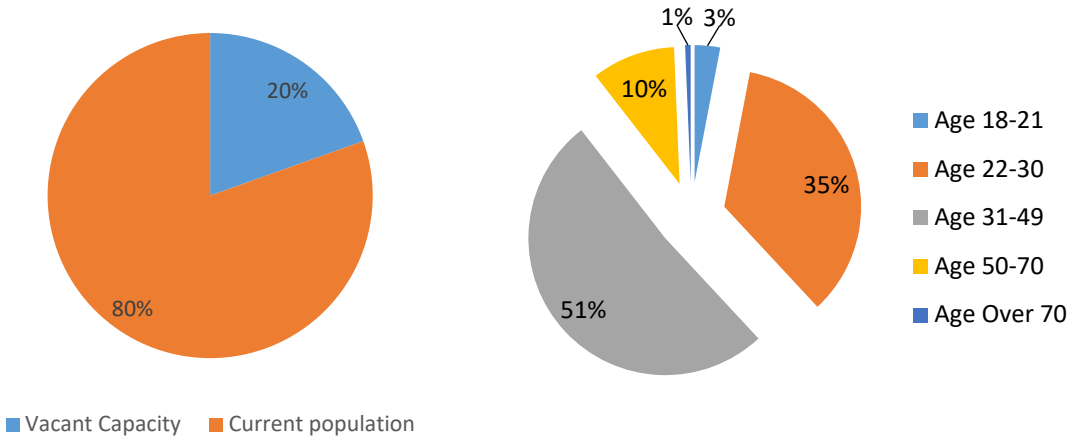
HMP BERWYN ANNUAL REPORT

This report provides the Quality, Safety & Experience Committee an overview of the delivery of the Health and Wellbeing services at HMP Berwyn, identifying current performance, and highlighting any areas for improvement alongside any area of good practice. The report covers 2020 to date (from January – August).

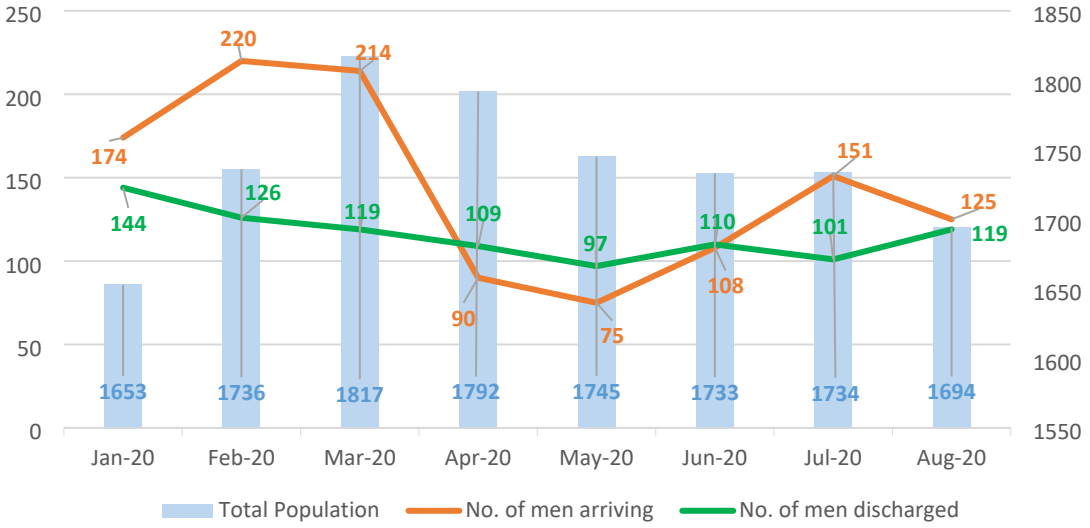
QUALITY

1. Demographics

At end of August 2020 HMP Berwyn's population was 80% of its full capacity. The majority of men remain with the 31-49 age range with 51% of the population within that category in August. This has been consistent since the opening of the prison with appropriately 10% of the population aged over 50. There are currently 11 men over 70 years old and no men over 80 years old.



The number of new arrivals has varied significantly over this year due to a reduction in new arrivals since March 2020 as a result of the Covid-19 pandemic, there was a slight increase in July; however arriving numbers have not increased to pre Covid levels to date. The number of discharges have remained relatively static this year.

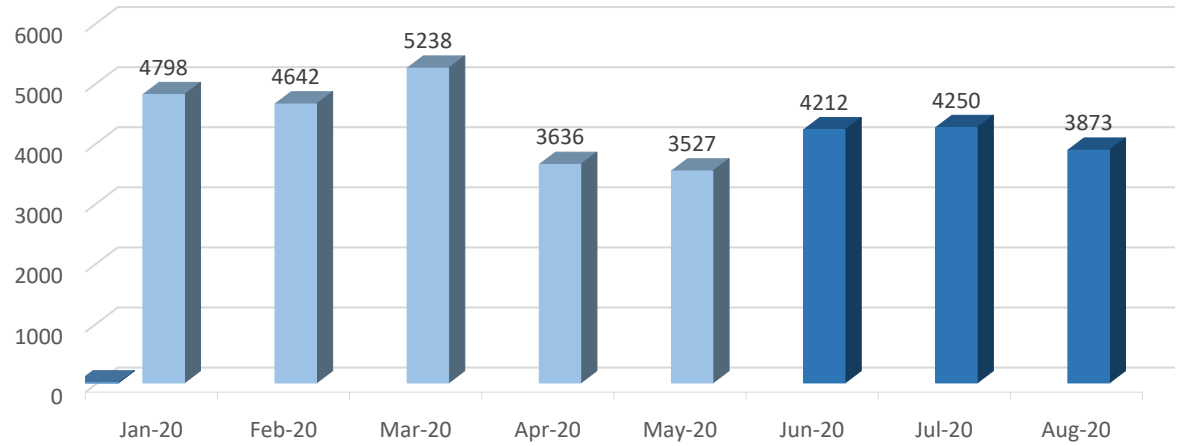


2. Service Delivery

All services listed below are currently on offer to men at HMP Berwyn to access on site, with the exception of dietetics whilst recruitment takes place.

- General Medical/GP led
- Primary Care nurse led clinics (long term condition management, vaccination, wound care etc.)
- Mental Health & Learning Disabilities team inclusive of psychiatry and clinical psychology
- Integrated Substance Misuse (Clinical and Psychosocial)
- Physiotherapy
- Occupational Therapy
- Speech and Language Therapy
- Podiatry
- Audiology
- Radiology
- Dental
- Pharmacy
- Optometry
- Sexual health
- Gastroenterology (Hepatitis C)

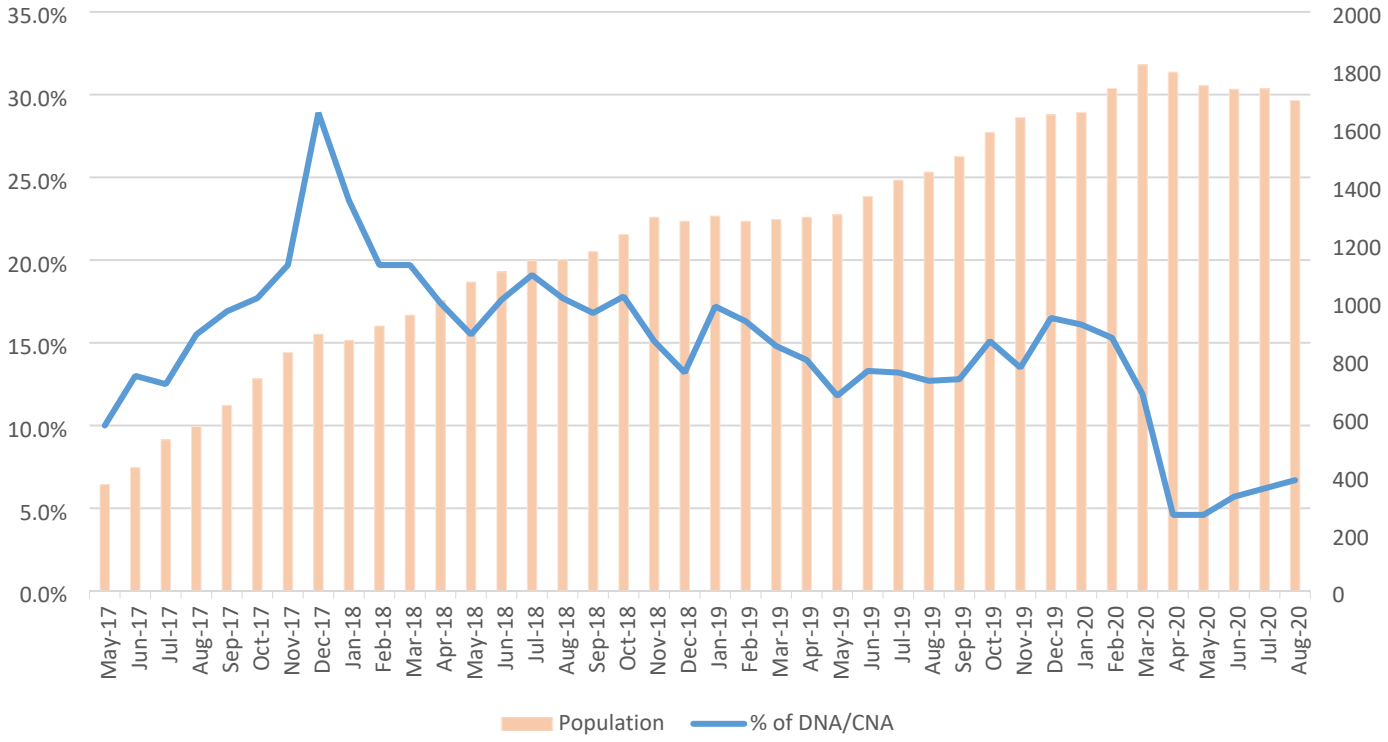
Service activity (as shown in the bar chart below) has increased but remains slightly lower during this current quarter; this has been a result of the reduced activity in place as part of the Covid-19 measures, this particularly relates to the reduction in visiting specialities. However, all services have, and continue to utilise, telephone consultations where appropriate.



Visiting specialities have access to the clinical system (SystmOne) remotely and have been able to access patients and make recommendations remotely. Urgent appointments have been facilitated where necessary.

3. Non-attendance at Health and Wellbeing Appointments

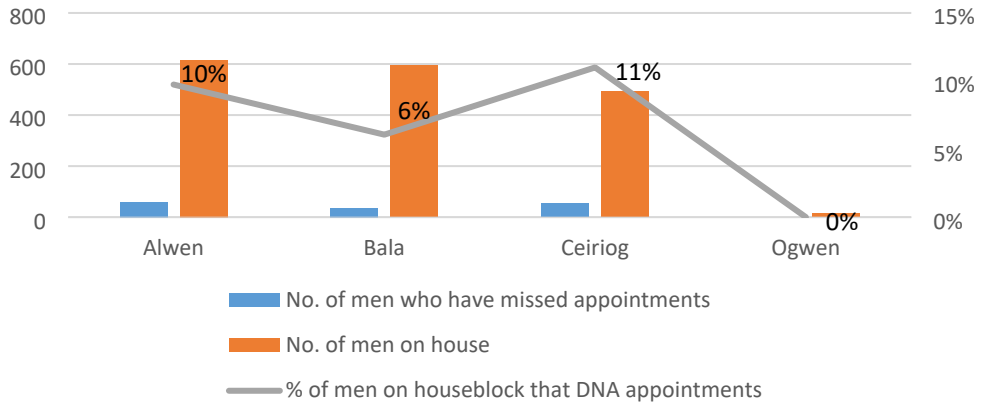
The number of men who have not attended planned Health and Wellbeing appointments has increased in recent months; the current rate is 6.7%.



