Bundle Quality, Safety & Experience Committee 6 July 2021

9.30am via Teams
Public Agenda v3.0

1.0   OPENING BUSINESS AND EFFECTIVE GOVERNANCE

1.1   09:30 - QS21/90 Chair's Opening Remarks

To welcome :
Mark Polin - Health Board Chair
Urvisha Perez - Audit Wales

1.2   09:31 - QS21/91 Declarations of Interest

1.3   09:32 - QS21/92   Apologies for Absence

Jo Whitehead
Adrian Thomas A/L
Dave Harries
Teresa Owen A/L (Mike Smith to attend from MHLD perspective)
Gareth Evans will need to leave at 1pm

1.4   09:33 - QS21/93   Minutes of Previous Meeting Held on 4th May 2021 in Public for Accuracy, Matters Arising and Review of Summary Action Log

       QS21.93a Minutes QSE 4.5.21 Public V0.03.docx

       QS21.93b Summary Action Log QSE Public.docx

1.5   09:48 - QS21/94 Patient Story : Gill Harris

Recommendation:
The Quality, Safety and Experience Committee is asked to receive and reflect upon the patient story.

       QS21.94 Patient Story.docx

1.6   09:58 - QS21/95 Quality Awards, Achievements and Recognition : Gill Harris

Recommendation:
The Committee is asked to note this report.

       QS21.95 Quality Awards Paper.docx

2.0   FOR DISCUSSION

2.1   10:03 - QS21/96 Quality Governance Review : Ysbyty Glan Clwyd - Gill Harris

Recommendation:
The Committee is asked to note this report.

Neil Rogers to attend

       QS21.96a YGC Review.docx

       QS21.96b YGC Quality Review Appendix 1 Action Plan_reformatted.pdf

       QS21.96c YGC Review Appendix 2 Action Plan Progress Update.docx

2.2   10:18 - QS21/97 Quality & Performance Report

Recommendation:
It is recommended that the Committee discuss and receive the report.

Kamala Williams to attend

       QS21.97a Q&PR front template.docx

       QS21.97b Q&PR May 2021 v0.8.pdf

2.3   10:33 - QS21/98 Board Assurance Framework   - Louise Brereton

Recommendation:
That the Committee review and note the progress on the Principal Risks as set out in the Board Assurance Framework (BAF).

       QS21.98a BAF v1.0 Approved.docx

       QS21.98b BAF Appendix 1 QSE V1.0.pdf

       QS21.98c BAF Appendix 2 QSE- Remapping BAF risks to Annual Plan.pptx

       QS21.98d BAF Appendix 3 QSE key field guidance updated.docx

2.4   10:43 - QS21/99 Corporate Risk Register - Simon Evans-Evans

Recommendation:
The Committee is asked to review and note the progress on the Corporate Tier 1 Operational Risk Register Report as detailed in the paper.

Justine Parry to attend

QS21.99 CRR - V3.4.doc

2.5	10:53 - QS21/100 Infection Prevention & Control Sub Group Update : Gill Harris

Recommendation:
The committee is asked to note the content of the report.

QS21.100a IPSG report template_revised.docx

QS21.100b IPSG slides_Appendix 1.ppt

2.6	11:08 - QS21/101 Covid-19 Update - Gill Harris

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

QS21.101a Covid-19 update FINAL.docx

QS21.101b Covid-19 Appendix 2 Nosocomial PRAID Log - Master - 2021-06-15 v.28.pdf

2.7	11:23 - QS21/102 Serious Incident Report - April and May 2021 (including separate Never Event Thematic Report)- Gill Harris

Recommendation:
The Committee is asked to note this report and the significant increase in the number of falls with harm that have occurred over the last 18 months and the planned improvement work.

QS21.102 Serious Incident report.docx

2.7.1	11:38 - comfort break
2.8	11:48 - QS21/103 Vascular Services Update - Arpan Guha

Recommendation:
The Committee is asked to receive the update from the Vascular Task and Finish Group.

Patrick Johnson to attend

NOTE: A range of supporting documentation referred to within the Action Tracker is provided as background for Committee Members

QS21.103a Vascular report_final amended and published.docx

QS21.103b Vascular Appendix 1 Action Tracker.pdf

QS21.103c Vascular Appendix 2 activity on DGHs.pdf

2.9	12:03 - QS21/104 Health and Safety Annual and Quarter 4 Report - Sue Green

Recommendation:
The Committee is asked to note the position outlined in the Annual and Quarter 4 Report support the recommendations identified within the findings:
1. Implement year 2 of the Occupational Health & Safety (OHS) Strategy.
2. Ensure adequate staffing is available to provide an appropriate H&S security function to BCUHB.
3. Ensure adequate staff and premises to provide Manual Handling training
4. Establish a permanent fit test program
5. Develop further policies and safe systems of work to provide evidence of practice.
6. Establish monitoring systems from the Divisions and Hospital Management Teams to measure performance including clear key performance indicators.
7. Train senior leaders and develop further competence in the workforce at all levels
8. Learn lessons from incidents and develop further the risk profile

QS21.104 Health and Safety Annual and Q4 update Report_Final V2.docx

2.10	12:18 - QS21/105 Mental Health – an Update from the Adult (MHLD) Division and the Child and Adolescent Service (CAMHs) - Teresa Owen

Recommendation:
The Committee is asked to:
1\. Note the update from both the Mental Health & Learning Disabilities Division\, and Child and Adolescent Mental Health Services \(CAMHs\)\.
2\. Discuss and agree the preferred reporting approach going forward\.

QS21.105 Mental Health_final published.doc

2.11	12:33 - QS21/106 Primary & Community Care Quality Assurance Report - Chris Stockport

Recommendation:
The Quality, Safety & Experience (QSE) Committee is asked to:
1. Note the significant contribution to healthcare provision made across all primary care and community services during the pandemic;
2. Note the increased demands and challenges facing the primary care sector in particular, and actions being taken to support contractor services.

QS21.106 Primary Care.docx

2.11.1	12:48 - lunch break
2.12	13:08 - QS21/107 Clinical Audit Forward Plan 2021/22 - Arpan Guha

Recommendation:
The Committee is asked to approve the draft Clinical Audit Plan 2021/22 as the current working document.

Recommendation:
The Committee is asked to receive the Annual Report for the period of 2020-2021 noting the progress, assurance and the innovative work led by the Corporate Safeguarding Team to implement learning throughout the organisation to help keep our patients, staff and organisation safeguarded.

Recommendation:
The Committee is asked to note the actions and mitigations being taken to recover the Planned Care waiting lists which have increased during the Covid-19 pandemic as a result of panned care activities having been curtailed to address the surge of admissions.

NOTE: A range of supporting documentation is provided as background for Committee Members as follows:
*1)**Example** spreadsheet showing current position of sites in delivering validation and mitigation for planned care*
2)Flowchart of the Validation Process
3)Specimen letter and questionnaire sent to patients on the validated list
*4)**Example** of non-responder spreadsheet*
5)Cancer Harm meeting assurance documents

Recommendation:
The Committee is asked to note the contents of this paper.

QS21.112.1 Patient Safety Quality Group 15.6.21 - Gill Harris
QS21.112.2 Strategic Occupational Health and Safety Group 25.5.21 - Sue Green
QS21.112.3 Clinical Effectiveness Group 27.4.21 and 17.6.21 - Arpan Guha
QS21.112.4 Patient and Carer Experience Group 29.4.21 - Gill Harris

Recommendation:
The Committee is asked to note the report

10.5.21 Primary Care Mental Health Discharges Report
22.6.21 Limited Assurance Internal audit reports

Private workshop 24.8.21
Committee (public session) 7.9.21

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."

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

Quality, Safety and Experience (QSE) Committee
DRAFT Minutes of the Meeting Held in public on 4.5.21 via Teams

Present:

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

In Attendance:

Jackie Allen	Chair of Community Health Council (CHC)
Louise Brereton	Board Secretary
Kate Dunn	Head of Corporate Affairs (*for minutes*)
Gareth Evans	Chair of Healthcare Professional Forum (*part meeting*)
Simon Evans-Evans	Interim Director of Governance (*part meeting*)
Sue Green	Executive Director of Workforce and Organisational Development (OD)
Arpan Guha	Acting Executive Medical Director
Dave Harries	Head of Internal Audit
Gill Harris	Executive Director of Nursing and Midwifery / Deputy Chief Executive
Debra Hickman	Secondary Care Nurse Director
Mandy Jones	Nurse Director – Ysbyty Gwynedd Hospital Management Team (*part meeting*)
Matthew Joyes	Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience
Melanie Maxwell	Senior Associate Medical Director/Improvement Cymru Clinical Lead (*part meeting*)
Karen Mottart	Hospital Medical Director – Ysbyty Gwynedd Hospital Management Team (*part meeting*)
Teresa Owen	Executive Director of Public Health (*part meeting*)
Urvisha Perez	Audit Wales (*observing*)
Georgina Roberts	Head of HR– Ysbyty Gwynedd Hospital Management Team (*part meeting*)
Dawn Sharp	Deputy Board Secretary (*part meeting*)
Mike Smith	Interim Director of Nursing for Mental Health and Learning Disabilities (*part meeting*)
Chris Stockport	
Adrian Thomas	Executive Director Primary and Community Services
Lesley Walsh	Executive Director Therapies and Health Sciences
Jo Whitehead	Head of Nursing – Ysbyty Gwynedd Hospital Management Team (*part meeting*)
Barry Williams	Chief Executive (*part meeting*)
Kamala Williams	Interim Hospital Director, Ysbyty Gwynedd Hospital Management Team (*part meeting*)
	Acting Head of Performance (*part meeting*)

AGENDA ITEM DISCUSSED	ACTION BY
QS21/58 Chair's Opening Remarks	

QS21/58.1 A warm welcome was extended to Urvisha Perez who was observing the meeting on behalf of Audit Wales.	
QS21/59 Declarations of Interest QS21/59.1 Jackie Hughes declared an interest in item QS21/63 in that she attended the strategic outbreak meetings on behalf in a Staff Side partner role and her substantive post was also based at Ysbyty Gwynedd.	
QS21/60 Apologies for Absence **QS21/60.1** None recorded	
QS21/61 Minutes of Previous Meeting Held in Public on 2.3.21 for Accuracy, Matters Arising and Review of Summary Action Log **QS21/61.1** The minutes were approved as an accurate record and updates provided for recording within the summary action log. *[Simon Evans-Evans joined the meeting]*	
QS21/62 Patient Story **QS21/62.1** The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience presented the patient story which focused on a patient's experience from diagnosis through treatment to his eventual death, as told by his wife. The story had been shared digitally with members and it was reported that more use would be made of technology to capture audio and video stories in the future. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience highlighted positive comments within the story around the North Wales Cancer Centre but also drew members' attention to the key themes and learning within the paper. He indicated that a case study would be prepared to share learning and that a Covid-19 patient experience training module had been relaunched with a stronger focus on communication and patient/carer involvement. **QS21/62.2** A discussion ensued. Members reflected on the importance of ensuring patients maintain dignity during their treatment and in staff knowing individual patient needs and preferences. In response to a question regarding the use of bank staff at the North Wales Cancer Centre the Executive Director of Workforce and OD confirmed that generally cancer services were proactive in managing their vacancy levels and the aim was always to minimise the reliance on agency staff. However, she assured the Committee that where vacancies did exist the focus would be on establishing a relationship with a core group of bank staff so they became almost an extended team. An Independent Member felt that the 'invisible patient' element described within the story was of concern and that ward staff needed to understand the importance of getting to know a patient and their family members. A question was asked regarding feedback to the family member who had provided the story and it was confirmed that the BCUHB team member who took the story had retained contact with her and would provide formal feedback following the Committee meeting. A concern was noted around the issue of missing healthcare records when attending another centre of care and the Chair would wish to see information governance and confidentiality processes used in a more enabling way. She also welcomed the personal touch that this digital story had provided.	