The increasing Did Not Attend (DNA) appointments is a concern and work is being undertaken to ensure that numbers do not increase to previous levels exceeding 10% when full service activity resumes.

The high number of planned appointments which were not attended was highlighted by the Independent Monitoring Board (IMB) in their annual report as a concern which was published in September 2020.

The chart below show the percentage of men on each houseblock who have missed appointments during August.



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4. Waiting Times

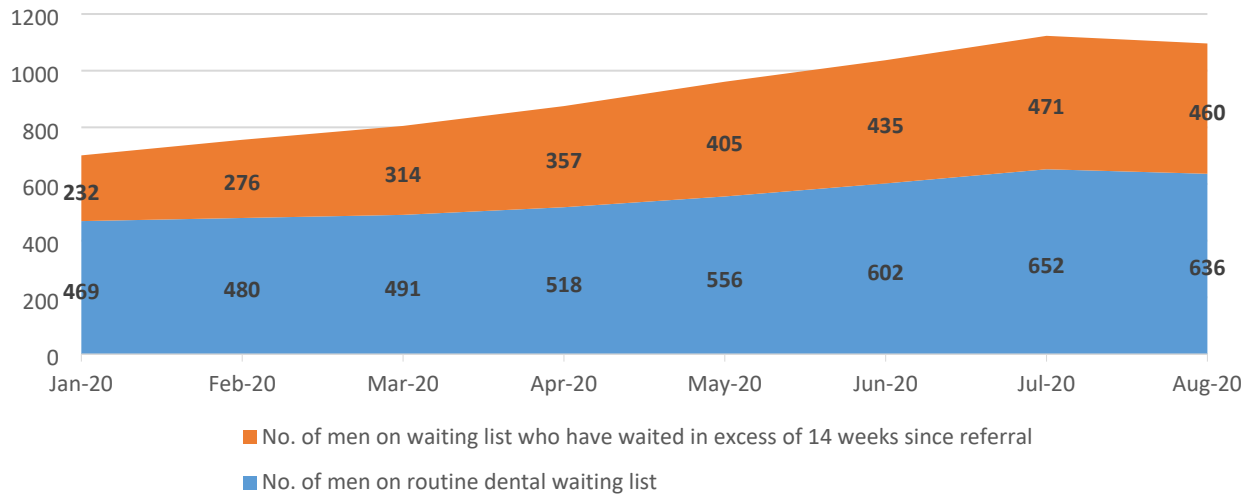
Waiting times for all services have increased due to reduced activity in recent months, with some services now exceeding 14 weeks since application for services.

HMP Berwyn is included in the Health Board submission to Welsh Government for the therapies referral to treatment (RTT) data with a robust process in place to ensure accurate reporting of the on-site therapies services. There have been breaches in some areas, however this has been accepted by Welsh Government due to extenuating circumstances; although the services have significantly reduced the waiting times during this reporting period.

There continues to be a waiting list to see a GP face to face with the current waiting time approx. 5 weeks, however telephone consultations are taking place and urgent same day appointments are available following triage by the nursing team.

The waiting list to see the Dental team for routine appointments has continued to increase during this period, due to no routine work currently being carried out in line with Covid-19 guidance. There were 636 men waiting at month end in August. 460 have been waiting in excess of 14 weeks with 10 men waiting 1 year and 7 weeks since application.

The following chart shows the dental waiting list numbers to date for 2020.

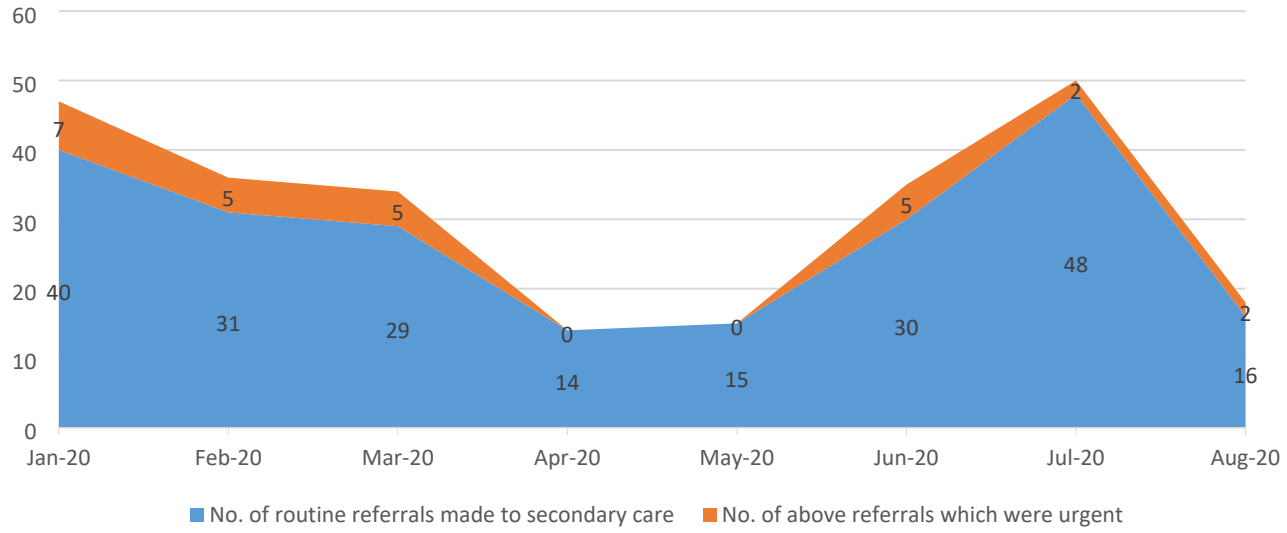


An issue in relation to the ventilation system within the dental surgery at HMP Berwyn could also further impact on access to services and waiting times. An inspection was conducted by ventilation system experts, Airmec, on the heat exchange unit. They have informed the dental team that the unit does not meet standards. The prison contractor, Amey have been informed and dental services will be removed until the situation is rectified. The dental service and HMP Berwyn are identifying solutions to ensure that the impact to patient care is mitigated.

5. Secondary Care

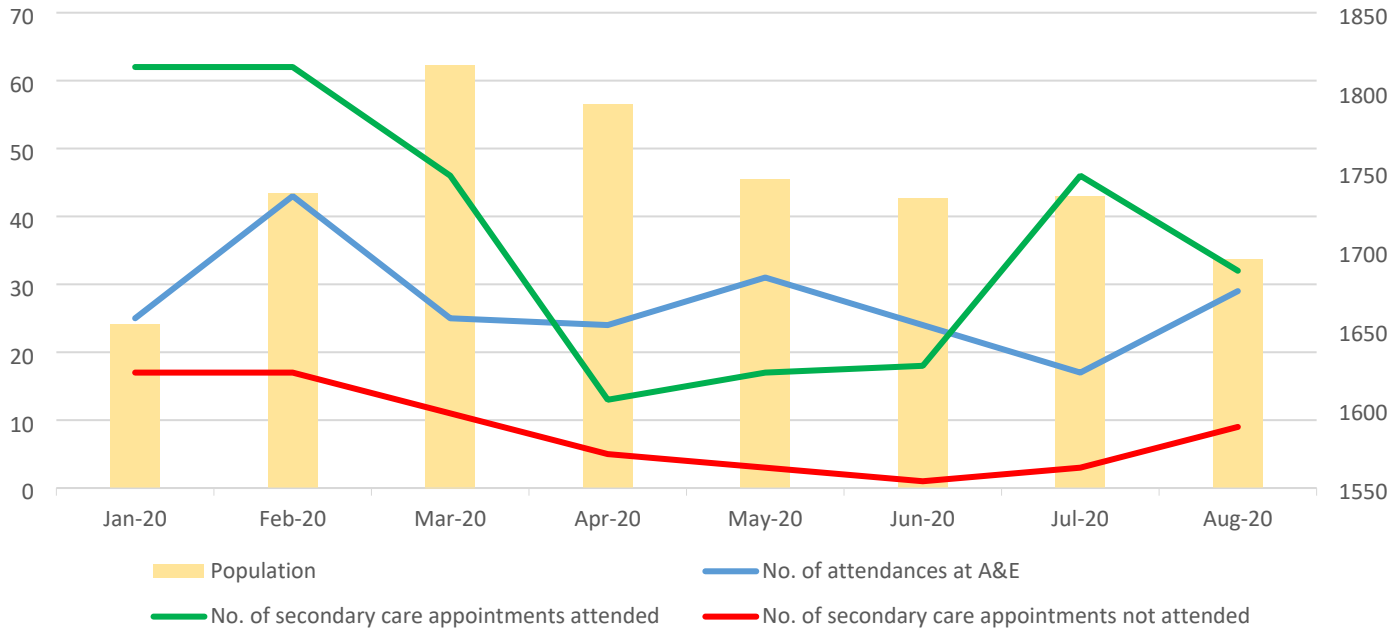
Referrals

The number of referrals made to secondary care remain in line with expected numbers, with a slight decline in during April / May 2020 which was related to reduced face to face activity linked to the impact of Covid-19. All referrals are monitored and reviewed, where necessary by the Lead GP.



Attendance

The number of men attending the local hospital in an emergency has been static since the prison opened in February 2017, with the percentage of men attending Emergency Department (ED) not exceeding 2% of the population since June 2018.



The graph above shows the number of men attending planned outpatient appointments at the local hospital has fluctuated due to reduced appointments being held within the acute settings during the pandemic, the last few months has seen a change in line with increased activity at acute hospitals, as well as a number of telephone consultations also taking place.

The number of men attending the Emergency Department had reduced but has increased to 'normal' activity levels. There has been reduced X-Ray cover over recent months due to a vacancy which has accounted for some of the urgent attendances and increased planned appointments during this period. The successful candidate is due to commence in post mid-September.

Non-attendance

Non-attendance at planned hospital appointments has reduced through the year with a slight increase in August. All non-attendances are highlighted to the Local Health Delivery Group on a monthly basis and information of non-attendance due to prison operational issues is shared with the HMP Berwyn Head of Security for further investigation.

The number of men refusing to attend their appointments is being focused on by the Health and Wellbeing Peer Mentors, with men who refuse to attend being contacted by a Peer Mentor to discuss the consequences of not attending on waiting times, service delivery but also in relation to their health and treatment needs. A number of men have refused to attend external hospital during this period, due to concerns in relation to Covid-19.

SAFETY

6. Governance

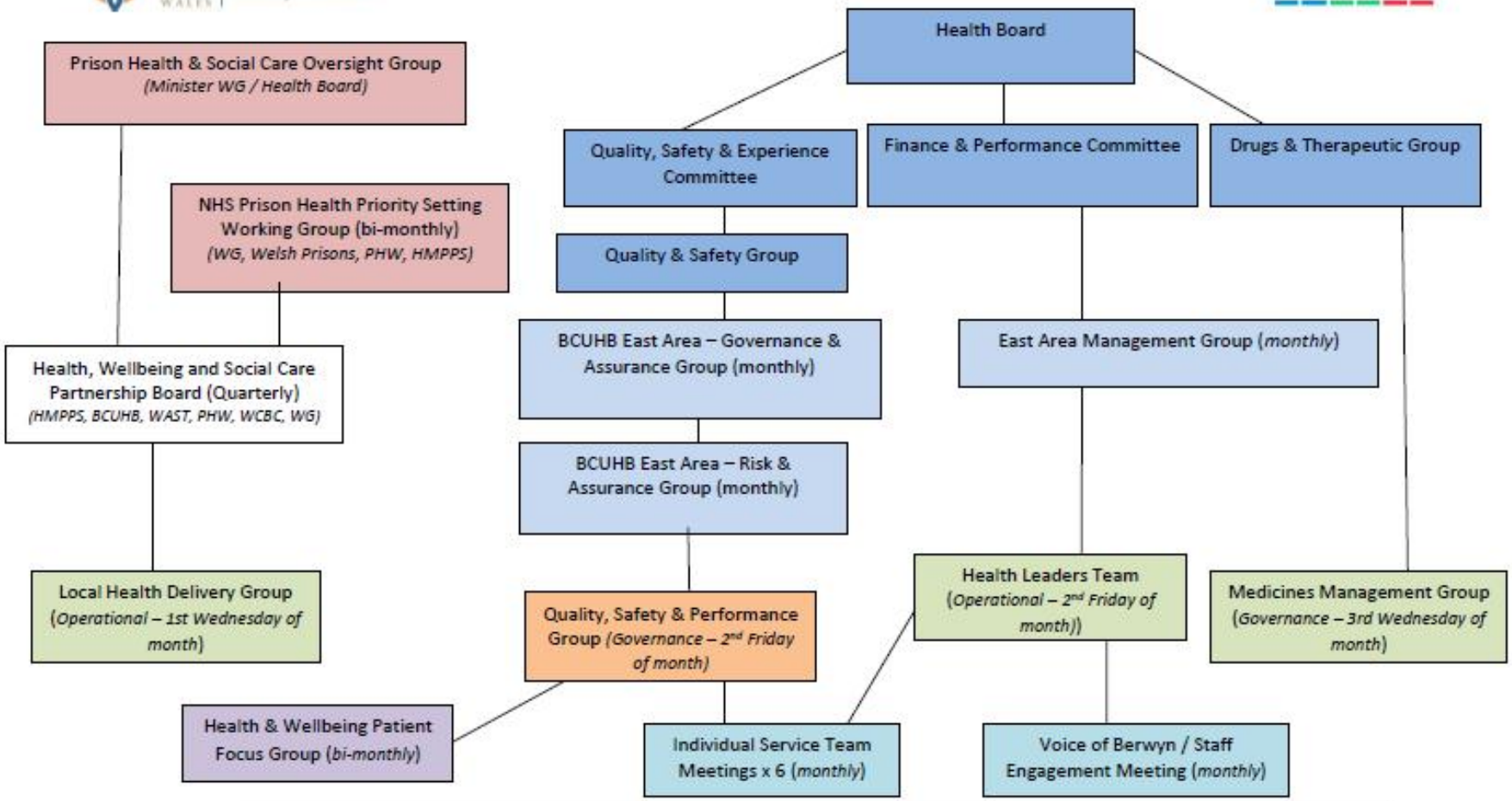
The Health and Wellbeing team at HMP Berwyn follow the governance arrangements detailed in the structure below, with escalation routes through the Health Board and via partnership routes for prison operational issues. All meetings have terms of reference in place which are reviewed annually.

The Health and Wellbeing team provide comprehensive quality, safety and performance reports at all meetings within the governance structure and a monthly report which is shared widely within the Health Board and with Her Majesty's Prison and Probation Service (HMPPS).

In addition to the governance structure detailed below, all prisons within the United Kingdom are subject to inspections by Her Majesty's Inspectorate of Prisons (HMIP) at regular intervals, the inspection is inclusive of health and wellbeing services.

A full inspection of HMP Berwyn was completed in March 2019, but HMIP have now implemented a scrutiny visit schedule to review prisons and how they have managed through the Covid-19 pandemic. For health and wellbeing services, the visit will review service delivery during this period and whether there was a detrimental effect on patient care. The scrutiny visit at HMP Berwyn is planned for w/c 2nd November 2020.

HMP Berwyn Health & Wellbeing Team - Governance Structure

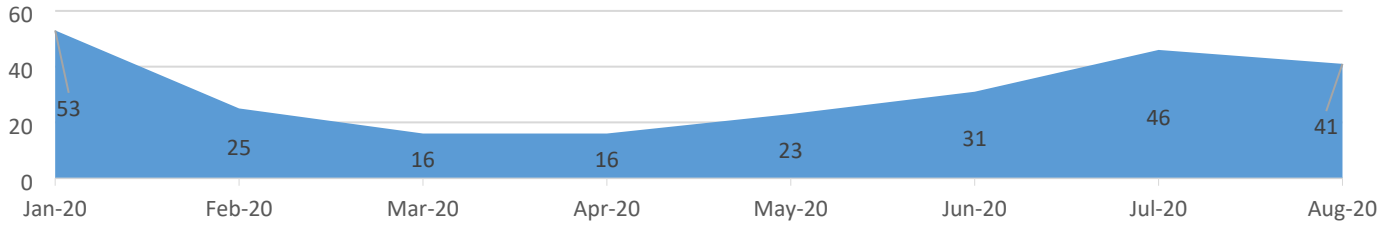


Health Board Meetings attended by Health and Wellbeing Team at HMP Berwyn to demonstrate BCUHB insight of service provision:

BCUHB Patient Records Group and Information Governance Group – attended by Quality, Safety & Performance Manager
Area ***Planning Board*** – attended by Clinical Lead ISMS
Area Divisional Safeguarding Forum – attended by Deputy Head of Healthcare
Infection Prevention Sub Group – attended by Head / Deputy Head of Healthcare

7. Incident Management

The chart below shows the number of incidents reported at HMP Berwyn this year to date.



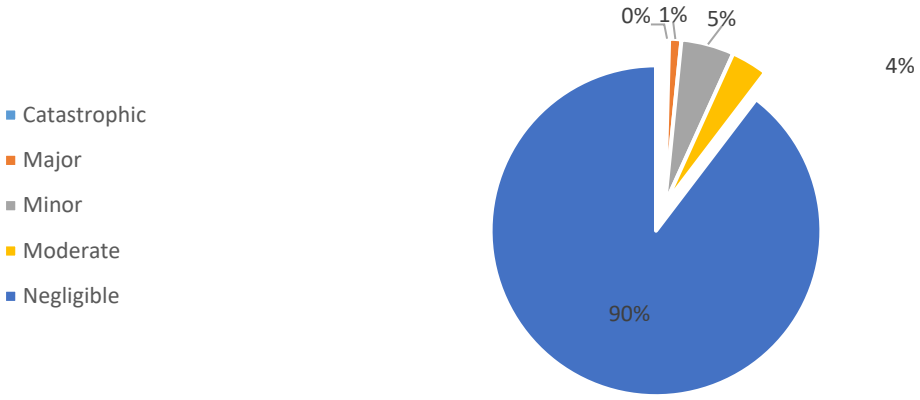
A detailed review of all incidents reported and investigated takes place during the monthly HMP Berwyn Health and Wellbeing Quality, Safety & Performance Group. Lessons learned and best practice are highlighted as part of this review. Any incidents that affect operational delivery are also discussed during the monthly Health Operational Leader's Group.

The top three themes for the incidents reported are below:

- Medication (handling / system issues)
- Issues in relation to lack of prison officer support to enable service delivery
- Service unable to be delivered on site due to no specialist staff available

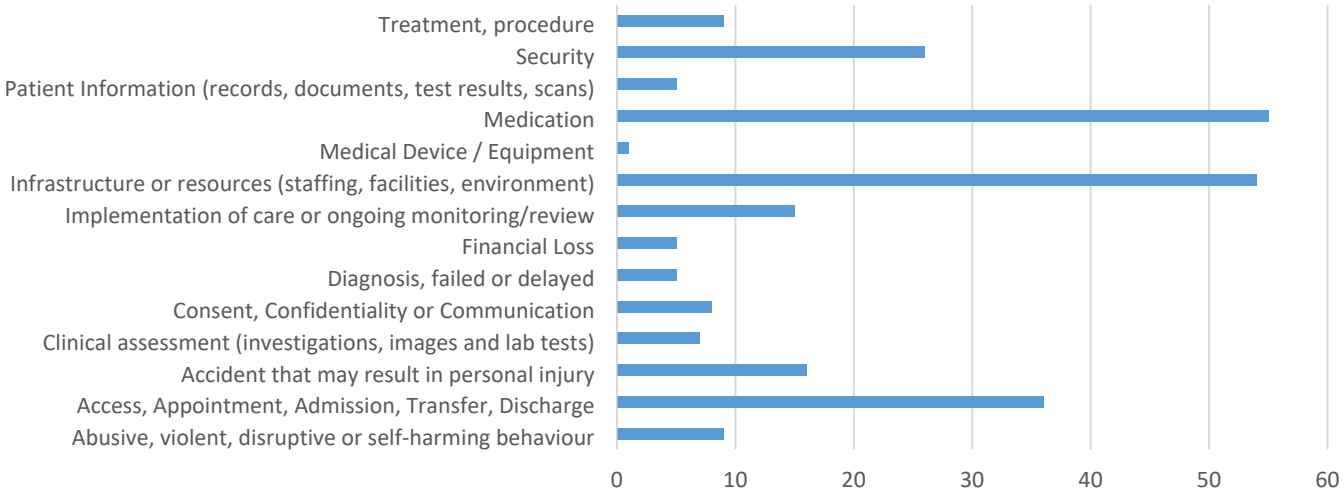
The following graphs relate to all Datix incidents submitted within this year.

Severity of Incident:

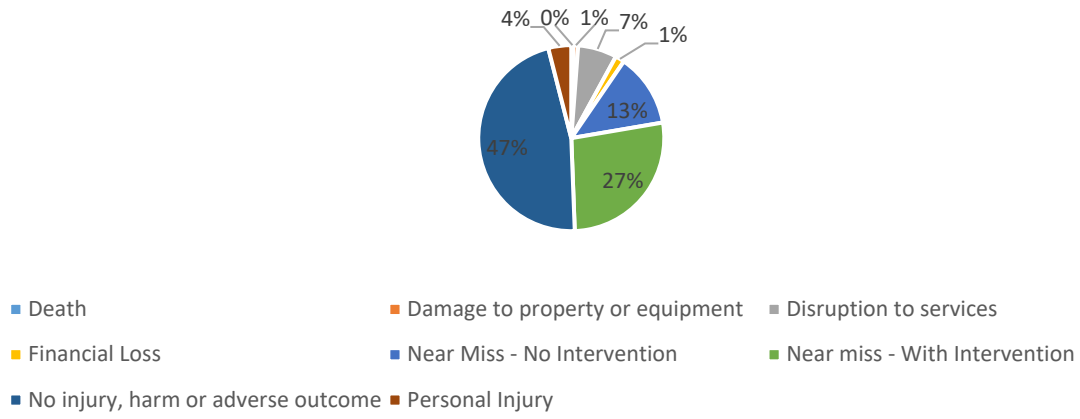


The majority of incidents were classed as negligible, the one incident classed as catastrophic related to a death in custody.

Classification of Incident:



The highest classification of incidents are infrastructure / resources and medication, this is a reoccurring theme. These incidents do not relate to patient risk or harm as the following graph shows, the large majority of incidents reported, 47%, did not cause injury, harm or adverse outcome.



There has been one death in custody within 2020, with seven incident overall since the prison opened in February 2017. All incidents are reported and managed within the 'Datix' system and in depth reviews completed. Any actions identified are reported and monitored through the relevant meetings within the governance structure. Wider East Area health board colleagues are involved in the review to provide an external perspective is applied to the process.