QS21/62.3 It was resolved that the Quality, Safety and Experience Committee receive and reflect upon the patient story.

QS21/63 Ysbyty Gwynedd Outbreak

QS21/63.1 The Chair introduced this agenda item and advised that an external review is being undertaken and that the report should be available for the July Committee meeting. She welcomed members of the Ysbyty Gwynedd (YG) Hospital Management Team (HMT) to the meeting. The Hospital Medical Director wished to record how sorry she and other team members were for the outbreak and the effect on patients, families and staff. A presentation was delivered by the HMT which encompassed:

- The timeline of the outbreak
- Contributory factors including complacency, fatigue and changes between first and second waves
- Control measures and learning from key themes (leadership/behaviours; operational practice; technical and infrastructure)
- Infection prevention control measures before and during the outbreak
- Lessons learned – highlighted key lesson related to social distancing and adhering to behaviours particularly in shared staff welfare areas such as canteens
- Approach to sharing learning - primarily an intention to become more outward facing and to improve clarity of communications
- Embedding and sustaining lessons

[Mr G Evans left the meeting]

QS21/63.2. In response to a question regarding domestic staff and cleaning, it was confirmed that following meetings with estates and facilities teams there were now enhanced cleaning hours on 5 wards but not all. Recruitment continued and there was a clear recognition of the need to meet Covid-19 standards with interim arrangements in place via additional healthcare support workers. A member raised a concern about reference to the training of staff in the use of Personal Protective Equipment (PPE) and the HMT acknowledged that refresher training hadn't been as timely across all staff groups during the second wave but that additional resources had now been offered to Infection Prevention & Control teams with the upskilling of key staff to enable cascade of training. In response to a question around culture it was acknowledged that good leadership was critical although there hadn't been a specific ward or area where culture had been identified as a major issue. The Hospital Nurse Director added that the main areas of challenge currently were around environmental contacts and heavy use touch points such as doors and telephones. A specific champion had been identified to address this and extra cleaning had been put into place for these areas.

QS21/63.3 A conversation took place around how the HMT and wider staff within the hospital felt following the outbreak. The HMT felt it was essential and appropriate to be open and honest about what had happened although this was challenging. Teams were clear that the harm and worry caused to patients and families must be acknowledged but that a focus must be on learning lessons and preventing similar occurrences. As a leadership team the HMT felt it was their responsibility to make it as easy as possible for staff to do the right thing in terms of compliance with infection prevention processes. The Executive Director of Nursing and Midwifery recognised the difficult situation that the HMT were in and thanked them for their candour at the Committee meeting. She acknowledged how tired the staff were as a

whole but commended them for responding to the outbreak so positively. She alluded to a perception that specific outbreaks and infection prevention control in general were still seen as predominantly a nursing issue. The Hospital Medical Director confirmed that all staff groups had taken responsibility and every clinical group was struggling to come to terms with the outbreak.

QS21/63.4 The Chair appreciated the transparency awarded within the presentation and discussion. She expressed her disappointment in that the reasons described for the outbreak were well known and were the same pressures that other health organisations were experiencing throughout the UK. She felt that leadership and accountability were key and that an enhanced check and challenge approach needed to be established. She asked whether the Committee could be assured that the same level of complacency would not return as the Hospital moved on from the outbreak. The Hospital Medical Director stated that there had been appropriate controls in place on the site however there were insufficiencies in terms of measuring compliance and in ensuring that the controls were embedded and sustainable. She added that the principle of making it hard for individuals to do the wrong thing was being followed, and it was noted that external 'critical friend' reviews would help the HMT in terms of a fresh approach. The Executive Director of Workforce & OD suggested there could be a useful exercise for the Health Board to reflect on the outbreak which could provide rich learning to help the organisation consider the effectiveness of its leadership. She also referred to the 'Stronger Together' route map which would help embed a learning culture as a positive opportunity.

QS21/63.5 The Executive Director of Primary and Community Services wished to record his thanks for the HMT's attendance in difficult circumstances and he commended the evident leadership. In terms of the outbreak he felt there was much to be learned collectively by the organisation. The Acting Executive Medical Director supported this and appreciated the candour and approach of the HMT. He asked whether there was a view as to how much of the learning from the Wrexham outbreak had filtered across other sites. The Interim Hospital Director confirmed that the HMT were sighted on the Wrexham outbreak but he felt that a more aggressive and proactive approach could have been taken to establish what actions could be taken prevent occurrence on the YG site. The Hospital Medical Director added that similarities were recognised from the report of the Wrexham outbreak and controls were put in place, however, the checking and refreshing of those controls should have been stronger to ensure they were properly embedded.

QS21/64 Covid Update

QS21/64.1 The Chair welcomed the comprehensive update and indicated that she found the composite report approach helpful and she would wish to see this continued. She suggested that as members would have read the report she would go straight to discussion and questions.

QS21/64.2 A member enquired whether it was thought that the Health Board was sufficiently agile to respond to the ever-changing nature of the vaccination and Test Trace Protect (TTP) programmes. The Executive Director of Public Health felt that agility had been proven to date but it was difficult to know what the future might hold, for example the impact of the pilots for large gatherings. She assured the Committee that the Board would continue to work with NHS Wales and other partners to deliver what was required. In response to a question regarding vaccination communications other than via the Health Board website, the Executive

Director of Nursing and Midwifery stated that a significant amount of work was being undertaken with Local Authority colleagues and other networks in terms of the hard to reach groups. A specific question was raised regarding the statement that over 4000 returns had been made from unpaid carers and whether the Board knew what the overall benchmark total should be. The Executive Director of Nursing and Midwifery would follow this up outside of the meeting and reply directly. In response to a point raised regarding discrepancies in take up figures across the East and West areas, the Executive Director of Nursing and Midwifery confirmed that work was ongoing but assured members that a number of vaccines were repatriated and additional clinics held. The Chair enquired how the vaccination programme would continue in the longer term once the Mass Vaccination Centres had been decommissioned. The Executive Director of Nursing and Midwifery indicated that a range of options were being considered, including consideration of 'pop up' venues with Local Authority colleagues. All options would need to take into account issues around vaccine storage and the additional challenges for delivery in a primary care setting. [*Teresa Owen left the meeting*] **QS21/64.3** The Chair referred to the statement in the paper regarding receipt of a contravention letter from the Health and Safety Executive (HSE), and the Executive Director of Workforce and OD confirmed that the requirements had already been met following a related matter around fit testing. An Independent Member enquired as to the situation with the outbreak within HMP Berwyn and the Executive Director of Primary Care and Community Services confirmed this was under control and he undertook to provide some data outside of the meeting. **QS21/64.4 It was resolved that** the Committee note the position outlined in the report	GH CS
QS21/65 Mental Health and Learning Disabilities Division receipt of and actions from the "Review of the Discharge of Mental Health Patients During the Covid-19 Pandemic" *[Gareth Evans and Teresa Owen rejoined the meeting]* **QS21/65.1** The Interim Director of Nursing for Mental Health and Learning Disabilities undertook to circulate a copy of the report prepared in August 2020 by Clare Darlington to Independent Members of the Committee. The report stemmed from an incident in March 2020 where a number of patients were inappropriately discharged from the Division back to primary care. The report found key points of learning around communications and capacity and the Interim Director of Nursing for Mental Health and Learning Disabilities confirmed that the Division accepted the findings and recommendations and had developed an associated action plan in response. **QS21/65.2** The Chair was aware that a reflective session had been held within the Division to go through the report and that it had been a challenging time for staff but she was pleased to have observed an improved communications culture in areas that she had visited. She also noted that the media coverage in 2020 had focused solely on the discharge of patients and noted that the investigation had clarified that safety net arrangements had been put in place for each patient. The Chair pointed out that the report itself had not been shared as part of the Committee papers so it was difficult for members to be assured that the Division had addressed the recommendations. She asked for the report to be shared with members after the meeting.	MS MS

QS21/65.3 A discussion ensued. An Independent Member made a comment around the use of acronyms in that they could mean different things depending on the setting and service – for example SLT was used for both Senior Leadership Team and Speech and Language Therapy. She felt that consistency and referencing of acronyms could be improved and the Board Secretary undertook to give this some thought in the wider terms of Board and Committee papers. An Independent Member enquired how many patients had been affected and it was confirmed this was over 100. The Chair advised it was a lot higher than this but could not recall the exact numbers. Another Independent Member noted there was reference to keeping in touch conversations with Local Authority leads in response to Recommendation 2 and asked if these had commenced and how any issues were escalated. The Interim Director of Nursing for Mental Health and Learning Disabilities indicated this was underway and that escalation would be through re-establishing the strategy and partnerships element within the Division. In response to a further question, he confirmed that the review of Part 1 of the Mental Health Measure had started as part of the adult and community pathway review. An Independent Member also enquired regarding the identification of harm and it was confirmed there was no evidence of actual harm although a small number of the patients discharged did go on to access mental health services. Finally, the Interim Director of Nursing for Mental Health and Learning Disabilities indicated that work continued to strengthen the Patient Carer Experience sub-groups to ensure they were more closely aligned to the Board's strategy and able to develop learning and actions from patient experience.	LB
QS21/65.4 The Chair stated that it was not clear from the report how the actions would actually address the recommendations. She acknowledged that the service had reflected on the findings of the review, but the Committee could not be assured from the report before it that the actions would fully address the recommendations. It was agreed that the Chair would meet with the Interim Director of Nursing for Mental Health and Learning Disabilities to go through the report and action plan. **QS21/65.4 It was resolved that** the Committee note:- 1. That the division fully accepts both the findings and recommendations of the report 2. That the division has considered and stated its learning from the report, subject to the actions agreed 3. That the division has stated its actions to prevent recurrence both tactically and strategically as it plans its next steps.	MS
QS21/66 Mental Health and Learning Disabilities Exception Report **QS21/66.1** The Chair indicated that as members would have read the comprehensive report she would go straight to questions. An Independent Member queried why the new Divisional Director of Operations post was referred to as interim; the Chief Executive reported that moving to make some interim appointments permanent was ongoing however it was important to get it right and ensure that particular employment complications were managed appropriately. In response to a question regarding communication between the various elements of the governance meeting structure the Interim Director of Nursing for Mental Health and Learning Disabilities noted that the Senior Leadership Team coordinated and attended all meetings but he would feed this point back. [*Melanie Maxwell left the meeting*] **QS21/66.2** A question was raised how the effectiveness of mental health services was measured, ensuring the right interventions at the right time. The Interim Director of Nursing for Mental Health and Learning Disabilities noted that this was supported through the	MS

performance dashboard and the Clinical Effectiveness Group (CEG). The Chair added that the next phase of the governance review would also address committee effectiveness including the Mental Health Act Committee. The Executive Director of Public Health added that the CEG was key to delivering NICE guidance and pulling together outcomes across a wider portfolio than just mental health.

QS21/66.3 The point was made whether both children and adult mental health services should be reporting in the same way as part of the Targeted Intervention arrangements. The Executive Director of Public Health noted that children's services had different challenges but accepted that papers needed to be more focused but convey the same information to Committee members. The Chair felt it would be helpful to receive similar updates from children's mental health services but suggested this was picked up as part of the review of Committee cycles of business within the ongoing governance review.

QS21/66.4 It was resolved that the Committee note the update from the Mental Health & Learning Disabilities Division.

QS21/67 Quality Governance Review : Ysbyty Glan Clwyd (YGC)

QS21/67.1 The Executive Director of Nursing and Midwifery presented the paper which set out progress with the planned review based on Care Quality Commission (CQC) methodology. The review had been undertaken following a number of concerns about service provided by YGC site and the report now provided a range of organisation-wide learning around the use of data for intervention, learning and decision making.