The death in custody which occurred during this reporting period related to a man who resided at HMP Berwyn but unfortunately died at Wrexham Maelor Hospital with cause of death recorded as relapse of chronic lymphocytic leukaemia secondary to SARS-CoV-2. The review was conducted in partnership with colleagues working at Wrexham Maelor Hospital.

8. Risk

A review has been undertaken of all risks within HMP Berwyn Health and Wellbeing risk register in line with the revised BCUHB guidance and scoring matrix as part of the East Area review.

The following risks remain on the HMP Berwyn risk register with the listed scores. The risk register is reviewed at all partnership and governance meetings.

Identifier	Title	Score / Tier
HMP6	Inability to deliver the health and wellbeing services resulting in delayed patient care and potential litigation due to inability to recruit and retain staff.	**Score 15** **Tier 1**
HMP4	Administration of medication is impacting on the delivery of health and wellbeing services and is not being completed during the allocated time slot to support the prison core day / regime.	**Score 12** **Tier 2**
HMP13	The inability to deliver the mental health and learning disability service guided by measure resulting in delayed patient care and potential litigation due to insufficient staff.	**Score 9** **Tier 2**
HMP7	Clinical and administrative rooms in the Health and Wellbeing building and other areas can be accessed by non-healthcare staff.	**Score 3** **Tier 3**

The following risks have been closed following the review for the reasons identified.

HMP12 - Insufficient accommodation to deliver planned service model ***– closed due to HMPPS having plans in place to provide the Health and Wellbeing team with additional accommodation to support effective service delivery.***

HMP14 - Unable to provide registered nurse cover during the night shift ***– closed but issues have been incorporated into HMP6.***

A risk relating to HMP Berwyn and the provision of dental services, as highlighted in point 4 Waiting Times (Page 6) is also on the BCUHB Risk Register and managed by the Dental Service.

9. COVID 19 Recovery Model

In response to Her Majesty's Government and Public Health guidance in relation to Covid-19, Her Majesty's Prison and Probation Service (HMPPS) and The Ministry of Justice (MOJ) developed a national Recovery Framework to return prisons to pre-Covid levels of regime delivery. The aim of the framework was to guide prisons back to normal regime management processes, through a staged model.

This recovery plan below summarises the Health and Wellbeing service plans and proposed timescales for resuming services that were suspended, reduced and amended during Covid-19. The plan aims to align the HMPPS recovery framework alongside BCUHB and Welsh Government guidance on Health Services delivery and recovery.

HMP Berwyn was at Stage 4 through the height of the first peak of the pandemic and is currently at Stage 3. Planning is in place to move to Stage 2 but is currently dependent on national and local restrictions.

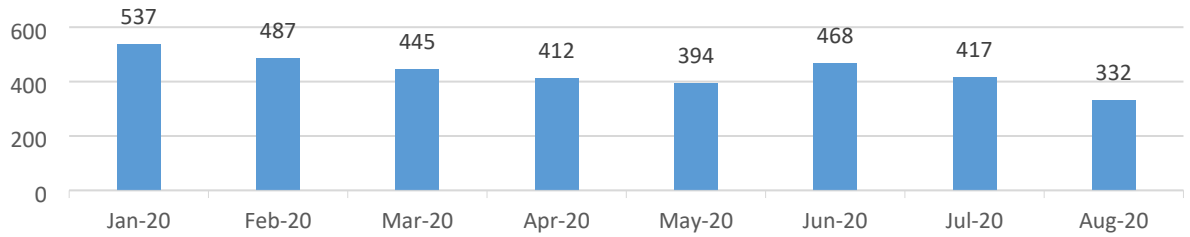
	Overview of Prison Regime	Overview of Health Delivery
STAGE 5 Complete Lockdown	Prison: as 'lockdown' but with an active outbreak ongoing that is not being contained by Level 4 lockdown. Prison staffing levels below minimum for the Exceptional Regime Management Plan (ERMP).	Emergency health service only. Telephone / remote service utilised.
STAGE 4 Lockdown	Prison: Significant number of infections within establishment or prison unable to implement compartmentalisation strategy. National: Significant number of establishments with new infections, which indicates systemic risks are not sufficiently controlled. Community: High levels of community infection and transmission (Alert Level 4/5). Prison staffing levels able to deliver ERMP.	Urgent / emergency appointments only. Telephone / remote service utilised by all teams for review of caseload and triage assessments. Peer Mentors conducting welfare checks for all men on isolation community. Urgent outpatient appointments only.
STAGE 3 Restrict	Prison: All foundations set out above can be met. Assessment is that infection levels in the establishment are under control. National: Small number of establishments with outbreak control teams in place. Community: At or transitioning to Alert Level 3 (epidemic in circulation) or	Non urgent / routine appointments to take place across all services with appropriate Personal Protective Equipment (PPE) / social distancing provision in place (in line with BCUHB guidance). Telephone continues to be utilised for follow ups / triage

	below. Prison staffing levels sufficient to deliver activities set out in Exceptional Delivery Models (EDM) for this Stage, including partner services.	to avoid face to face where appropriate (this will take place during periods of time where access to men is not possible). Dental continues with urgent appointments but also provision of definitive care for those who received urgent care during reduced service. Maintenance of waiting list to address dental problems and symptoms. Specialities visiting from secondary care (Sexual Health, Podiatry, Audiology & Gastroenterology) will resume on site. Some routine outpatient appointments will take place dependent on agreed secondary care processes. Liaison between HMPPS / BCUHB will take place as more information available.
STAGE 2 Reduce	Prison: All foundations set out above can be met. No infection present in the prison, or very low levels were spread is contained. National: infection present only in small number of prisons. Community: At or transitioning to Alert Level 2 (Covid-19 present, but transmission is low) or below. Prison staffing levels sufficient to deliver activities set out in EDMs for this Stage, including partner services.	As above. Dentistry will treat dental conditions with minor / low symptoms. This includes patients who have ongoing treatment need. Group work would recommence with reduced numbers.
STAGE 1 Prepare	Prison: No infection within establishment National: No known infections in prisons. Community: At or transitioning to Alert Level 1 (Covid-19 not known to be present) Prison staffing levels near target and sufficient for normal regime delivery, including partner services.	Pre-Covid level of service delivery across all services. Dentistry will reinstate routine assessments and care. Group work would recommence as pre Covid.

EXPERIENCE

10. Health and Wellbeing Peer Mentors

The Peer Mentor Service continues to receive a high level of contacts (as shown in the bar chart below), with the men finding the service useful. During the Covid-19 period, the Peer Mentors have continued to conduct the service by telephone only which has resulted in reduced numbers. The Peer Mentors have made daily welfare checks to all men who are within the isolation community due to Covid-19; this has been extremely well received by the men.



The Peer Mentors manage a Health and Wellbeing Helpline which is a free telephone call for all men at HMP Berwyn, men are able to cancel their appointments, request information or ask queries in relation to Health and Wellbeing Services. The service is available weekdays from 8.30am – 3.30pm.

The Peer Mentors have received recognition in the form of a 'Hidden Heroes' award which is a HMPPS initiative at HMP Berwyn to recognise those making a positive contribution to the prison. This was nominated by the men at HMP Berwyn for the following reasons:

- For continuing to provide support and assistance throughout the last few months
- For providing information to everyone, including men on the Covid-19 wing
- They are there for people when they are at their lowest to help show their humanity

Comments received by men at HMP Berwyn in relation to the Health and Wellbeing Helpline and Peer Mentor are below:

"you do a really good & important job for all the lads"

"I really appreciate you going out of your way to check on me & help me"

"I asked you because I know I can trust you to get me an answer"

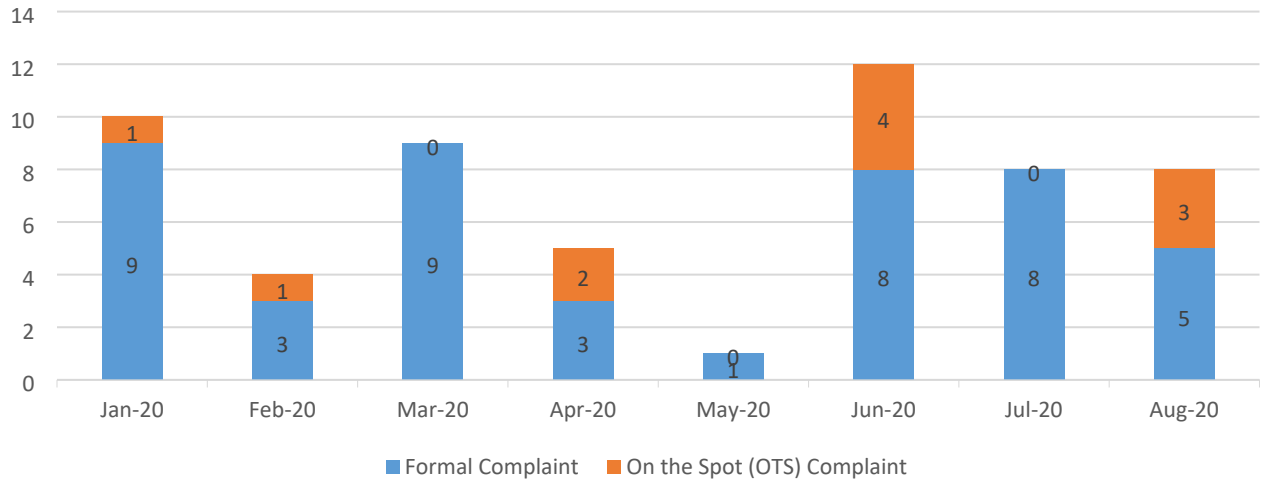
"Can't thank you enough for the time you've taken to listen to me and help me with my problems"

"You're the first person to listen to me and actually try to help me"

11. Complaints

Complaints received by the Health and Wellbeing service at HMP Berwyn continue to be low. The tiered complaints process allows men to contact Health and Wellbeing Peer Mentors in the first instance with any queries or concerns, either in person or through the Health and Wellbeing Helpline. Due to this, there are low numbers of 'On the Spot' and 'Formal' complaints.

The chart below shows the number of complaints received to date this year.



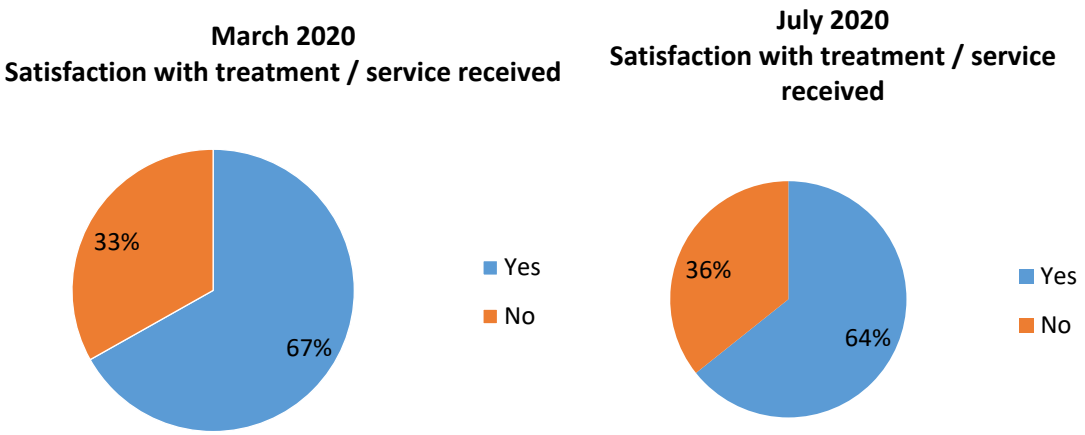
Themes of complaints and concerns raised as both On the Spot and Formal are listed below:

- Waiting time / access to treatment
- Medication
- Concerns in relation to treatment received
- Perceived neglect

12. Patient Feedback

This year has seen the reintroduction of patient surveys; two surveys have been completed this year to date and collect views of men through the UniLink system available in prisons. The response rate has been 32% / 33% of the population, which is a high rate of return within the prison population.

There are a range of questions asked in relation to services generally and areas for improvement, the results of the survey are shared with all residents and staff. The response to the overarching question of whether patients are satisfied with the treatment / service is below.



The surveys were conducted during the Covid-19 pandemic and some of the responses, particularly in the second survey of July 2020 were frustrations in relation to reduced face to face appointments.

Bi-monthly focus groups are held with residents, including Health and Wellbeing Peer Mentors to discuss issues and areas of improvement. During Covid-19 have been unable to hold groups, however we held a meeting with Peer Mentors and asked men to submit any questions in advance of the meeting; these questions were then discussed. A summary of the meeting, including responses to questions and feedback on the Patient Surveys was shared with all men at HMP Berwyn via the UniLink system.

The patient feedback will continue on a quarterly basis.

Chair's Report

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting	Patient Safety and Quality Group
Chair of meeting	Debra Hickman
Date of meeting	09 October 2020
Version number	1
List Appendices, if applicable	None

Reporting To	
Name of meeting	Quality, Safety & Experience (QSE) Committee
Date of meeting	03 November 2020
Presented by	Debra Hickman

1. **Alert –** include all critical issues and issues for escalation

There are no matters for formal escalation.

A number of high risk issues are identified in the assurance section for the Committee to be aware of.

2. **Assurance** – include a summary of all activity of the group for assurance

The Group met for the first time in its new format on 09 October 2020. The group considered and approved the terms of reference and cycle of business which have been submitted to QSE for final approval.

A number of Chair's Reports were received from sub-groups which are summarised below:

Infection Prevention Control (IPC) Steering Group

A risk was noted around the lack of capacity within the IPC Team given the pandemic impact and a business case is being developed. All Welsh Health Boards have seen increases in both Pseudomonas and Clostridium Difficile Infections (CDI). BCU are over trajectory for all organisms except for E.coli. Overall BCU are in-between 2nd & 3rd position for August. 70% of patients are coming into hospital with infection. Klebsiella cases are down 18% to last year compared to all Wales 12%. BCU are less than all Wales numbers per 100k population. Pseudomonas BSIs have also increased in numbers, 46% compared to all Wales down 6%. However there is an all Wales increase recently in Pseudomonas infections possibly related to secondary infections related to Covid-19. Surveillance and intervention is in place. An Environmental Group has been formed.

Personal Protective Equipment (PPE) Steering Group

Communications activity is heavily reliant on electronic channels, which we know many clinical staff do not have easy access to. Greater assurance that leadership is disseminating information to their teams via other means e.g. team meetings, huddles, phone calls is required. There is a risk that there is a breakdown in communication between leaders/managers and their teams resulting in limited assurance that communication messages are being delivered. An update was received around the Health & Safety Executive (HSE) Improvement Notice response and plan. Assurance regarding fit testing compliance remains limited due to manual collation and variable data sets. Electronic solution via the Electronic Staff Record (ESR) for future accredited trainers test outcomes will provide assurance if ESR hierarchy aligned to managers structure. Interim manual process to be followed. Weekly meetings of the group continue.

Medication Safety Group

Lithium carbonate (Priadel) is to be discontinued in April 21. The Mental Health & Learning Disabilities (MHLD) Division have been working closely with Pharmacy & Medicines Management, phlebotomy and primary care to agree a safe transition of patients onto and alternative brand. An audit is taking place in primary care GP practices to ensure that all patients have been identified. All three areas are looking at their top 5 themes from medication errors, which include second checks, omitted and delayed administration, prescribing.

A new chair is to be appointed for the group as a result of the previous lead moving to a new role. This will be done alongside a review of the terms of reference as part of the wider quality governance review.

Concerns and Quality Systems Group

An updated implementation plan has been developed for the new Once for Wales Concerns Management System (April 20021 – redress, complaints, incidents, mortality and April 2022 – other modules including safety alerts, risk register, claims). The procurement of the Once for Wales Patient Feedback System is completed and details are expected to be received soon. A business case for funding is being developed in anticipation. A data quality issue has been identified where the lessons learned codes within Datix are regularly not completed for incidents and complaints.

The poor form design within the system and poor workflow design is considered to be a main cause. This will be addressed within the new system alongside improved training.

Quality Dashboard Task and Finish Group

Pilot implementation of the new dashboard has been rescheduled from 31st August 2020 to 2nd November 2020, due to reduced IT capacity to develop the dashboard. Following the initial pilot and early learning, a presentation will be made to a future QSE Committee meeting.

HASCAS/Ockenden Improvement Group

The current status of the total 35 recommendations for both HASCAS & Ockenden is: 14 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; 10 recommendations have now been agreed as fully implemented.

Reports were received from divisions which are summarised as follows:

Secondary Care

Following concerns raised by Infection Prevention Team (IPT) about possible Covid-19 transmission within Ward 19, the Hospital Management Team (HMT) requested on SBAR options appraisal recommending potential ward swaps that would reduce the risk for further nosocomial hospital acquired infections. Options appraisal and consultation between Central Acute and Area resulted in the closure of Ward 19 and opening of sub-acute Care of the Elderly (COTE) ward in Aberconwy Ward, Llandudno Hospital.

An update was received on safety improvement work including Peripherally Inserted Central Catheter (PICC) line insertions and the development of an improvement plan regarding Local Safety Standards for Invasive Procedures(LocSSIPS) and the World Health Organisation (WHO) Surgical Checklist. A detailed plan is awaited and scheduled for November 2020.

Updates were received on the Covid-19 outbreaks a Wrexham Maelor Hospital and Ysbyty Glan Clwyd. The Group were updated on the letters being issues to affected patients and families.

Secondary Care meeting structure has been reviewed to support changes to the Health Board quality governance structure. September saw the separation of quality and clinical effectiveness to a Clinical Effectiveness Group alongside the Quality Group.

West Area

There is a risk that diabetic patients and their families do not receive equitable care for their condition across the Health Board due to the lack of consistent clinical pathways. This is caused by not having a clinical lead for the speciality. This may lead to patient harm as care and treatment may not be current as per National Institute

Clinical Excellence (NICE) guidance and all Wales standards and guidance, including the All Wales diabetes plan.

Neurodevelopmental team not meeting Welsh Government (WG) targets, recruitment challenges and ability to undertake assessments due to Covid restrictions.

Delays in obtaining IT hardware to enable staff to work remotely. Incidents and complaints increasing regarding access to community pharmacies in Caernarfon.

Incidents and complaints remain high for Managed GP practice in Holyhead. 2 sites Cambria and Longford now merged as one patient list being seen across the 2 sites.

Central Area

Urgent need to re-establish all dentistry general anaesthetic (GA) services remains. Backlog of patients who have had to be managed with repeated doses of antimicrobials. Risk of further pain and severe sepsis. Mitigated by maxillo facial access, and restart of GA services (Wrexham Maelor Hospital) and ongoing work to restart GA across North Wales.

Significant risk regarding the lack of podiatry cover on the vascular ward, Ysbyty Glan Clwyd. Risk has been added to area risk register.

'Access to Attend Anywhere' is not possible for Speech & Language Therapy (SALT), Dietetic and Podiatry staff working from home. Staff are working from home due to significantly limited access to appropriate clinic/office space with social distancing. This is impacting on capacity within therapy services.

Managed Practices in Conwy are still in a precarious position. There is only one clinical lead working at the moment and no permanent staff. This risk cannot be overstated and is of immense concern. Senior Primary Care Managers are continually reviewing options to mitigate the associated risks.

Primary care medicines management team staffing – due to unfilled vacancies, secondments and maternity leave, currently staffing is very fragile and the team has reduced support to General Medical Services (GMS) practices, prioritising managed practices and community hospitals. Any further sickness or annual leave means core managed practice and community hospital services may be compromised.

East Area

Continued engagement and support with Local Authority around specific care packages and allocation of social workers. A need to re-establish the Continuing Health Care (CHC) eligibility process following COVID-19 pandemic and WG suspension of the eligibility process. Continued engagement with North Wales GP Out of Hours to ensure palliative care patients have direct access (West).

Womens and Midwifery

The Thematic Review of Still Births was received. A detailed and in-depth review of the clinical care of women who had stillbirth in 2019 in BCUHB was undertaken because of the relatively higher numbers of stillbirths in 2019. Case notes and reports

from serious incidence review (SIR) panel for each case of stillbirth were reviewed by a Junior Doctor, Consultant Obstetrician and Gynaecologist, Risk Midwife and Lead for Clinical Risk and Governance. Most of the areas for improvement identified within this review are well known. Areas for improvement include; reducing maternal obesity, appropriate triage, carbon monoxide monitoring, detection of SGA (small for gestational age) baby during the antenatal period and the need to implement appropriate surveillance in babies diagnosed to be SGA. Delay in carrying out a caesarean section was identified in one complex case. There was no evidence of delay or inappropriate action after mothers reported reduced or no foetal movement. In almost 40% of mothers, the enquiry about domestic abuse was not documented. Areas of socio-economic deprivation was associated with stillbirth. However, this review also revealed that the care of pregnant women had many positive connotations.

Mental Health and Learning Disabilities

The Heddfan Quality Improvement Team, led by the Interim Director of Improvement, oversee the triangulated Heddfan Quality Improvement and Safeguarding Quality Improvement plans. Meetings are held fortnightly to review progress and there has been a noted significant improvement in Safeguarding with a reported reduction in serious allegations and incidents. Meetings are supported by both the Corporate Nursing Quality Improvement Team and Corporate Safeguarding. Due to ongoing improvement the Corporate Safeguarding Team are planning a phased withdrawal of the single point of contact (SPoC).

All Older Person's Mental Health (OPMH) falls have been reviewed and the expected BCUHB policy and procedure has been followed for each. From analysis of DATIX reports it would appear that adult and learning disability wards also are compliant with expected process.

3. **Achievement** – include any significant achievements and outcomes

The new meeting format overall was positive. Some improvement areas were identified regarding the time allocated for the meeting, the flow of agenda items and guidelines on the content of divisional reports, all of which will be addressed.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Chair's Report

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting	**Clinical Effectiveness Group Meeting**
Chair of meeting	**Dr Melanie Maxwell, Senior Associate Medical Director, Office of the Medical Director**
Date of meeting	**15th October 2020**
Version number	**1**
Appendices	**None**

Reporting To	
Name of meeting	**Quality, Safety and Experience Committee**
Date of meeting	**3rd November 2020**
Presented by	**Dr Melanie Maxwell, Senior Associate Medical Director, Office of the Medical Director**

1. Alert – include all critical issues and issues for escalation

- **NICE Compliance in BCUHB:** Seeking assurance regarding compliance with NICE guidance from directorates in BCUHB continues to be a cause for concern for NICE Assurance Group (NAG). A new policy is in development and its implementation will be key to resolving this.
- **Timeframes for Tier 1 and Tier 2 audits:** there is concern that the timescales may need to be further amended with a second surge in Covid 19.
- **Consent Process**: Welsh Risk Pool requires staff to use EIDO leaflets where they are available. Issues have been raised in relation to gaps in the leaflets available from EIDO particularly within uro-gynaecology. It is acceptable to use collegiate guidance where this is the case. There is a process for updating and renewing guidance from EIDO and we need to use this. The need to audit this was noted.
- This group was asked to decide whether the main BCUHB audit of the completion of the All Wales Consent Form 1 should be postponed until 2021 / 2022, especially due to the Covid-19 situation. There has been a request to identify any local consent audit completed in year; further discussion is planned with Associate MD for Clinical Law and Ethics (Dr Ben Thomas).
- **Cardiac Arrest training**: is being adversely affecting due to Covid-19 (RR ID: 3575, 2823 and overarching Risk ID 1660). Work is ongoing to escalate via the Resuscitation Service Risk Register. This is due to lack of suitable environments for face to face training required for level 2 &3; currently only a small proportion of the places required are available. This is similar to other HBs and is being actively reviewed.