QS21/67.2 A discussion ensued. The Chair indicated that she had expected to have received the Improvement Plan as part of the agenda pack, and the Secondary Care Nurse Director responded that the initial focus had been on strengthening governance and leadership, and implementation of 'Make it Safe' processes. The Committee were assured that a range of immediate actions had been put in place as set out in the paper, and there were other areas of progress which were difficult to articulate. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience stated that the Improvement Plan would be developed by the new Director of Nursing when appointed. The Chair responded that whilst she understood the reasons for the delay she remained concerned that there was not yet an agreed Improvement Plan.

QS21/67.3 An Independent Member raised a point around the self-assessment process in that the review team might not come to the same conclusions which should require the gaps to be addressed. The Secondary Care Nurse Director indicated that they would need to identify the evidence to find the common ground, and that there was extensive triangulation from a number of sources as part of the review process. In response to a question regarding how the Executive Team will ensure that the new site leadership team are supported to deliver what was required of them, the Chief Executive indicated a more proactive approach was required, to build on areas such as the use of dashboards to provide timely clinically relevant information.   She referred to recent walkarounds on hospital sites and that she had been pleased to see scores displayed forward accreditation which linked in to the conversations the Board was having around a balanced scorecard approach and signalled the commitment to put patients at the heart of everything.

QS21/67.4 It was resolved that the Quality, Safety and Experience Committee receive the update.	
QS21/68 Healthcare Inspectorate Wales Update **QS21/68.1** The Chair indicated that as members would have read the report she would go straight to questions. She enquired regarding an overdue action pertaining to ligature risk assessments and the Interim Director of Nursing for Mental Health and Learning Disabilities confirmed that although there had been extensive estates work to address this risk, new guidance meant that the risk assessments were having to be revisited. **QS21/68.2** In response to a question regarding the timeframe for a pathway of age appropriate mental health beds, the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience undertook to obtain an update from the service and circulate this outside of the meeting. **QS21/68.3** An Independent Member noted that given the pandemic the summary of inspections for 2020-21 was on the whole positive. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience agreed but added a caveat that about a quarter of the inspections were follow up reviews. **QS21/68.4** A concern was raised regarding the implications of findings relating to infection prevention control at Ward 11 in YGC. It was agreed that this would be followed up by the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience with the Executive Director of Nursing and Midwifery. **QS21/68.5** The Chair enquired how issues raised by HIW relating to independent providers were followed up, and the Executive Director of Primary Care and Community Services confirmed that this was the case, with breach notices raised where applicable but he accepted this was not clear in the paper. This would be addressed in future reports. *[Mike Smith left the meeting]* **QS21/68.6 It was resolved that** the Quality, Safety and Experience Committee receive the report for assurance.	MJ MJ MJ/CS
QS21/69 Healthcare Inspectorate Wales Maternity Review : BCU Action Plan **QS21/69.1** The Chair indicated that as members would have read the report she would go straight to questions. An Independent Member enquired how the first action relating to patient language of choice would be audited, and the Executive Director of Public Health undertook to check this with the service and confirm outside of the meeting. A formatting error against recommendations 3 and 4 was noted and the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience would circulate a corrected version. The Chair referred to recommendation 12 around patient stories and felt that the response was very localised and should be strengthened to cover all services at Board / Corporate level. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience confirmed there was a plan for this level of meetings.	TO MJ

QS21/69.2 It was resolved that the Quality, Safety and Experience Committee receive the report for assurance.	
QS21/70 Quality Governance Self Assessment Action Plan (Maternity Services) **QS21/70.1** The Chair indicated that as members would have read the report she would go straight to questions. She referred to the stated timescale for national clinical audits and the green rating within the paper, but was conscious that clinical audit activity had been paused. The Acting Executive Medical Director confirmed that clinical audit had now recommenced and the Clinical Effectiveness sub group was re-engaging with this agenda with the intention of ensuring clinical audit was aligned to the development of the overarching clinical strategy. The Chair felt that on this basis the RAG rating should not be green, and the Acting Executive Medical Director undertook to pick this up with the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience outside of the meeting. **QS21/70.2 It was resolved that t**he Committee note the report and update of the Quality Governance Self-Assessment Action Plan.	AG MJ
QS21/73 Quality & Performance Report *[Agenda item taken out of order at Chair's discretion. Kamala Williams joined the meeting]* **QS21/73.1** The Chair indicated that as members have read the report she would go straight to questions. An Independent Member noted the statement that there was a high percentage of re-referrals for mental health and asked whether this meant there were low waiting lists. The Acting Director of Performance indicated there was an upward trajectory for assessments within 28 days however there remained significant issues within children's mental health services – particularly for neuro assessments. Another Independent Member asked why there was such a widening gap between adult and children's services. The Acting Director of Performance undertook to take this away as an action to be considered at the accountability review meetings later that week. In terms of neuro assessments, the Executive Director of Primary Care and Community Services noted the challenges of undertaking these remotely with children and whilst face to face activity had increased there was a backlog. He would work with the team to provide a recovery projection over the next few months. In response to a question regarding delivery of the sepsis bundle the Acting Executive Medical Director was cautiously positive and confirmed there were conversations ongoing with the site lead clinicians regarding these responsibilities. **QS21/73.2 It was resolved that** the Committee note the report *[Kamala Williams and Jo Whitehead left the meeting]*	KW CS
QS21/71 Patient and Carer Experience Q4 Report **QS21/71.1** The Chair felt that the reporting style had matured and although there was still more to do, it was pleasing to see evidence of increased engagement and learning. She indicated that as members would have read the report she would go straight to questions. In response to questions from an Independent Member, the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience confirmed that reference to complaints response performance included children's services, and that a central complaints contact point was established some 12 months ago which had helped to ensure urgent matters were escalated in a timely fashion. A point was then raised regarding patient	

feedback methodologies and the role of volunteers. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience accepted there were limitations with the current system, and feedback levels had decreased during the pandemic. A new multi-layered system, procured on a once for Wales basis, was being rolled out and would be live by end of June. Patient Experience and Patient Advice and Liaison Service teams had been trained up in its use together with some Robin volunteers.

QS21/71.2 An Independent Member raised that a common concern from families was around communication and telephones not being answered. The Executive Director of Nursing and Midwifery acknowledged that this was frustrating and set out her ambition for more ward clerks and support staff to free up nursing time more appropriately. Another Independent Member welcomed the introduction of the bereavement service which she was aware had been well-received. She also raised the 'pay as you go' TV facility in Ysbyty Gwynedd which she felt was an infection risk in terms of the touch points, and it was noted this was likely to be phased out with the introduction of ipads as an alternative. Finally, it was confirmed that photographs could be included within the 'letters to loved ones' scheme.

QS21/71.3 It was resolved that the Committee note the ongoing planned improvement work, including review of various Health Board processes.

[Jo Whitehead rejoined the meeting]

QS21/72 Patient Safety Q4 Report **QS21/72.1** The Chair indicated that as members would have read the report she would go straight to questions. In response to a query regarding information on catastrophic events, the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience reminded members that Welsh Government had stood down this reporting requirement for this year so there was no rolling comparison. He assured the Committee that the number reported was not of significant concern and he accepted that a more thematic rolling report would be helpful going forward. **QS21/72.2** A comment was made that it was difficult to track inquest data and the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience acknowledged there were issues with the current system which was still based on the former Clinical Programme Groups structure, but would improve from July. An Independent Member asked about support to staff around inquests and it was reported that this did happen but some types of inquest did not require witness statements. An Independent Member added that she had received positive feedback from staff around the support they had received in relation to writing witness statements or attending inquests. **QS21/72.3** The Chair was pleased to note evidence of improved triangulation coming through in the report, however, she still felt that the reporting of Never Events could be strengthened in terms of closing the loop. She would wish to discuss further with the Executive Director of Nursing and Midwifery and the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience. The Chair also referred to the section within the report on significant claims and learning. As a general point she felt it was helpful to provide details of the amount paid against each claim. She went onto refer to a specific claim around delay in diagnosis of appendicitis and said that the narrative did not include learning nor was it clear which governance meeting was being referred to. The Acting Associate Director of	MJ GH

Quality Assurance / Assistant Director of Patient Safety and Experience would check and ensure consistency in future reports. Finally, the Chair noted reference to issues with the return of documentation and/or evidence and asked if these delays had resulted in any issues. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience indicated that Welsh Risk Pool had been more flexible with deadlines over the past year so these were not areas of concern. **QS21/72.4 It was resolved that** the Quality, Safety and Experience Committee: 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. Note the delay of the Once for Wales Concerns Management System. 4. Receive this report and provide feedback on its evolving content and layout. *[Jackie Allen and Gill Harris left the meeting].*	MJ
QS21/75 Board Assurance Framework and Corporate Risk Register *[Dawn Sharp joined the meeting]* **QS21/75.1** The Chair reported that in consultation with the other Independent Members it had been agreed not to receive the Corporate Risk Register report as there were dates and information within the paper that did not align to the actions that the Committee was being asked to take. In addition, there were decreases in scores which were not explained within the narrative, and some of the dates when the risks were last reviewed were incorrect. She asked that these matters be resolved outside of the meeting. **QS21/75.2** In terms of the Board Assurance Framework (BAF), the Deputy Board Secretary invited questions on Appendix 1. A discussion took place regarding BAF20-14 (Security Services). The Executive Director of Workforce and OD stated there had been recognition that health, safety and security had been under-resourced and that the pandemic had also impacted disproportionately on this area. She suggested that the Board did recognise the need for additional resource and improved connectivity and stated that she would be concerned if additional support had not been mobilised by the next Committee meeting. The Chair queried whether this particular risk merited the increase in score (from 15 to 20) given its proportionality to other clinical risks within urology, cancer or ophthalmology for example. *[Jo Whitehead left the meeting]* The Executive Director of Workforce and OD noted that she did not envisage the risk remaining at 20 for any length of time and accepted the points around calibration and moderation as a whole, which would be taken back to the Risk Management Group. *[Gill Harris rejoined the meeting]* **QS21/75.3** The Chair acknowledged the amount of work going into developing the BAF which she could see was progressing positively. **QS21/75.4 The recommendation was amended and it was resolved that** the Committee review and note the progress on the Principal Risks as set out in the Board Assurance Framework (BAF) *[Dawn Sharp left the meeting]*	SEE SG

QS21/76 Annual Assurance Report on compliance with Nurse Staffing Levels (Wales) Act 2016 **QS21/76.1** The Secondary Care Nurse Director presented the paper which incorporated both the annual report and a triannual amalgamated report, highlighting that the template was prescribed on an all Wales basis. The Executive Director of Nursing and Midwifery noted that this was the first time the triannual report had been produced and it was a challenging year with the high levels of staff redeployment and therefore caution should be exercised in comparing levels to previous years. The Secondary Care Nurse Director added that the duty would also be extended to paediatric in-patient wards from October 2021. **QS21/76.2** A discussion ensued. An Independent Member referred to BAF20-25 regarding the impact of Covid-19 on staffing levels and suggested that the narrative could be more explicit to clarify this risk related to a direct and indirect impact. She also enquired whether compliance could be colour-coded but it was clarified that the template was prescribed. In response to a question from the Chair as to whether people had returned to the organisation post redeployment, it was agreed that the Executive Director of Workforce and OD would follow up this data. **QS21/76.3 It was resolved that** 1. The Committee note and support the following next steps which are incorporated into the overall Health Board recruitment and retention programme : a. Targeted focus of innovative Nurse recruitment campaigns both locally, nationally and internationally b. Succession planning for the future, ensuring we are developing our next generation leaders c. Creatively co-designing our post graduate programmes as key attractors d. Analysing workforce data to better inform Nurse recruitment and retention initiatives e. Review of implementation of new roles to support the nursing recruitment pipelines f. Expansion of quality improvement driven collaborates to assist in reducing variation and harm reduction with a zero tolerance approach g. Development of a Nurse performance dashboard as a further monitoring and assurance tool in real time h. Further analysis of deviations from previous reporting periods and analysis of the first triennial reporting period of the Act 2. The Committee support the sharing of outputs of the Nurse Staffing reviews with the Finance and Performance Committee to support changes to the Nurse staffing establishments as presented	SG
QS21/77 Patient Safety Quality Group : Chair's Triple A Report QS21/77.1 The report was noted.	
QS21/78 Antimicrobial Prescribing Policy **QS21/78.1** It was noted that the policy has been agreed at Antimicrobial Steering Group; Medicines Policies and Procedures Group; Drug and Therapeutics Group and the former Quality Safety Group. The Chair enquired how prescribers would be alerted to the changes within the revised policy – given they were substantial. The Executive Director of Nursing and Midwifery indicated there was an associated programme of training and rollout which would include primary care prescribers.	