- **Mortality Alert**: the Health Board has received an alert from the National Bowel Cancer Audit regarding increased 2 year mortality on one site – this is being investigated and will be reported back within secondary care.
- There are national plans across Wales to replace the electronic palliative care patient record (CaNISC) after March 2021. This work is being undertaken by NWIS. This has raised concerns regarding ensuring a suitable replacement system in place and retention of existing data.

2. Assurance – include a summary of all activity of the group for assurance

- As part of the Clinical Care Pathways development process, a standard operating procedure and checklist have been agreed. These will ensure any published NICE guidance/Quality standard is reference within pathways and so ensure they are embedded within the planned care.
- The Covid-19 pandemic has necessitated changes to the operation of the Clinical Law and Ethics Group (CLEG) and related pathways to provide a more flexible and accessible resource and provides a forum in which individual cases can be discussed to support clinical decision-making in these challenging circumstances. The group also fulfils a similar function to the 'ethical support units' that have been set up across France and Clinical Ethics Committees within NHS England.
- Datix mortality module roll out plan for acute sites has been agreed. Some community hospital GPs in West & East have been trained and discussions are underway to train others. ALL sites should be paperless by the end of this year.
- Ten Year Stocktake Report submitted to All Wales End of Life Care Board (September 2020) & meeting scheduled for 22nd October 2020 to discuss the findings
- National Audit of Care at the End of Life (NACEL) response and action plan sub mitted and the Strategic and Operational Development Groups for Palliative and End of Life Care will progress
- The draft Corporate Clinical Audit Plan 20/21 and Annual Report 19/20 were received by the group. The recommendations within the annual report were agreed.

3. Achievement – include any significant achievements and outcomes

- Resumption of NAG's work and liaison/discussion in progress with NICE executives to include cost-savings for Wales rather than just for England
- Role of the CLEG during the COVID-19 pandemic has been to provide an ethical perspective on policies as required by Clinical Advisory Group, Clinical Pathways Group and other committees within BCUHB. They have beem part of the 'Covid-19 Moral and Ethical Advisory Group Wales' (CMEAG-Wales) to ensure that a consistent and responsive national approach is adopted.
- Approval of the Pan BCU Resuscitation Committee defibrillator replacement bid to include My Kit Check. 7 years' work by the service and a number of business cases later we have received WG approval!
- Datix mortality icon is now on each PC across BCUHB to enable the roll out of paperless reviews.
- Datix roll out is completed within YGC with paperless reviews from October 2020. This system should support enhanced reporting and learning.
- A comprehensive Health Needs Assessment for Palliative and End of Life Care was presented; this will underpin the strategy to ensure an equitable service.

Archwilio Cymru
Audit Wales

Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: September 2020

Document reference: 2021A2020-21

This document has been prepared for the internal use of Betsi Cadwaladr University Health Board as part of work performed/to be performed in accordance with statutory functions.

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Contents

Audit Committee Update

About this document

1 This document provides the Audit Committee with an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General's wider programme of national value-for-money examinations and the work of our Good Practice Exchange (GPX).

Accounts audit update

2 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2020-21.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of the 2019-20 Accountability Report and Financial Statements	Completed. Certified by the Auditor General on 2 July 2020 and laid by the Senedd on 3 July 2020.
Audit of the 2019-20 Funds Held on Trust Accounts	The audit will be commencing in late September and is scheduled to be completed (and the accounts certified) in December 2020, ahead of the Charity Commission's deadline of 31 January 2021.
Audit of the 2020-21 Accountability Report and Financial Statements	Audit planning is scheduled to start in December.

Performance audit update

3 The following tables set out the performance audit work included in our current and previous Audit Plans, summarising:

- completed work since the last Audit Committee update (**Exhibit 2**);
- work that is currently underway (**Exhibit 3**); and
- planned work not yet started or revised (**Exhibit 4**).

Exhibit 2 – Work completed

Area of work	Considered by Audit Committee
Review of interim director appointment arrangements	March 2020
The Refurbishment of Ysbyty Glan Clwyd	Received final draft 'in committee' July 2020, prior to publication in September
Effectiveness of Counter-Fraud Arrangements	September 2020

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Continuing Healthcare management arrangements Executive Lead: Chris Stockport	This review considers the extent to which the corporate CHC function is able to maintain strategic oversight and monitor compliance and performance of continuing healthcare services.	Draft report issued for clearance 3 September 2020

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Structured Assessment 2020	Our annual structured assessment is one of the main ways in which the AGW discharges his statutory requirement to examine the arrangements NHS bodies have in place to secure efficiency, effectiveness and economy in the use of their resources. In the context of Covid-19, this work will examine governance arrangements, managing financial resources and operational planning.	Drafting report December 2020
Review of Welsh Health Specialist Services Commissioning Committee	This work will focus on the governance and assurance arrangements of WHSSC. Fieldwork was well-progressed prior to the pandemic, but we revised the methodology for capturing views of health board Chairs and CEOs. We are seeking to complete fieldwork in September.	Fieldwork ongoing December 2020
Orthopaedic services – follow up Executive Lead – Chief Operating Officer	This review will examine the progress made in response to our 2015 recommendations. The findings from this work will inform the recovery planning discussions that are starting to take place locally and help identify where there are opportunities to do things differently as the service looks to tackle the significant elective backlog challenges.	Report being drafted December 2020
Test, Track and Protect	In response to the Covid-19 pandemic, this work will take the form of an overview of the whole system governance arrangements	Fieldwork underway TBC

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Executive Lead – Director of Public Health	for Test, Track and Protect, and of the Local Covid-19 Prevention and Response Plans for each part of Wales.	
A cross-cutting review focussed on North Wales partnerships Executive Lead: Chris Stockport	The exact nature of this work will be discussed with the Health Board and other partners, including local government bodies. The scoping meeting is scheduled for September 2020	Scoping

Exhibit 4 – Planned work not yet started or revised

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Ophthalmology services Executive Lead: Gill Harris and Chris Stockport	Our review will assess the economy, efficiency and effectiveness of ophthalmology services alongside wider service modernisation plans.	In light of the demands cause by COVID-19, we are considering options to postpone or replace this work

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Review of Unscheduled Care Executive Lead TBC	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. Once completed, we will use this data analysis to determine which aspects of the unscheduled care system to review in more detail.	Data analysis currently being completed Further work postponed to 2021 and replaced with work on Test, Track and Protect TBC
Quality Governance Executive Lead TBC	This work will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows, and reporting. This work follows our joint review of Cwm Taf Morgannwg UHB and as a result of findings of previous structured assessment work across Wales which has pointed to various challenges with quality governance arrangements.	Fieldwork on hold TBC

Good Practice events and products

4 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research.

5 **Exhibit 5** outlines the upcoming and recent Good Practice Exchange (GPX) events which have been held in the last 12 months. Materials are available via the links below. Details of future events are available on the GPX website.

Exhibit 5 – Good practice events and products

Event	Details
Cyber Resilience in Wales Wednesday 23 September 2020 15:00 – 16:30.	Delegates will get a preview of the emerging findings from our national study on cyber resilience in Welsh public sector bodies. To register for the seminar please complete our online booking form [opens in new window].
Unearth the value in your data (January 2020)	This webinar was for organisations that want to transform the way they collect, analyse and use data, at all levels. There are no materials available following the webinar.
Working together to identify and reduce vulnerability (February 2020)	This seminar focussed on how to achieve effective governance and accountability in partnership working to deliver efficient public services. There are no materials available following the seminar.

6 In response to the Covid-19 pandemic, we have established a **Covid-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to help prompt some thinking, and hopefully support the exchange of practice. We have produced a number of outputs as part of the project which are relevant to the NHS, the details of which are available here.

NHS-related national studies and related products

7 The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh

Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure.

8 **Exhibit 6** provides information on the NHS-related or relevant national studies published in the last 12 months. It also includes all-Wales summaries of work undertaken locally in the NHS.

Exhibit 6 – NHS-related or relevant studies and all-Wales summary reports

Title	Publication Date
'Raising Our Game' - Tackling Fraud in Wales	July 2020
Rough Sleeping in Wales – Everyone's Problem; No One's Responsibility	July 2020
NHS Wales Finances Data Tool - up to March 2020	July 2020
Findings from the Auditor General's Sustainable Development Principle Examinations	May 2020
Progress in implementing the Violence Against Women, Domestic Abuse and Sexual Violence Act	November 2019
Primary care services in Wales	October 2019
Review of Public Services Boards	October 2019
Fuel Poverty	October 2019
Public Spending Trends in Wales 1999-00 to 2017-18	September 2019
Preparations in Wales for a 'no-deal' Brexit - follow-up letter	September 2019

Title	Publication Date
The well-being of young people	September 2019
The ‘front door’ to adult social care	September 2019

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 3rd November 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Debra Hickman, Acting Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Kate Dunn, Head of Corporate Affairs
Craffu blaenorol: **Prior Scrutiny:**	None
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

The Committee is asked to note the report

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

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

Sefyllfa / Situation:

To report in public session on matters previously considered in private session

Cefndir / Background:

Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

Asesiad / Assessment

The Quality, Safety and Experience Committee considered the following matters in private session on 28.8.20:

- Executive briefings on the management of personal protective equipment
- Executive briefing on the establishment of a task and finish group relating to speech and language therapy services
- Draft report from Healthcare Inspectorate Wales following an unannounced visit to the Heddfan Unit

Betsi Cadwaladr University Health Board

Decontamination

Internal Audit Report

BCU 2019/20

July 2020

NHS Wales Shared Services Partnership

Contents **Page**

Review reference:	BCU-1920-30
Report status:	Internal Audit Report
Fieldwork commencement:	13th February 2020
Fieldwork completion:	8th April 2020
Discussion draft report issued:	8th April 2020
Draft report issued:	10th June 2020
Management response received:	23rd June 2020
Final report issued:	23rd June 2020
Auditor/s:	Principal Auditor Head of Internal Audit
Executive sign off:	Executive Director Nursing and Midwifery
Distribution:	Decontamination Advisor Assistant Director Of Nursing - Infection Prevention Acting Board Secretary Statutory Compliance, Governance & 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

Decontamination is a term used to describe a range of processes, including cleaning, disinfection and/or sterilization, which remove or destroy contamination and thereby prevent infectious agents or other contaminants reaching a susceptible body site in sufficient quantities to cause infection or any other harmful response.

The Health Board has a legal obligation under the Health and Safety at Work Act (1974) and is also committed to continually improving the quality and safety of its services through ensuring every medical device will be adequately cleaned, disinfected or sterilized according to its function. This protects as far as reasonably practical the health, safety and welfare of its staff, patients and those recipients who are involved in inspection, service, repair or transportation of medical devices or equipment.

Compliance is required by all staff involved in decontamination which includes those directly involved in reprocessing equipment as well as those involved in procurement, management, storage and transportation.

The Health Board has published procedure IPC17 - Decontamination of Medical Devices Procedure (Version 3.0) which sets out key principles along with clear process on what to do, articulating roles and responsibilities within.

The Health Board receives a Welsh Government Decontamination Survey with associated action plan. The Health Board has established quarterly self-audit tool for all relevant areas to assess their own compliance, with an identified action plan to remedy any highlighted issues.

2. Scope and Objectives

The objective of this review was, working in partnership with the Health Board Decontamination Advisor, to ensure the requirements set out in IPC17 Decontamination of Medical Devices Procedure (Version 3.0) are being complied with.

The scope of this review was limited to:

- Reviewing the governance reporting arrangements from the Health Economy Local Infection Prevention Groups to Infection Prevention Sub Group and identify any matters of significance are reported to Quality and Safety Group.
- Reviewing receipt of the self-audit tool(s) to ensure all areas have submitted returns in accordance with the set timelines.
- Using the self-audit tool findings, we will identify a sample of areas to visit with the Decontamination Advisor and seek assurance of evidence at time of submission

3. Associated Risks

The associated risks identified at the outset of this review were:

- Breach of Health & Safety at Work Act (1974) COSHH Regulations

2002;

- Reputational risk through increased publicity of increased patient infection and any associated litigation; and
- Patient and staff safety is compromised through an inefficient process to destroy or remove contamination.

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 NHS Wales Staff Survey – Delivering the Findings review is limited assurance.

RATING	INDICATOR	DEFINITION
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.

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	Self-audit tool findings and evidence of submission			✓	
2	Governance arrangements, matters of significance are reported through to Quality and Safety Group		✓		

** 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 Decontamination

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weakness in the operation of the designed system/control for Decontamination.

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan.

This report is based upon the information provided to us by the Decontamination Advisor and the designated lead for the departments we visited - we would like to express our gratitude for their input and support during the review.

We have relied solely on the documents, information and explanations provided to us and except where otherwise stated, we have not contacted or undertaken work directly to verify the authenticity of the information provided.

Background to audit tool

Following a decision at the Strategic Decontamination Group Meeting on the 16th April 2019, it was decided that the Decontamination Advisor would no longer be responsible for the co–ordination of audits. The responsibility for this process would now sit with the designated department leads/managers responsible for the decontamination processes within their units/departments.

It was agreed that the previous quarterly audit process would be changed to take place on a 6 monthly basis (audit deadline return dates 31st December and 30th June) as it was deemed by management to be more efficient. The first decontamination audit was due to be completed in December 2019.

To monitor this process the Decontamination Advisor undertakes an annual review of random units/departments carrying out the decontamination process. The current audit tool is being used for this processes with a random number of questions asked and evidence is provided.

Self-audit tool findings and evidence of submission

We identified Wrexham Maelor (Wrexham), Ysbyty Glan Clwyd (YGC), Ysbyty Gwynedd (YG) and Deeside Community Hospital to visit in partnership with the Decontamination Advisor. Using a sample of the self-audit tool questions, we sought evidence at to support their submission.

Although it was apparent by way of evidence provided that compliance of the audit tool was in place, we were unable to evidence that documentation for the self-audit tool within two of the departments had been completed. Without these being completed it makes it difficult for the Decontamination Advisor to complete his annual audits. The action tracker on the back of the audit tool will not be completed also, this allows the department to keep track of any issues which have been highlighted.

Another of the audit tools was also delayed in completion, we were advised this was due to confusion over the change from quarterly completion to every six months – we cannot corroborate this assertion.

Evidence of completed documentation for the traceability audit logs for Nasoendoscopes (a clinically invasive procedure) contained within the audit tool was provided, this enables the user to track the Nasoendoscopes through the whole process of decontamination.

In reviewing the audit tool it was noted that although questions on Control of Substances Hazardous to Health (COSHH) were asked concerning the storage of chemicals, no questions regarding the assessment of the chemicals were included as part of the audit tool. When staff were asked regarding assessments, safety data sheets on the chemicals were produced but no assessments. The COSHH assessment process will identify all hazardous substances used within the departments and also assess the use of these substances safely.

Table 1 records our findings by department we visited detailing the questions reviewed and evidence provided. Questions are numbered differently owing to the departments requiring different questions to be asked due to the working variations within departments.

Table 1: Decontamination Audit Tool findings from onsite visits

Department/Date Visited	Completed every 6 months	Self-Audit question	Evidence supported
Central Area			
Endoscopy YGC 17/02/2020	20/12/19	1.4 Are all of the training records for each month team member in date?	All records up to date, checked also by the decontamination advisor with their annual audit.
		1.7 Are robust accurate legible records completed and maintained for all stages of the decontamination process?	Traceability records/documentation in place and observed.
		1.12 Are weekly taking place on AER's	Yes documentation displayed no lapses within the last month.
		1.16 Has annual re-re validation taken place?	Yes documentation kept in Sister's office.
		2.1 Are there dedicated wash hand basins in the decontamination area?	Observed.
		2.6 If no physical segregation, is there a clear SOP in place to manage the flow path of a scope from the dirty to clean area.	Paper format available and kept on the desktop of computer.
		2.12 What date was the last ventilation check carried out?	Informed it was kept in the Sister's office but we did not corroborate this.
		2.19 Is there an SOP in place to control access to all personnel involved in any maintenance/breakdown/testing activities?	Permits to work provided as evidence for control of contractors.
		3.6 Are gloves aprons and face visors in use for decontamination,	Observed that all personal protective equipment was available.

Department/Date Visited	Completed every 6 months	Self-Audit question	Evidence supported
Central Area			
		in accordance with standard precautions?	
		3.9 Are brushes used during manual cleaning process single use?	Observed single use brushes.
		3.17 Do all manual pre wash decontamination activities take place using the submersion method?	Yes water line marks within the sink to prevent areolation.
ENT YGC 17/02/2020	17/12/19	1.1 Who is the designated Lead/User for the department? *(See notes at the end of this section re; definition of the user).	Sister of the ward.
		1.6 Are robust accurate legible records completed and maintained for all stages of the decontamination process?	Traceability records/documentation in place and observed.
		1.13 Are weekly final rinse water tests taking place for AER's?	Ward undertake a weekly test as well as a company tests.
		2.2 Are there hand hygiene posters on display?	Yes observed.
		2.9 Are there twin sinks used for the manual cleaning stage?	Yes observed.
		2.12 If there is a drying cabinet in use is there an in date testing / maintenance / annual revalidation contract in place with the company.	Yes the documentation was supplied, testing and maintenance undertaken December 2019.
		3.6 Are gloves aprons and face visors in use for decontamination, in accordance with standard precautions?	All water tests recorded and kept in estates. Any issues estates contact the department.
		3.1 Is there an SOP in place for each stage of the decontamination process?	Yes, paper format available on the wards.
		3.9 If an electronic dosing system is in place, has it been validated and calibrated?	N/A electronic dosing system removed.
Deeside Community 17/02/2020	23/12/19	1.1 Who is the designated Lead/User for the department? *(See notes at the end of this section re; definition of the user).	Sister of the ward.
		1.7 Are robust accurate legible records completed and maintained for all stages of the decontamination process?	Traceability records/documentation in place and observed. From the information available within the documentation we completed a traceability audit log to establish that the information was complete.
		1.8 Is the Infection Prevention and Team actively involved providing advice and guidance on decontamination practises?	Information and contact details available on the self-audit tool.
		2.1 Are there dedicated wash hand basins in the decontamination area?	Yes observed.

Department/Date Visited	Completed every 6 months	Self-Audit question	Evidence supported
Central Area			
		2.9 Is there a dedicated cupboard / room for the storage of equipment for the cleaning Environment?	Yes colour coded.
		2.12 Are all detergents/chemicals stored and disposed of in compliance with COSHH regulations?	Yes dedicated storage cupboard, however COSHH assessments require updating. Safety data sheets also require a review.
		3.3 Are all SOP's in place in the format agreed with the Decontamination Advisor?	Yes folder of evidence produced.
		3.9 Are all cloths used in any part of the decontamination process single use, non-linting and disposable	Yes standard across the health board where the Decontamination Advisor undertakes the self-audit tool.
		3.10 Does the leak test take place on the scope in accordance with the manufacturer's instructions?	Yes written into the safe operating procedure (page1, point 14).

Department/Date Visited	Completed every 6 months	Self-Audit question	Evidence supported
East Area			
Endoscopy Wrexham 3/3/20	Contacted but no evidence provided	1.1 Who is the designated Lead/User for the department? *(See notes at the end of this section re; definition of the user).	Sister of the ward.
		1.3 Are all of the training records for each team member in date?	All records up to date, checked also by the decontamination advisor with their annual audit.
		1.6 Are robust accurate legible records completed and maintained for all stages of the decontamination process?	Traceability records/documentation in place and observed.
		1.7 Is the Infection Prevention and Team actively involved providing advice and guidance on decontamination practices?	Staff asked and replied that they were in regular contact with the Infection Prevention Team.
		2.4 Is the decontamination unit clear of clutter?	Yes observed.
		2.6 Does physical segregation exist between clean and dirty areas/processes?	Yes staff ran through the process.
		2.14 Has an assessment been carried out in relation to fumes/smells (COSHH requirements)?	Yes undertaken annually, company contacts both department and Decontamination advisor.
		2.15 Is there a dedicated cupboard /room for storage	Yes kept in domestics cupboard

Department/Date Visited	Completed every 6 months	Self-Audit question	Evidence supported
East Area			
		equipment for the cleaning environment?	
		3.1 Is there an SOP in place for each stage of the decontamination process?	Yes all stages kept within one document currently out of date. Review date 17/07/19
		3.6 Are gloves aprons and face visors in use for decontamination, in accordance with standard precautions?	Yes observed
Outpatients Wrexham 3/3/20	23/12/19	1.1 Who is the designated Lead/User for the department? *(See notes at the end of this section re; definition of the user).	Sister of the ward.
		1.3 Are all of the training records for each team member in date?	Yes, currently one member of staff required to be trained. Records of training are kept upstairs within theatres.
		1.6 Are robust accurate legible records completed and maintained for all stages of the decontamination process?	Traceability records/documentation in place and observed.
		2.1 Are there dedicated wash hand basins in the decontamination area?	Yes observed.
		2.10 If drying cabinets are in use are the located in a 'clean' area.	Yes, clean area
		2.12 If there is a drying cabinet in use is there an in date testing/maintenance/annual revalidation contract in place with the company?	Yes in place examined on a quarterly basis by company. Company informs department and Decontamination Advisor when examinations are due.
		3.1 Is there an SOP in place for each stage of the decontamination process?	Yes stages kept within one folder. Needs to be finalised into one document.
		3.5 Is an SOP in place for the transportation of endoscopes? (describe in comments box or attach copy of SOP to audit return)	Yes stages kept within one folder. Needs to be finalised into one document.
		3.6 Are gloves aprons and face visors in use for decontamination, in accordance with standard precautions?	Yes observed.
Theatres Wrexham 3/3/20	Contacted but no evidence provided	1.1 Who is the designated Lead/User for the department? *(See notes at the end of this section re; definition of the user).	Sister of the ward.
		1.3 Are all of the training records for each team member in date?	All records in place, evidence observed showing that the training is about to be updated with latest training. Checked also by the decontamination advisor with their annual audit.