QS21/78.2 A wider point was raised around the management of clinical policies and the route for approval. The Board Secretary confirmed she was looking at the governance route for policies with the Interim Director of Governance. The Executive Director of Workforce and OD suggested it might be helpful to consider the tiered approach taken by the Remuneration and Terms of Service Committee. **QS21/78.3 It was resolved that** the Committee approve the Antimicrobial Prescribing Policy.	LB
QS21/79 Committee Annual Report 2020-21 **QS21/79.1** The Chair informed members that in conjunction with the Executive Director of Nursing and Midwifery the annual report had been amended to reflect that delivery against a range of committee objectives had been stepped down in-year. She confirmed that she had alerted other Committee Chairs and the Board Secretary to the fact that the QSE report would look different to others when submitted to the Audit Committee workshop. [*Debra Hickman left the meeting*]. The Board Secretary added that she agreed the amendments made the report more meaningful and she would support a flexible approach but would ensure she discussed the matter with the Audit Chair ahead of the workshop. **QS21/79.2** The Executive Director of Therapies and Health Sciences referred to the attendance record within the report and suggested that it could be clearer which meetings had been held with a reduced attendance in line with governance processes during the pandemic as context for the record of attendance. **QS21/79.3 It was resolved that** pending the agreed amendment the Committee approve the annual report for submission to Audit Committee.	KD
QS21/80 Issues Discussed in Previous Private Session **QS21/80.1 It was resolved that** the Committee note the report	
QS21/81 Documents Circulated to Members 25.2.21 Operational Plan Monitoring Report and Quality Performance Report 13.4.21 Internal Audit Limited Assurance Report - MH&LD Governance Arrangements	
QS21/82 Board of Community Health Councils in Wales "Feeling Forgotten?" Report **QS21/82.1** The report was noted. The Executive Director of Nursing and Midwifery added that the Board would reflect on the report and develop its response.	
QS21/83 Issues of Significance to inform the Chair's Assurance Report To be agreed outside of the meeting	
QS21/84 Date of Next Meeting 6.7.21	

QS21/85 Exclusion of Press and Public

QS21/85.1 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
15th January 2021				
G Harris	**QS21/9.3** Follow up the matter of a communications plan for the Holden report recommendations, involving the CHC	31.1.21	19.1.21 Meeting arranged between CHC and M Joyes on 25/01/2021. 2.3.21 A member enquired whether a communications plan was now available. G Harris confirmed that different options were being explored and she would ensure an update be provided in due course. 27.4.21 The Health Board is continuing discussions with the ICO and will update the Committee fully once these are concluded. 4.5.21 G Harris confirmed that when appropriate there would be a progress update given to the Committee. Members were happy to close the action which had been clarified outside of the meeting.	~~Closed~~ May July Closed
L Brereton	**QS21/20.1** Pickup concerns around reporting lines for safeguarding matters as part of a wider review of CoBs	2.3.21	17.2.21 L Brereton confirmed matter will be addressed through the ongoing review of the Board and Committee business cycles linked into the governance review work. 2.3.21 L Brereton confirmed that mapping of cycles of businesses was being progressed alongside the governance review, and assured the Committee that safeguarding reporting would be picked up but the timescale for completion of this action would need extending. L Reid agreed to this extension.	Update to be provided in May

			She also reported she was meeting with M Denwood regarding reporting to the MHAC.	
			26.4.21 Safeguarding item was deferred, with Chair's agreement, to the July Committee	July
			29.6.21 Safeguarding report on July agenda	Closed
2nd March 2021				
T Owen L Brereton	**QS21/39.3** Review controls in BAF20-08 and make learning aspect more visible	23.3.21	26.4.21 Controls have been reviewed as part of BAF risk review process. Learning as a control requires further reflection within the BAF risk. 4.5.21 T Owen linking in with governance team to use an approach that all are comfortable with. The Committee were happy to close the action.	Closed
G Harris L Brereton	**QS21/39.3** Review controls in BAF20-11 and make learning aspect more visible	23.3.21	26.4.21 Risk reviewed with Risk lead. Further controls to be explored as part of next risk review. 4.5.21 The Committee were happy to close the action.	Closed
G Harris	**QS21/39.4** Determine with team their ambition for demonstrating improvement against CRR20-08 (clinical capacity re vision loss)	23.3.21	4.5.21 G Harris confirmed that a meeting has been arranged. 27.5.21 Confirmation that meeting held and matter resolved.	Closed
~~L Brereton~~ Simon Evans-Evans	**QS21/39.4** Arrange meeting with G Harris, L Reid, M Wilkinson and S Hill to work through cross-over issues on CRR20-08 (clinical capacity re vision loss)	23.3.21	26.4.21 Meeting being convened 27.5.21 Confirmation that meeting held and matter resolved.	~~Closed~~
S Green	**QS21/41.2** Include demographic breakdown including socio-economic and ethnicity factors into next H&S report, together with themes from the Make it Safe reviews.	21.4.21 (deadline for May papers)	26.4.21 Following agenda setting meeting, Chair had indicated she did not require stand-alone H&S report to May meeting. 4.5.21 L Reid would have wished to have seen H&S themes included within the Covid report. S Green confirmed that these elements had been provided and should have been incorporated.	July

			22.6.21 The combined report on COVID did include H&S information. Sally Baxter has been approached for regarding the inclusion of this information in the Q1 report, as team were previously advised it was not required.	September
A Gralton C Stockport	**QS21/42.2** Provide information outside of the meeting on face to face and remote consultation figures for neurodevelopment assessments of children and young people	23.3.21	26.4.21 IMs have not received this information. A Gralton has been asked to expedite on his return from leave. 4.5.21 C Stockport agreed to follow up	
M Maxwell	**QS21/44.2** Follow up with L Reid the comments around content and presentation and ensuring actions addressed findings in mortality reports.	23.3.21	26.4.21 M Maxwell updated – meeting held with Committee Chair around Covid HCAI mortality work as part of a larger piece of work on learning lessons from Covid HCAIs more generally. At the time of the meeting the definitive review list for deaths had been made available to sites and it was clear that the backlog of stage 2 reviews will take time to complete. A further action was taken away for M Maxwell to consider guidance and emergent information timelines could be superimposed on the learning. CEG will consider the timeline for stage 2 reviews. 4.5.21 A Guha assured QSE there was pace around this work. The Committee were happy to close the action.	Closed
A Kent	**QS21/46.3** Reflect on comments and expectations around ensuring a richer narrative for future planned care papers.	21.4.21 (deadline for May papers)	26.4.21 Planned Care item was deferred, with Chair's agreement, to the July Committee 4.5.21 G Harris confirmed that in future a lead clinician will also be involved in providing updates to the QSE. 29.6.21 Refreshed paper on planned care on July agenda.	July Closed
4th May 2021				

G Harris	**QS21/64.2** A specific question was raised regarding the statement that over 4000 returns had been made from unpaid carers and whether the Board knew what the overall benchmark total should be. The Executive Director of Nursing and Midwifery would follow this up outside of the meeting and reply directly	25.5.21	20.5.21 The relevant IM was notified that a benchmark total is difficult to ascertain as it was agreed at a National level not to validate individuals coming forwards through the Unpaid carers form as it was agreed that there was no effective, timely or viable solution to enable this to happen.	closed
C Stockport	**QS21/64.3** An Independent Member enquired as to the situation with the outbreak within HMP Berwyn and the Executive Director of Primary Care and Community Services confirmed this was under control and he undertook to provide some data outside of the meeting.	25.5.21	24.6.21 The HMP Berwyn outbreak was confirmed closed on 13 April	Closed
M Smith	**QS21/65.1** The Interim Director of Mental Health and Learning Disabilities undertook to circulate a copy of the report regarding Primary Care Discharges prepared in August 2020 by Clare Darlington to Independent Members of the Committee	25.5.21	Copy circulated on 10.5.21 1.6.21 L Reid has met with MHLD Team and discussed the actions that the division has taken regarding the primary care discharges and how they link to the TI maturity matrix.	Closed
M Smith	**QS21/65.2** Circulate copy of the primary care discharges report to members	11.5.21	Copy circulated on 10.5.21	Closed
L Brereton	**QS21/65.3** Give further thought to improving consistency and referencing of acronyms in Board and Committee papers.	1.6.21	29.6.21 Committee support provide a QA process as part of report sign off. Consistency and referencing of acronyms are being addressed through this QA.	Closed
M Smith	**QS21/65.4** It was agreed that the Chair would meet with the Interim Director of Nursing for Mental Health and Learning Disabilities to go through the primary care discharges report and action plan.	June	29.6.21 the meeting took place as suggested and matter completed	Closed

M Smith	**QS21/66.1** In response to a question regarding communication between the various elements of the governance meeting structure the Interim Director of Mental Health and Learning Disabilities noted that the Senior Leadership Team coordinated and attended all meetings but he would feed this point back	25.5.21	29.6.21 The Division reviewed all its tier 1 and 2 governance meetings at the beginning of 2021 following the Internal Audit report into governance . The Divisional Senior Leadership Team chair every meeting and also are in attendance / invited to all other governance meetings which are minuted and shared. Attendance is monitored at all meetings. The different meetings for governance, have all reviewed and confirmed their terms of reference and these are now embedded and established in the divisions working practices . Communication has not been an issue in the governance structure for the SLT. .	Closed
M Joyes	**QS21/68.2** In response to a question regarding the timeframe for a pathway of age appropriate mental health beds, the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience undertook to obtain an update from the service and circulate this outside of the meeting.	1.6.21	11.6.21 The pathway has been approved and is now in place on the intranet.	Closed
M Joyes	**QS21/68.4** A concern raised regarding the implications of findings regarding infection prevention control at Ward 11 in YGC would be followed up by the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience with the Executive Director of Nursing and Midwifery.	1.6.21	11.6.21 As advised verbally in the meeting, this relates to a HIW Quality Check which found an action plan had not been developed in response to an infection control audit. As a result of this issue, and the Quality Governance Review which identified the same issue, all audits are now formally received at the Local Infection Prevention Group ensuring site leaders are sighted on the audits and the corresponding action plans.	closed