Department/Date Visited	Completed every 6 months	Self-Audit question	Evidence supported
East Area			
		1.6 Are robust accurate legible records completed and maintained for all stages of the decontamination process?	Traceability records/documentation in place and observed.
		1.9 Does all testing and validation take place in accordance with WHTM 01-06?	Contracted out quarterly.
		2.2 Are there hand hygiene posters on display?	Yes observed.
		2.6 Does physical segregation exist between clean and dirty areas/processes?	Yes observed.
		2.11 If there is a drying cabinet in use is there an SOP in place for its control and use?	Yes observed.
		2.23 Are final rinse water tests recorded?	Yes observed.
		3.1 Is there an SOP in place for each stage of the decontamination process?	Yes two separate SOPs for dirty and clean area.
		3.6 Are gloves aprons and face visors in use for decontamination, in accordance with standard precautions?	Yes observed.
		3.12 Do all manual pre wash decontamination activities take place using the submersion method?	Observed activity in process when testing.
Other evidence of good practice provided at the time of the testing by theatres • Eqolab dosing system • Calibration Certificates • New traceability log book • Learning scenarios for staff • Purchase of COSHH cabinet and spillage kit			

Department/Date Visited	Completed every 6 months	Self-Audit question	Evidence supported
West Area			
OPD YG 13/3/20	26/02/20 (Informed that the undertaking of the audit delayed due to the switch over from the quarterly audits.)	1.1 Who is the designated Lead/User for the department? *(See notes at the end of this section re; definition of the user).	Staff nurse.
		1.3 Are all of the training records for each team member in date?	All records up to date, checked also by the decontamination advisor with their annual audit.
		1.6 Are robust accurate legible records completed and maintained for all stages of the decontamination process?	Traceability records/documentation in place and observed.

		1.10 Are daily test taking place on AER's?	Yes observed documentation, highlighting tests undertaken every morning.
		2.6 Does physical segregation exist between clean and dirty areas/processes?	Yes observed.
		2.11 If there is a drying cabinet in use is there an SOP in place for its control and use?	Yes observed.
		2.23 Are final rinse water tests recorded?	Yes observed, Estates undertake PH water tests and staff complete a final rinse.
		3.1 Is there an SOP in place for each stage of the decontamination process?	Yes observed. Review date 30/09/20.
		3.7 s the manual pre-washing sink in use marked with the water volume in accordance with the dosage required?	Yes observed.

Governance arrangements, matters of significance are reported through to Quality and Safety Group

Based on discussions with management at the outset of the review, we focused on governance reporting arrangements from the Health Economy Local Infection Prevention Groups to Infection Prevention Sub Group, identifying matters of significance are reported to the Quality and Safety Group.

We sought evidence of issues of significance for escalation regarding decontamination, in addition we also sampled agendas and minutes to establish that issues were being escalated within the Infection Prevention governance and reporting arrangements.

Having reviewed at all the evidence provided, we note that issues of significance (IOS) can be seen on the agendas and within minutes. However we found little evidence to support that IOS are being escalated from the Health Economy Local Infection Prevention Groups to the Infection Prevention Sub Group.

Additionally we note that several meetings have been cancelled - at the time of writing this report, East Health Economy Local Infection Prevention Group had not met since November 2019.

The findings below is the evidence of agendas and minutes provided to us concerning the Infection Prevention governance and reporting arrangements beginning with the Quality and Safety Group.

Quality & Safety Group (QSG)

We reviewed the minutes of QSG to identify issues of significance from the Infection Prevention Sub Group. It has been agreed with the Associate Director of Quality Assurance that the completion of quarterly reports (including the IOS) would be undertaken and presented to the QSG, our review identified the following:

- 8th May 2019 – Report from the Infection Prevention Sub Group escalating issues of significance.
- 11th June 2019 - Infection Prevention (IP) Report Q4 – January to March 2019, issues of significance included.
- 14th August 2019 - Infection Prevention (IP) Report Q1 (April to June 2019) issues of significance included.
- 8th November 2019 - Infection Prevention (IP) Report Q2 (July to September 2019) issues of significance included.
- 18th February 2020 – Evidence provided to us records that the Infection Prevention (IP) Report Q3 (October to December 2019) was forwarded for submission to QSG but we have been unable to locate the report on the official QSG agenda.

Infection Prevention Sub Group

We were provided with minutes from 27th August 2019, 22nd October 2019 and the 17th December 2019 (in draft), the meeting arranged for 11 February 2020, was cancelled.

Issues of significance for escalation to the QSG highlighted within the IPSG meetings on the 27th August 2019 and 22nd October 2019 regarding decontamination were sampled.

Infection Prevention Sub Group (IPSG) Tuesday 27 August 2019

Issues of Significance for Escalation to Quality & Safety Group (QSG)

- *IPSG 19/32 Decontamination Update - Laryngoscope Handles*
- *IPSG 19/32 Decontamination Update Welsh Government (WG) visit and Dental Survey*
- *IPSG 19/33.1 Quarter 1 Report - ADN IP – Mattress decontamination.*

Infection Prevention Sub Group (IPSG) Tuesday 22 October 2019

Issues of Significance for Escalation to Quality & Safety Group (QSG)

- *IPSG 19/50.3 Quarter 2 Central*

  Decontamination

  Autoclaves within HSDU YGC are nearing end of life and are damaged. This is highlighted via the decontamination risk register and will be progressed by the Theatre Manager with support from Chief Engineer.

We were able to corroborate that the IOS identified within the IPSG meeting on the 27th August 2019 were discussed within the QSG on the 4th October 2019.

However we unable to verify that the IOS regarding the autoclaves on the 22nd October had been escalated to the Quality and Safety Group. We were informed that minute taker was required to step out of the meeting for a short period and discussion may have taken place during this time - we are unable to corroborate this assertion.

West - Health Economy Local Infection Prevention Group

We were provided with minutes from the 26th July and the 27th September 2019. November 2019 meeting was cancelled [we have not been able to ascertain why it was cancelled] with January 2020 minutes still draft.

For the meeting 26th July no issues of significance for escalation reporting into the Infection Prevention Sub Group have been identified for the minutes.

For the meeting of 27th September 2019 mask fit testing was highlighted but we were unable to locate the issue within the minutes of the Infection Prevention Sub Group provided to us.

Minutes of Local Environmental Cleanliness, Decontamination, Infection Prevention and Antimicrobial Stewardship Joint Meeting 27 September 2019

020/03/19 - Issues of significance for escalation to next meetings of

- *Strategic Infection Prevention Group*
- *Hospital Management Team*
  - *Fit testing.*

Central - Health Economy Local Infection Prevention Groups

We were provided with minutes from 9th October 2019 and 26th February 2020 (draft); 11th December 2019 was cancelled due to the number of apologies received.

We were able to identify an issue with regards to the HSDU autoclaves within the 9th October 2019 minutes which has been escalated to the Infection Prevention Sub Group.

Health Economy Local Infection Prevention Group Meeting Wednesday 9th October 2019

HELIP19/07 Review Infection Prevention Risk Register Central

- *The life span of the HSDU autoclaves (scored 12) and has been escalated/managed through the Strategic Decontamination Group*

At the meeting of the 9th October 2019, the rate of infections has been highlighted as an issue of significance but we were unable to locate the issue within the minutes of the Infection Prevention Sub Groups provided to us:

Health Economy Local Infection Prevention Group Meeting Wednesday 9th October 2019

HELIP19/15 Issues of Significance for Escalation

- *Central has the highest rate of infections for the organisms under surveillance. There is a higher rate of antimicrobial resistance and CDI.*

For the meeting 26th February 2020 there were issues of significance identified within the minutes (draft) however at the time of writing this report the Infection Prevention Sub Group for April 2020 had not taken place and therefore we are unable to confirm the issues were formally escalated.

Health Economy Local Infection Prevention Group Wednesday 26th February 2020

LIPG20/15 Issues of Significance for Escalation

- *K Boardman was delighted to announce Ward 19 would be moving on the 31st March 2020 to a nicer area for COTE patients.*
- *The Antimicrobial business case is being completed and escalated, no developments.*
- *A Griffiths advised escalation of the new risk in terms of the risk register.*

East - Health Economy Local Infection Prevention Group

We were provided with agendas from the 10th September 2019, 12th November 2019 and the 10th December 2019. We were provided with the minutes for the 9th July 2019, 10th September 2019 and the 12th November 2019.

Meetings scheduled for the 13th August 2019, 8th October 2019, 10th December 2019 and the 19th February 2020 were stood down and we have not been able to ascertain at the time of this report, why the four meetings were postponed.

For the meeting of 9th July 2019 the issue below has been highlighted but we were unable to locate the issue within the minutes of the Infection Prevention Sub Group provided to us.

Local Infection Prevention Group (WMH) Tuesday 9th July 2019

Issues of Significance for Escalation to Next Meeting of SIPG and/or Next Strategic Decontamination Group

- *The classification of the Theatre Recovery area being deemed an augmented care area is to taken to IPSG.*

For the meeting of the 10th September 2019 and the 12th November 2019 no issues of significance for escalation reporting into the Infection Prevention Sub Group have been identified from the minutes.

As a point of note the area Health Economy Local Infection Prevention Groups we were unable to see any discussion on the decontamination audit tools. This would allow for an opportunity for the area groups to monitor the department's action tracker completed on the back of the audit tool as well as any issues which departments may have highlighted.

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	**2**	**1**	**0**	**3**

Finding - ISS.1 – Governance – Local Infection Prevention Groups (Operating effectiveness)	Risk
The review has identified a lack of reporting of issues of significance for escalation from the Local Infection Prevention Groups through the Infection Prevention Sub Group. Evidence provided to us demonstrates that several meetings have been cancelled which undermine the delivery of governance and assurance reporting.	Issues not escalated.
Recommendation	**Priority level**
The Local Health Economy Local Infection Prevention Groups ensure all issues of significance recorded in Minutes are escalated.	**High**
Management Response	**Responsible Officer/ Deadline**
Decontamination to become a standing agenda item on all LIPGs, with minutes including and Issues of Significance to be escalated to the IPSG.	Assistant Director Of Nursing - Infection Prevention June 2020

Finding - ISS.2 – Self-audit tool (Operating effectiveness)	Risk
The Decontamination Department demonstrated a planned approach with the self-audit tool, however we noted the following: • Self-audit tools are not routinely discussed at the Local Health Economy Local Infection Prevention Groups. • The review identified Self audit tool not being completed within two departments. • No questions on the undertaking of COSHH assessments were included within the self-audit tool.	Lack of monitoring for the completion of the self-audit tool.
Recommendation 2	**Priority level**
Chairs of the Local Health Economy Local Infection Prevention Groups ensure self-audit tools are routinely presented and discussed in accordance with current timescales.	**High**
Recommendation 3	**Priority level**
Decontamination Advisor to include a question on COSHH assessment which identifies that the chemicals have been assessed correctly for the area and reviewed.	**Medium**
Management Response	**Responsible Officer/ Deadline**
A Decontamination/Infection Nurse role has been agreed and funding. This has been out for expressions of interest and will interview w/c 13th July 2020. This post will support the Decontamination advisor pan BCU supporting the governance structure regarding practice, self-audit and reporting.	Assistant Director Of Nursing - Infection Prevention August 2010

Decontamination to become a standing agenda item on all LIPGs, with minutes including and Issues of Significance to be escalated to the IPSG. Question on COSHH assessments to be added to audit tool.	Assistant Director Of Nursing - Infection Prevention June 2020 Decontamination Advisor June 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.