M Joyes C Stockport	**QS21/68.5** Ensure clarity in future reports as to how issued raised regarding independent providers were followed up.			
T Owen	**QS21/69.1** Check with the service how the first action from HIW maternity review relating to patient language of choice would be audited and confirm outside of the meeting.	June	29.6.21 Action No.1: *"**Ensure that women are aware of how they can request information or support in their language of choice".** Women are asked about their language of choice and in which language they wish to receive information at the very early starting point of the booking stage. Their choice is then recorded on the All Wales Hand Held Notes for all future visits and contacts and as per the Welsh Language Act (1993). We have in place a local policy that promotes the Welsh Language Act in addition to bilingual maternity documentation across all services. Should a woman require language assistance, for example an interpreter or other communication support, this will be arranged through the Wales Interpretation and Translation Service (WITS). This meets all types and levels of language needs. Information is also accessible in various formats, to meet sensory needs. Patient leaflets are available to provide the necessary contact information for WITS and is available on the intranet (ISU02). Patient Information Booklets for Maternity Services are also available through a wide range of languages to meet a variety of cultural needs. Local audits to validate whether language of choice has been promoted, takes place by Senior Matrons across acute and community services, reporting to the Head of Women's Services and the North Wales Women's Board. This is monitored via	Closed

			the Women's newly developed Clinical Effectiveness Group (previously WCD meeting) who monitors all audit activity.	
M Joyes	**QS21/69.1** Circulate correctly formatted version of the Healthcare Inspectorate Wales Maternity Review : BCU Action Plan	25.5.21	Copy emailed 5.5.21	Closed
A Guha M Joyes	**QS21/70.1** Review the RAG rating of the national clinical audits within the Quality Governance Self Assessment Action Plan (Maternity Services) following discussion that it should not be green if clinical audit had been paused.	1.6.21	11.6.21 The Acting Executive Medical Director and Acting Associate Director of Quality Assurance have discussed and the rating has been changed appropriately.	Closed
K Williams	**QS21/73.1** Ensure the matter of the widening gap between adult and children's services performance be considered at the accountability review meetings later that week.	11.5.21	17.6.21 The Issue was discussed at the Primary and Community Care Executive Divisional Accountability meeting on the 6.5.21. In addition the June 2021 QSE Q&P report includes an update detailing the latest position with regards to the action taken/planned and associated timelines for improvement in CAMHS performance.	Closed
C Stockport	**QS21/73.1** In terms of neuro assessments, the Executive Director of Primary Care and Community Services noted the challenges of undertaking these remotely with children and whilst face to face activity had increased there was a backlog. He would work with the team to provide a recovery projection over the next few months	July	24.6.21 Christina Billingham is preparing a position paper with Liz Fletcher, who has kindly stepped in to cover during Andrew Gralton's absence. The paper will then be developed further into a recovery plan.	September
M Joyes G Harris	**QS21/72.3** The Chair was pleased to note evidence of improved triangulation coming through in the report, however, she still felt	1.6.21	11.6.21 The Chair, Executive Director of Nursing and Midwifery and the Acting Associate Director of Quality Assurance met to discuss. A specific	closed

	that the reporting of never events could be strengthened in terms of closing the loop. She would wish to discuss further with the Executive Director of Nursing and Midwifery and the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience.		thematic paper on Never Events is being presented at the meeting in July 2021. Additionally, a workshop learning event is planned for August 2021.	
M Joyes	Check and ensure consistency in future reports following Chair's comments regarding the narrative of a claim around delay in diagnosis of appendicitis which she felt did not include learning nor was it clear which governance meeting was being referred to.	1.6.21	11.6.21 The feedback has been shared with those developing the papers and will be amended for future reports.	Closed
S Evans-Evans	**QS21/75.1** The Chair reported that in consultation with the other Independent Members it had been agreed not to receive the Corporate Risk Register as there were dates and information within the paper that did not align to the actions that the Committee was being asked to take. In addition there were decreases in scores which were not explained within the narrative, and some of the dates when the risks were last reviewed were incorrect. She asked that these matters be resolved outside of the meeting.	1.6.21	29.6.21 Discussions with the Chair have taken place outside of the meeting – a revised paper is on the agenda	Closed
S Green	**QS21/75.2** The Chair queried whether this BAF20-14 (Security) merited the increase in score (from 15 to 20) given its proportionality to other clinical risks within urology, cancer or ophthalmology for example. The Executive Director of Workforce and OD noted that she	July	22.6.21 The Security Risk went to the Risk Management Group on 15th June and will be further explored at the next meeting where a deep dive of the Security BAF will be undertaken at the request of S Green.	Closed

	did not envisage the risk remaining at 20 for any length of time and accepted the points around calibration and moderation as a whole, which would be taken back to the Risk Management Group			
S Green	**QS21/76.2** In response to a question from the Chair as to whether people had returned to the organisation post redeployment, it was agreed that the Executive Director of Workforce and OD would follow up this data.	1.6.21	23.6.21 data circulated to Committee members. IMs subsequently sought further context around the issue which related to the numbers of (nursing) staff having left the organisation because of redeployments who then did or did not return and whether this was problematic.	
L Brereton	**QS21/78.2** A wider point was raised around the management of clinical policies and the route for approval. The Board Secretary confirmed she was looking at the governance route for policies with the Interim Director of Governance. The Executive Director of Workforce and OD suggested it might be helpful to consider the tiered approach taken by the Remuneration and Terms of Service Committee.	July	29.6.21 Review of policy on policies due to commence shortly, informed by governance review and approach across the Health Board. Process due for completion by September 21.	September
K Dunn	**QS21/79.2** The Executive Director of Therapies and Health Sciences referred to the attendance record within the report and asked that it be made for explicit which of the meetings had been run on a reduced attendance basis.	14.5.21	Relevant section updated and submitted for Audit Committee	Closed

29.6.21

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 6th July 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Patient Story
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris Executive Director of Nursing and Midwifery/Deputy Chief Executive
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance Carolyn Owen, Head of Patient and Carer Experience Courtney Thomas, Patient Advice and Liaison Service
Craffu blaenorol: Prior Scrutiny:	Review by: - Debra Hickman, Nurse Director - Matthew Joyes, Acting Associate Director of Quality Assurance - Presentation at the Corporate Patient Safety and Quality Group and Corporate Patient and Carer Experience Group
Atodiadau Appendices:	1. Patient Story Transcript Form
Argymhelliad / Recommendation:	
The Quality, Safety and Experience Committee is asked to receive and reflect upon the patient story.	

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

Betsi Cadwaladr University Health Board

Patient Stories Transcript Form

Who took the story?	Facilitator name:
	Courtney Thomas
	Patient Advice and Liaison Officer
	Patient Experience Team
	Date taken:
	10/05/2021
	Venue taken:
	Glan Clwyd Hospital
What is the title of the story?	Zoe's story
What area does the story relate to? E.g. Cancer Services	Emergency Department (ED), Surgical Assessment Unit (SAU), Diabetes

What is the format of the story?	Audio	**CLICK HERE** for the audio version (accessible only when connected to the BCUHB network)

Overview of the story Completed by PALS Officer Courtney Thomas	This patient story transpired after Patient Advice & Liaison Service (PALS)had closed a case with the patient's mother regarding patient's admission to Glan Clwyd Hospital's Emergency Department and Surgical Assessment Unit. Since the initial case, the patient was re-admitted but to Acute Medical Unit (AMU) with the same ongoing issues (high blood sugars and sickness), that the patient's mother, Zoe, felt had not been dealt with properly the first time round. Although Zoe was happy with the care the patient received upon their second admission at AMU, she felt if patient received appropriate care and treatment the first time round, then he would not have needed the second admission. Zoe stated that diabetic patients should not be discharged unless they can keep fluids and food down for 12 hours, as this is the time where things can go wrong. Zoe explained that the patient had an infection, but that the hospital were not sure where it was and had now been given antibiotics. Zoe mentioned that every time the patient is admitted to hospital, he is asked whether he takes drugs or drinks alcohol and that he finds this very degrading, which forces him to highlight that he does not and cannot do things that other 21 year-olds do. Patient's mother feels that every patient's diabetic experience is different and believes that what might be a 'hypo' (hypoglycaemia) for one person, would not be a 'hypo' for another. Zoe also feels that nursing staff need further awareness on this matter. Zoe explained that when diabetic patients go into hypo they might refuse food or drink, but that they could be in a confused state where they do not really know what is going on. Therefore, nursing staff should try to explain the situation clearly to patients to help them understand the importance of eating or drinking something at that time.
Key themes emerging and lessons learned Completed by Wendy Thistlewood-Price (Practice Development Nurse ED)	• The patient has badly controlled diabetes since his childhood that has long lasting illnesses as the result of this that now means he has daily struggles, with weakness to legs and hips, and also losing eyesight. • Because of the poor control he has, he usually has very high blood sugars, so what looks like normal range to nurses, is in fact low for this patient. • At present in my role, I am in fact organising diabetes training and that I will emphasise the need to see what is normal range for patient is, as well as what looks like normal range may in fact be out of range for some patients, and I will encourage nurses to find out what is patients normal. This will share the learning across the team in the ED.

	• Patient Experience Training (formerly known as customer care training) will be delivered by the Patient and Carer Experience Team which includes a focus on listening to the patient and their families and carers. • From conversation with mum it was encouraged to gain further support with GP for diabetes control and further investigation for his heart rate, as although his Electrocardiogram (ECG) and blood levels were normal, he has a continuous increased heart rate which may require further examination, he is a very anxious patient which may be a contributor, but still not reasonable to run at this rate all the time, also his medications may require reviewing, this was agreed and accepted as a plan going forward. • The situation may have been less anxious for the patient if mum would have been allowed to stay.
Suggested service improvements to be made Completed by Wendy Thistlewood-Price (Practice Development Nurse ED)	• Those patients with chronic conditions and anxiety issues, a note could be made that family could be present where required; this may alleviate some anxieties, and help understand process. This is especially important when visiting restrictions may be in place due to the COVID-19 pandemic. • In this story, the chronic longstanding issues are a factor and a process where a nurse can suggest recommendation to GP surgery may be possible (this may prevent further admissions to hospital if anxieties and conditions were managed better in the community). Long-term service improvement as nurses at present do not liaise with GPs. • A holistic approach to care taking in factors such as condition, anxieties, what is normal for patient. • Ongoing training around Diabetes management. • Patient Experience Training (formerly known as customer care training) will be delivered by the Patient and Carer Experience Team which includes a focus on listening to the patient and their families and carers. • The story will be shared with the diabetes specialist nurses network to support learning and improvement across the Health Board.

Responsibility for actions required Completed by Wendy Thistlewood-Price (Practice Development Nurse ED)	Information shared with relevant manager/s: Sian Jones Matron ED Deborah Coverley Senior Sister ED Wendy Thistlewood-Price PDN for training	Date shared: 13/05/2021

Actions taken **(You Said, We Did)**	You said: take into account patients usual BM

Completed by Wendy Thistlewood-Price (Practice Development Nurse ED)	We did: implemented into training to provide holistic care and find out what is normal for patient.

Consent / Sign off	Patient Sign off: Yes	Thank you letter sent? Yes

Summary of where Story Shared:	• The service • Patient Safety and Quality Group • Patient and Carer Experience Group • Clinical Effectiveness Group • Quality, Safety and Experience Committee

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 6th July 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quality Awards, Achievements and Recognition
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris Executive Director of Nursing and Midwifery/Deputy Chief Executive
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance
Craffu blaenorol: Prior Scrutiny:	Review by: - Debra Hickman, Nurse Director - Matthew Joyes, Acting Associate Director of Quality Assurance - Presentation at the Corporate Patient Safety and Quality Group and Corporate Patient and Carer Experience Group
Atodiadau Appendices:	None.

Argymhelliad / Recommendation:

The Committee is asked to note this report.

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

Sefyllfa / Situation:

This paper provides an outline of quality related awards, achievements and recognitions. It is important to note that the COVID-19 pandemic has had a significant impact in this area, with the focus rightly being on service delivery and services changes in response to the pandemic, and many award and recognition schemes were deferred or cancelled.

Cefndir / Background:

During the last six months, a number of staff, services and initiatives have received a quality related award, achievement or recognition, a summary of which is below:

- A life-saving project to provide access to hundreds of defibrillators across North Wales and teach people how to respond to a cardiac arrest has been hailed a success. In the last three years more than 500 new community public access defibrillators (CPAD) have been made available, while 315 more have been reinstated – including one in every Secondary School in the Betsi Cadwaladr University Health Board area. The project is a partnership between the

Health Board, the Welsh Ambulance Services NHS Trust and the cardiac charity SADS UK. The project is also being supported by funds raised through Cadwch Curiadau / Keep the Beats which is part of the Health Board's charity Awyr Las. Keep the Beats has so far managed to raise more than £20,000 and invested in new equipment, training videos and lifesaving defibrillators.

- The Cardiac Rehabilitation Team from Wrexham Maelor Hospital created a film with StoryJar to show the misconceptions around heart attack symptoms and encourage people to call 999 within 10 minutes. The film features staff members from Wrexham Maelor Hospital, Wrexham County Borough Council, and Welsh Ambulance Service NHS Trust.

- A Health Board team who provide rehabilitation for people with learning disabilities and Mental Health difficulties have received an award for their work during the COVID-19 pandemic. Staff at the Tan y Coed Rehabilitation Unit at Bryn y Neuadd Hospital, Llanfairfechan, are winners of the Seren Betsi Star Award, which recognises the hard work and dedication of Betsi Cadwaladr University Health Board staff. The team were presented with the award by Nichaela Jones – Head of Nursing for Learning Disability Services, and Will Williams - Head of Operations and Service Delivery for Specialist Commissioned Services, during a surprise ceremony.

- Diana Rooney, a Domestic Assistant at the Ablett Mental Health Unit at Glan Clwyd Hospital, was nominated for a Seren Betsi Star award by her colleagues, who praised her for going 'above and beyond' for patients. Diana, who has worked at Glan Clwyd Hospital for over 30 years, was presented with the award by colleagues during a surprise ceremony.

- Betsi Cadwaladr University Health Board has maintained its accreditation (ISO 15189) for its Blood Science laboratories following assessment by the national UK accreditation Service (UKAS). The Blood Science laboratories incorporates collecting blood from patients for examination, carry out blood tests to diagnose illnesses, match donated blood to patients who need it, investigate immune diseases, and much more.

- A Nurse from Wrexham Maelor Hospital has been appointed as the first Specialist Nurse in Wales for the charity Crohns and Colitis UK (CCUK). Diane Upton specialises in Inflammatory Bowel Disease (IBD) and has been awarded the role of IBD Nurse Specialist for CCUK, a leading UK charity in the battle against Crohn's Disease and Ulcerative Colitis, collectively known as Inflammatory Bowel Disease or IBD. CCUK aims to support those living with IBD with access to qualified IBD Nurse specialists, and has launched a new programme to build a community of nursing specialists and bring together IBD teams. The programme has also helped Diane become an Advanced Nurse Practitioner for the Royal College of Nursing (RCN), through the RCN credentialing process, which will help Diane gain formal recognition for her level of expertise and skill in clinical practice, leadership, education and research skills, and will continue to support her development in the profession.

- The Anaesthetic department at Ysbyty Gwynedd in Bangor has been recognised for providing the highest quality of care to their patients. The hospital has become the first in Wales to be awarded the prestigious Anaesthesia Clinical Services Accreditation (ACSA) from the Royal College of Anaesthetists (RCoA). The ACSA accreditation is the RCoA's peer-reviewed scheme that promotes quality improvement and the highest professional standards of anaesthetic service. To receive accreditation, anaesthetic departments are expected to demonstrate high standards in areas such as patient experience, patient safety and clinical leadership.

- A Consultant from Wrexham Maelor Hospital has landed two Trainer of the Year Awards from the UK-wide Royal College of Obstetricians and Gynaecologists (RCOG) and from Trainees in Wales Obstetrics and Gynaecology Society. Sujeewa Fernando, a Consultant Urogynaecologist, was nominated for the prestigious awards by his trainees for his support and encouragement. Mr Fernando is a Consultant in Obstetrics, Gynaecology and specialises

in Urogynaecology, which treats issues with pelvic floor, prolapses and bladder problems in women. Trainees, who nominated Mr Fernando for the RCOG award, said: "We feel Mr Fernando deserves Trainer of the Year because he is one of the most supportive team members that many of us have worked with, and always encourages individuals to achieve their best. He will use his experiences and endless achievements to provide support, making even the most difficult task feel manageable. He is an asset to Obstetrics and Gynaecology, and is an inspiration to us all." The Trainees in Wales Obstetrics and Gynaecology Society award recognises trainers who have gone above and beyond the requirements as a clinical or educational supervisor.

- A North Wales Nurse has won an academic award for her work in assessing how service improvements can have a positive impact on patient care. Diabetes Specialist Nurse Carolyn Thelwell is the 2020 winner of Swansea University's Frederick Banting Award. The award recognizes outstanding education and research as part of studying to complete a degree. Carolyn, who works with colleagues in the community and hospitals in Rhyl and the area to support people living with Diabetes, has studied for two years for a Masters in Diabetes Practice from Swansea University.

- Cardiac patients in North Wales can now have heart monitors fitted from the comfort of their home, reducing the need to come into hospital. Betsi Cadwaladr University Health Board are offering around 1,300 patients the opportunity to have heart monitors sent to them in the post, where they can be fitted and analysed without needing to attend one of North Wales' three District General Hospitals. The initiative has been introduced in response to reduced clinic space and staffing levels because of the COVID-19 pandemic. The CardioSTAT monitors, provided by medical equipment company Icentia, detect patients' heart rhythm and electrical activity in a procedure known as an electrocardiogram (ECG). Sensors attached to the skin are used to detect the electrical signals produced by the heart each time it beats. The results will be analysed by Icentia and any significant abnormalities will be highlighted immediately to NHS staff, enabling patients to receive prompt treatment, which can range from changes to medication, to having pacemakers or even cardiac defibrillator devices fitted. The remote heart monitors are typically used for patients who suffer from troublesome palpitations or episodes of dizziness.

- A new project is looking to tackle the impact of fatigue experienced by people living with Cancer. Thanks to funding from the Welsh Cancer Network, additional resources are being developed to help improve understanding and treatment of Cancer Related Fatigue (CRF), which many people experience following a Cancer diagnosis. The project will start with a survey to help determine understanding of CRF among NHS Cancer services staff in North Wales. Clinicians behind the project will also pilot a telephone helpline to offer direct support for people adversely affected by fatigue, who are living with breast and prostate Cancer. CRF refers to a feeling of exhaustion all or most of the time. It differs from everyday tiredness and isn't helped by rest and can affect people physically and emotionally. CRF is widespread and reported in up to 99 percent of people with Cancer. Up to 66 percent of Cancer patients reporting moderate to severe CRF. It is consistently rated as the most challenging symptom reported by patients with a range of different Cancers on the Holistic Needs Assessment tool, which is used to identify Cancer patients' concerns.

- A new project helped improve treatment times and reduce pressures on GPs and Emergency Care services during winter. The Health Board was been successful in obtaining Welsh Government funding until the end of March 2021 for an Urgent Primary Care Centre (UPCC) project in Wrexham and Flintshire. The initiative will deliver two primary care centres, one within the Outpatient department at Wrexham Maelor hospital and another at Mold Minor Injuries Unit. The project targeted on the day urgent primary care presentations, creating capacity to support GP surgeries and reducing unnecessary Emergency Department (ED)

attendances. A team including Advanced Nurse Practitioners, GPs and Physiotherapists worked together to provide care to people who have sought care from their GP or the ED.

- Refurbishment work on the CT scanning suite at Glan Clwyd Hospital has brought improved facilities and first-of-its-kind in Wales technology. The hospital's Radiology department is the first in the country to have a Dual Source CT system, which delivers a lower dose of radiation to patients, providing increased safety for people undergoing regular scans. The new scanner also features an image-quality improving infrared camera, and remote-access training software. The work included renovation of the facilities linked to the scanner, with a new changing room and en-suite providing greater comfort and dignity to patients undergoing scans.

- A senior Nurse who leads Abergele's District Nurses has landed a top UK-wide health award. Team Leader Amanda Hughes won the prestigious Nurse Manager of the Year award at the Nursing Times Workforce awards. Described as the "go to" person to help her staff, Mandy was shortlisted by judges for her tireless work to support the Abergele team over the last three-and-a-half years.

- A volunteer who has given a quarter century of service to a North Wales based mental health helpline has been recognised with a special award. Karl Bailey has been presented with a surprise Seren Betsi Award in recognition of his 25 years of voluntary service at the CALL 24/7 Mental Health Helpline for Wales. The Seren Betsi Award celebrates the hard work and dedication of NHS staff and volunteers across the region. Funded by the Welsh Government and run by Betsi Cadwaladr University Health Board, the CALL 24/7 Mental Health Helpline for Wales provides emotional support and signposting to a range of local, regional and national mental health and wellbeing services. Karl has been volunteering with CALL Helpline since it was founded in 1995 and has supported the introduction of the DAN 24/7 Wales Drug and Alcohol Helpline in 2008, and the Wales Dementia Helpline in 2010. During his three decades of selfless service it is estimated that he has gifted 3,600 hours and answered more than 7,200 calls from people in need.

- An 'outstanding Nurse and human being' has been presented with a surprise award for his commitment to deliver the very best care to adults with learning disabilities. Kevin Jones, a Learning Disability Nurse at the Tan y Coed rehabilitation unit at Bryn y Neuadd Hospital in Llanfairfechan has become the latest member of Betsi Cadwaladr University Health Board staff to receive the Seren Betsi Star award. The monthly award recognises the hard work and dedication of NHS staff and volunteers across North Wales. Tan y Coed is a rehabilitation unit that enables people with learning disabilities to live as independently as possible, while receiving person centred support from a range of healthcare professionals. Kevin was nominated for the award by his colleague, Beth Woolley, who described his enthusiasm and patient care as being 'second to none'.

- A team of Healthcare Support Workers were nominated to receive a top health award. The Tuag Adref/Homeward Bound project has been shortlisted in the 'Community Nursing' category at this year's Nursing Times Awards. The project aims to prevent delays for patients leaving hospital by offering support for those, who are ready to leave hospital but may be waiting for a care package, in their own home. The initiative began in 2018 at Ysbyty Alltwen, and has now been rolled out across Gwynedd and Anglesey.

- An 'amazing Nurse and role model' has been given a special award for her tireless work to improve the specialist care provided to people with learning disabilities. Stephanie Moores, a Deputy Ward Sister on the Foelas Learning Disability Ward at Bryn y Neuadd Hospital, Llanfairfechan, has become the latest winner of the Seren Betsi Award. Established in 2016, the award honours the hard work and dedication of North Wales NHS staff and volunteers. Nestled in woodland between the sea and the Carneddau Mountains, Foelas Ward provides specialist care to up to eight adults with learning disabilities and complex health needs. The

team have continued to provide specialist person-centred care throughout the COVID-19 pandemic.

- A Glan Clwyd Hospital renal Nurse has won a national award celebrating outstanding achievement in renal nursing care. Melanie Hayward, from Buckley, won the Liz Baker Award for Excellence in Renal Nursing, presented by the Welsh Renal Clinical Network. Since becoming a home therapies Nurse 18 months ago, Mel has worked tirelessly to support patients in accessing home Haemodialysis. By learning how to dialyse at home, patients with renal and kidney issues are able to avoid numerous trips to hospital for lifesaving dialysis, instead treating their condition at home. Mel's work involves providing a point of access for renal patients accessing dialysis in their own homes.

- A Wrexham Maelor Hospital based psychologist has scooped a number of top national awards for her work to improve the care and support offered to people living with diabetes. Dr Rose Stewart, a Principal Clinical Psychologist at Betsi Cadwaladr University Health Board. was recognised at the prestigious Quality in Care Diabetes Awards, where she received an award for her Outstanding Contribution for Services in Diabetes in NHS Wales. Dr Stewart also scooped the Unsung Hero Award and was highly commended for her work with the All-Wales Diabetes Group to introduce a range of self-help resources for people living with the condition. The Quality in Care Diabetes Awards recognise and reward innovative practice demonstrating quality in diabetes management, education and services across the UK. This year's awards ceremony took place virtually on October 15th, due to COVID-19 restrictions. Diabetes is a condition where there is too much glucose in the blood because the body cannot use it properly due to a lack of insulin. There are over 194,000 people living with diabetes in Wales, the highest prevalence in the UK. There are a further 61,000 people in Wales living Type 2 diabetes who haven't received a formal diagnosis. People with diabetes are twice as likely to experiences issues such as depression and eating disorders, and specialist psychological support has been consistently identified as a significant area of need across the UK for many years.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience (QSE) Committee 6th July 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quality Governance Review – Ysbyty Glan Clwyd (YGC)
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy Chief Executive
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance
Craffu blaenorol: Prior Scrutiny:	Review by: - Debra Hickman, Nurse Director - Matthew Joyes, Acting Associate Director of Quality Assurance
Atodiadau Appendices:	1. YGC Quality Governance Review Action Plan 2. Action Plan Update 21 June 2021

Argymhelliad / Recommendation:

The Committee is asked to note this report.

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

Sefyllfa / Situation:

This paper provides the Committee with the latest available (21 June 2021) version of the action plan developed by the hospital management team at Ysbyty Glan Clwyd (YGC) in response to the Quality Governance Review completed in 2020.

Cefndir / Background:

The Quality Governance Review process is designed to provide the service with an honest and supportive assessment of its arrangements and outcomes in relation to the governance of quality (covering patient safety, patient and carer experience, and clinical effectiveness). The primary aim is to drive improvement and to facilitate the sharing of best practice. A secondary purpose is to provide the Health Board with assurance on quality governance within the service, complementing other internal arrangements (such as clinical audit, ward accreditation) and independent or external arrangements (such as internal audit, Healthcare Inspectorate Wales inspections.

Ysbyty Glan Clwyd was selected as the service for the first review due to concerns expressed by the Health Board regarding quality governance at the site arising from performance and quality information.

The report of the review was summarised for the QSE Committee in January 2021, and formally presented in May 2021.

The management team of the site provided an action plan in response to the review however this was rejected by the responsible executive director in March 2021. A summary of immediate actions was reported to the Committee in May 2021 along with revised recommendations.

Since the original (rejected) action plan there has been significant change in the management team of the site and a number of acting appointments are in place with new leaders now coming into post. The interim team put in place a framework to develop a new plan, with a senior clinician leading the work and designated action owners for each action. A bi-weekly panel, consisting of the hospital management team, meet to support and scrutinise delivery. This includes the designated action owner presenting evidence to the panel. The panel also have a plan to review actions 6 and 12 months post implementation to monitor sustainability. A revisit was recommended as part of the review in 12 months, and therefore on the basis that the new plan commenced in Q1 of 2021/22 the revisit will be planned for Q1 of 2022/23.

It is however important to note the new leadership team now coming into post and it is acknowledged they will consider the review alongside their own observations and may wish to further amend the action plan in light of wider changes they may wish to pursue.

Additionally it is important to note that Internal Audit are also planning a review of YGC and discussions have already been held to ensure alignment with the Quality Governance Review. As part of their work, Internal Audit will follow up on the actions being taken forward following the Quality Governance review.

Finally, for the Committee' assurance, attached to this paper is the action plan and a report detailing the progress of the actions as of 21 June 2021.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.

Recommendation		Actions		Responsible officer	By when	Assurance reporting
1	The site HMT will define clear areas of accountability and responsibility for all Clinical and Operational leads linked to the Health Board's PADR and job planning processes, ensuring there is a clear improvement focus around governance and learning from patient safety incidents and experiences in a timely and effective manner	1.1	The HMT will confirm a key question within each Clinical and Operational leads PADR to be asked within each JP & PADR ensuring that the YGC teams have a clear improvement focus. A key question will need to be asked within the PADR/ Job planning process: eg Provide an example where you have changed your practice and improved your service from learning from a patient safety incident- describe the incident or complaint and what lessons have you learnt	Hospital Management Team	30/06/2021	Sample of anonymous PADR
		1.2	Explore options of including the above statement in Corp PADR documention Health Board wide - Interim for YGC site statement, once agreed, to be circulated to all Clinical and Operational Managers to be included in PADR invites.	Hospital Management Team	30/06/2021	PADR records
		1.3	Nursing teams to develop a QI plan from answers to the above question. A list of Top 10 themes to be identified and support provided to make sustained improvements using QI methodology for tabling at New Site Grand round for Nurses	Hospital Management Team	30/06/2021	QI plan and outcome reporting

Recommendation		Actions		Responsible officer	By when	Assurance reporting
2	The site will ensure that there is consistent and appropriate representation at all key operational and governance meetings within the HB e.g. safeguarding. This will be monitored via attendance records, minutes etc.	2.1	The Site will allocate appropriate respresentation at all core meetings and will provide requested reports using the agreed template.	Emma Hosking (CEG) Tracey Radcliffe (PSQ) Mark Andrws (H&S) Dafydd Williams (LIPG) Delyth Williams (Safeguarding) Tania Bugelli (NICE) Pharmacy (Safer Medicines)	01/06/2021	Minutes & attendance lists of meetings attended monitored by HMT

Recommendation		Actions		Responsible officer	By when	Assurance reporting
3	The site must ensure an effective clinical audit programme is in place which is risk-based, in particular ensuring surgical safety is assured	3.1	Nursing: An audit programme (Ward accreditation) is in place and reported on Iris and is monitored as follows: Ward Manager – Weekly- Monitored by Matron Matrons – Monthly – monitored by HoN. The Site will undertake agreed Nursing Audit plan annually for SHINE, Outlying patients, SBAR handover and Enhanced Observation.	Heads of Nursing	Nursing - ongoing and annually	Directorate & Site PSQ
		3.2	Medical: The Site will ensure timely audits are undertaken with regard to Surgical Safety to include WHO checklists, Compliance to LocSSIPs & NAT SSIPS, SSI, Hip fracture.	Tania Bugelli	Medical - ongoing and annually	PSQ Minutes Clinical Effectiveness Group (CEG)minutes

Recommendation		Actions		Responsible officer	By when	Assurance reporting
4	the site will ensure there is an effective audit of clinical and safeguarding documentation with a focus on improvement. This will be monitored via the audit programme, returns and evidenced via the governance framework	4.1	Nursing: The Site Teams will complete the Monthly Audit which includes samples of 3 sets of nursing documentation to measure against the NMC Documentation standards and all risk assessments to be audited monthly.	Head of Nursing	Ongoing	Monthly audits on IRIS
		4.2	DoLs & Safeguarding (to include Child at risk reports) – Improvement in the quality of information on referral form is required to avoid a delay in the decision making process. Training to be focussed for the poor performning areas first (as detailed in the report) with a sample of "what good looks like" as a template for expected standard of documentation (Site Wide plan)	Delyth Williams & Jane Owen	30th September 2021	Bi annual audit of quality of documentation on SG and DoLS referrals reporting to Site PSQ. Evidence of Training records
		4.3	Therapy Teams - will undertake annual audit of documentation	Stephen Grayston	30th July 2021	Annual audit report to Central Area PSQ
		4.4	Medical Staff - The Site will provide annual audits of the quality of documentation of Clinical notes (Medical)	Tania Bugelli	30-Sep-21	Annual audit records

	Recommendation		Actions	Responsible officer	By when	Assurance reporting
5	The site will ensure that the Local Infection Prevention Group has the appropriate and consistent membership and receives assurance data and has a clear plan regards HCAI prevention / improvement. This will monitored via the LIPG and IPSG submissions and improvement trajectories	5.1	The divisions must fully complete the reporting template to LIPG detailing all completed audits and provide and update on ongoing action plans	Heads of Nursing	30th May2021	Minutes of LIPG agenda
		5.2	The Directorates will, in conjunction with IPT draft an action plan when a deficit in IP standards is identified to be monitored at directorate PSQ. All completed action plans will require re audit at 3, 6 and 12 months to give assurance that learning is embedded	Directorate Management teams - HoN, DGM, CD - Medicine, Surgery and EC	Immediate as IP non complaince is identified	Minutes of Directorate PSQ 3,6 & 12 months post initial audit
		5.3	The Site will agree, in conjunction with the IPT a plan on a page for Infection prevention and Control and will take this forward under the umbrella of SCCHF	DMT	30thMay2021	LIPG meeting minutes

Recommendation		Actions		Responsible officer	By when	Assurance reporting
6	The site will ensure there is a sustainable improvement plan developed for areas that demonstrate repeated poor performance identified through the Medication Safety Audit with the appropriate support from Pharmacy and Corporate quality governance teams. This will be monitored via performance and improvement trajectories	6.1	The Site must define the plan to ensure the All Wales medication safety audits are consistently completed- these have ceased as data not tabled, reviewed and used to improve quality	Rhys Davies Pharmacy	Plan agreed 31st May 2021	Meds audit available on dashboard; minutes of meds review group
		6.2	Establish and embed bi monthly minuted Safe Medicines Incident review group with agreed TOR and standardised lessons learnt	Heads of Nursing	21st May 2021	Medicines errors and learning to be tabled every 2 months in divisional & Site PSQ. MM SpN to provide annual report to SC PSQ with copes of LL shared
		6.3	Clear line of professional accountability for Medicines management SpN to be confirmed	Director of Nursing	21st May 2021	Clear kine management arrangements

Recommendation		Actions		Responsible officer	By when	Assurance reporting
7	The site will ensure there is a robust and auditable process regards the implementation of NICE guidance ensuring there is clear evidence of monitoring of and escalation where there is deviation from the agreed standards. This will be monitored via the clinical effectiveness framework	7.1	The site must establish a clinical effectiveness group with an agreed terms of reference and reporting template to implement and monitor compliance and address any deviation to NICE guidance	Emma Hosking & Tracey Radcliffe	30/05/2021	CEG minutes and reports chaired by the Associate Medical Director for Q&S

Recommendation		Actions		Responsible officer	By when	Assurance reporting
8	The site will ensure (1) the Health Board process for Mortality Reviews is in place, (2) that it is monitored and there is evidence of learning and improvement actions in place and assurance is provided via the Health Board governance routes. This will be monitored via the Reducing Avoidable Mortality Review Group	8.1	Site plan is required for outstanding Covid and non covid mortality reviews – there is currently a backlog of both that require focussed intervention	Emma Hosking & Tania Bugelli	30th July 2021	Monthly review of trajectory for site at Site PSQ. Attendance and reporting to the Reducing Avoidable Mortality review Group
		8.2	Clarity is needed on numbers of MR outstanding for Pre Covid, non covid and covid related deaths to enable the site to understand the breadth of work associated with these reviews in order to plan the trajectory for completion	Emma Hosking & Tania Bugelli	1st July 2021	Monthly review of trajectory for site at Site PSQ. Attendance and reporting to the Reducing Avoidable Mortality review Group
		8.3	The Lead will provide a trajectory for completion of Mortality Reviews, monitored via this improvement plan review process	Emma Hosking & Tania Bugelli	30th July 2021	Monthly review of trajectory for site at Site PSQ. Attendance and reporting to the Reducing Avoidable Mortality review Group

Recommendation		Actions		Responsible officer	By when	Assurance reporting
9	The site will co-produce with patients, staff and stakeholders a sustainable quality improvement plan focussed on improving the key quality underperformance across urgent and emergency care metrics	9.1	The Site Emergency Care Directorate will establish and embed monthly review of performance data and present their improvement plan and trajectory to the Hospital Director monthly	Geraint Parry Delyth Williams Richard Morgan	30th May2021	QI plan tabled and minuted at Directorate PSQ
		9.2	The Leads will provide a trajectory for improvement monitored via this improvement plan review process	Geraint Parry Delyth Williams Richard Morgan	30/06/2021	Site report to be tabled at Secondary care PSQ
		9.3	Site will review current discharge and flow workstreams as a whole system approach. Will re-visit to maximise upstream flow promoting discharge to include Mental Health and Childrens directorates.	Paul Andrew	30th July 2021	Site report to be tabled at Secondary care PSQ

Recommendation	Actions		Responsible officer	By when	Assurance reporting
10 The site will align its workforce plans with those of the strategic Health Board intent to provide a sustainable recruitment and retention plan, targeting key hotspot areas in the first instance	10.1	Nursing: Matrons to meet monthly with Ward managers and HR to plan actions and track progress to reduce % absence to 4.2% by proactively managing absences & supporting staff back to work	DGM line of management HoN (Nursing)	Monthy Meetings to review dashboard data be established by end June 2021	Monthly accountability and performance meetings % absence to be included in directorate & Site PSQ reports
	10.2	Other professions: Divisional line managers to proactively manage sickness absence according to policy with engagement from HR	DGM line of management HoN (Nursing)	Monthy Meetings to review dashboard data be established by end June 2022	Monthly accountability and performance meetings % absence to be included in directorate & Site PSQ reports
	10.3	All staff leaving their post will be offered an exit interview to enable the Site, in conjunction with HR to undertake a thematic review of reasons for leaving to enbale tarteged intervention in these areas if themes emerge.	Kay Hannigan	30-Sep-21	Directorate Performance meetings
	10.4	The Site nominated lead (Linzi Shone) will attend the Health Board Recruitment & retention group focussing on hotspot areas, taking the lead in coordinating vacancies to include overseas nurses recruitment.	Linzi Shone, Head of Nursing Medicene	30th June2021	LS Takes the Site position to the R&R meetings. An improved position month on month is reported for nurse vacancies.
	10.4a	The nominated Lead will provide a trajectory for recruitment monitored via this Improvement Plan review process twice monthly	Linzi Shone, Head of Nursing Medicene	Twice monthly	LS Takes the Site position to the R&R meetings. An improved position month on month is reported for nurse vacancies.

	Recommendation		Actions	Responsible officer	By when	Assurance reporting
11	The site will focus on its profile and engagement both internally and externally with staff, patients and the wider community, positioning itself as the local employer of choice	11.1	Work in collaboration with the PALS teams to promote initiatives to actively encourage and act upon service user experience feedback.	Deputy HoN Jane Owen	30-Aug-21	report to Site PSQ
		11.2	Introduce and establish plans in Workforce Partnership Forum to ensure regular dialogue with trade union partners	DoN	30th May2021	WPF minutes
		11.3	Introduce initiatives to promote staff engagement taking into account equality and diversity, acting of staff feedback to shape future services	Deputy HoN Jane Owen	30th August 2021	Staff engagement activities and outcomes
		11.4	The HMT will engage in the Stronger Together whole system /OD initiative as a vehicle for staff engagement (Initial workshops) June to August 2021	HMT	30-Aug-21	Stronger Together involvement
		11.5	The Site leadership teams will actively encourage teams to bring forward good news stories for celebrating on social media platforms	Dep HoN Jane Owen	30th August 2021	Number of stories
		11.6	The Site teams will fully engage with BCU recruitment drives to positively market the YGC site with external institutions selling the site as the place to work	Kay Hannigan	Plan to be established by end August 2021	Monitoring of Site representation at recruitment events

	Recommendation	Actions		Responsible officer	By when	Assurance reporting
12	The site will align its governance structure to that of the overarching Health Board, with a focus on timely intervention and escalation of key areas or issues of concern	12.1	The Site will identify key meetings to align their governance structures to the overarching HB structure: CEG, Patient and Carer experience, PSQ, LIPG, H&S Safeguarding. Capacity and Consent The Site will be required to embed quality as core business within their directorate with monthly Divisional PSQ groups who have clear TOR and minuted for assurance reporting.	Emma Hoskins(CEG) Tracey Radcliffe (PSQ) Mark Andrews(H&S) Dafydd Williams (LIPG)	31st July 2021	Directorate & Site PSQ Minutes. CEG Minutes H&S minutes LIPG Minutes Safeguarding minutes, Capacity and Consent meeting
		12.2	The AAA is the agreed reporting template for the Health Board and should be used for all meeting reports	DMT	31st March 2021	Copies of Dir & Site PSQ
		12.3	There needs to be a defined & documented chain of communication from Ward to Board to escalate significant issues in a timely manner. This will require a ToR to ensure consistency	Head of Nursing with governance support	immediate	ToR for Datix review meetings
		12.4	All incidents relating to patient harm will be reviewed via monthly/ bi monthly scrutiny meetings designed to promote a culture of openness and shared learning. HAPU Falls Infection & Medicines errors will follow standard TOR lessons learnt template for shared learning across the Site and beyond	Head of Nursing with governance support	30th June 2021	Minutes of harms meetings
		12.4.1	Review of current TOR & agree update	Head of Nursing with governance support	30-Jun-21	Meeting documentation
		12.4.2	Standardised template for lessons learnt and process for dissemination	Head of Nursing with governance support	30-Jun-21	Evidence of cascade and action taken
		12.4.3	Monthly Ward Managers & Matron meeting to have a quality focus with clear ToR to mandate attendance to include COB for each harm Develop a "Grand Round for Nurses" to disseminate learning	Head of Nursing with governance support	30-Jun-21	Divisional report in PSQ

Recommendation	Actions		Responsible officer	By when	Assurance reporting
13 The site will address underperformance in areas such as complaints and incident compliance. The site must also ensure that assurance is obtained that lessons learned from complaints and incidents are embedded and sustained	13.1	Backlog of incidents & Complaints Agree process for Review and scrutiny of backlog of Complaints and Incidents per Directorate chaired by DoN (or delegated)	Head of Nursing supported by Tracey Radcliffe	31st July 2021	Numbers of CoM and INC to be included in Directorate and Site PSQ to include any LL circulated. Divisional PSQ to table re audit of LL at 6 & 12 months
	13.2	Leads will provide a trajectory for closure of all INCs and COMs monitored via this Improvement plan	Head of Nursing supported by Tracey Radcliffe	31st July 2021	Numbers of CoM and INC to be included in Directorate and Site PSQ to include any LL circulated. Divisional PSQ to table re audit of LL at 6 & 12 months
	13.3	Thematic reviews will be undertaken on Datix monthly, by the Directorates and tabled at PSQ to ascertain opportunities for shared learning across Site and the Health Board and reaudited and tabled at PSQ at 6 and 12 months.	Head of Nursing supported by Tracey Radcliffe	31st July 2021	Numbers of CoM and INC to be included in Directorate and Site PSQ to include any LL circulated. Divisional PSQ to table re audit of LL at 6 & 12 months
	13.4	Frontlog Actions: The Directorates will define a process for the timely review of their concerns and INCs, in line with the newly launched complaints review process with scrutiny by DoN monthly	Head of Nursing supported by Tracey Radcliffe	30-Jun-21	Numbers of COMs and INCs to be included in the Direcorate & site PSQ to include any lessons learnt to be shared with Site teams via an agreed template

Recommendation		Actions		Responsible officer	By when	Assurance reporting
14	The site will review all Risk Registers ensuring that the registers reflect key issues and are reviewed and updated in line with Health Board policy. The HMT will be versed on all key risks and issues, cited on controls and gaps in assurance which are then escalated deescalated as necessary	14.1	The Directorates in conjunction with the Risk manager will ensure that directorate open risks are reassessed,managed and risk register updated via attendance at the Bi mothly group.	Neil Rogers and Claire Brown	31st August 2021	Minutes of the risk report meeting
		14.2	The Leads will provide a trajectory for closure of risks monitored via this Improvement plan review process	Neil Rogers and Claire Brown	30th March 2021	Minutes of the risk report meeting
		14.3	Further work is required to ensure every risk is transferred onto the 3 tier system adopted by BCUHB. All new risks to be reviewed by the RM team in collaboration with the Site teams ensuring appropriatley placed within the 3 tier system	Neil Rogers and Claire Brown	30th March 2021	Minutes of the risk report meeting
		14.4	A separate piece of work is required,to review of the cross-cutting risks for the divisions that are based on YGC site but outside the sphere of YGC management to provide a true reflection of risks held within services under the direct management of the YGC HMT eg infection control and safeguarding in oncology, mental health, children's services.	Neil Rogers and Claire Brown	30th September 2021	Minutes from the risk management group

Appendix 2

Quality and Governance Review Ysbyty Glan Clwyd

Update report 21st June 2021

Action	RAG Status 21.5.21	RAG Status 14.6.21	RAG Status 21.6.21	
				1. The site HMT will define clear areas of accountability and responsibility for all Clinical and Operational leads linked to the Health Board's PADR and job planning processes, ensuring there is a clear improvement focus around governance and learning from patient safety incidents and experiences in a timely and effective manner
1.1	Red	Amber	Green	HMT & HR have agreed statement to be included in PADR documentation. Further discussion is required to include statements in Medical Appraisals.
1.2	Red	Amber	Amber	HR will review whether PADR/Medical Appraisal documentation should be updated across BCU.
1.3	Red	Red	Red	QI plan for nurses to be developed from themes collected from PADR
				2. The site will ensure that there is consistent and appropriate representation at all key operational and governance meetings within the HB e.g. safeguarding. This will be monitored via attendance records, minutes etc.
2.1	Red	Green	Green	All HB meetings now defined and named individuals identified to attend. Attendance consistent and evidenced through meeting minutes and attendance records attached to the evidence file
				3. The Site must ensure an effective clinical audit programme is in place which is risk based ensuring surgical safety is assured
3.1	Red	Amber	Green	Nursing audits are undertaken and uploaded to Iris. The Site has undertaken the suite of audits however; action plans for areas of poor compliance are awaited (SHINE/SBAR handover audit).
3.2	Red	Amber	Amber	Theatre WHO audits are carried out monthly and are evidenced There is clarity on tier 1 and 2 audits but consistency of these cannot be evidenced. Work ongoing with regards to audit of EIDO leaflets (information in evidence file). Medical Director will support AMD Q&S with further work.
				4. The site will ensure there is an effective audit of clinical and safeguarding documentation with a focus on improvement. This will be monitored via the audit programme, returns and evidenced via the governance framework
4.1	Red	Green	Green	Nursing documentation audits are carried out monthly and are evidenced on Iris

4.2	🟥	🟧	🟧	The site now has a plan for auditing the quality of DoLS and safeguarding documentation – this will be reported bi annually via the Site PSQ via a report from Safeguarding team. No audit yet carried out. Safeguarding to advise the cycle of business for reporting.
4.3	🟥	🟧	🟧	Last audit of Therapy documentation was undertaken in 2019. There is a plan for re audit this year & annually thereon
4.4	🟥	🟧	🟧	Annual plan for audit of quality of documentation by Drs – updated on 25th May 21 – re-audit likely to be September 2021.
	5. The site will ensure that the Local Infection Prevention Group has the appropriate and consistent membership and receives assurance data and has a clear plan regards HCAI prevention / improvement. This will monitored via the LIPG and IPSG submissions and improvement trajectories			
5.1	🟥	🟩	🟩	The Directorates are all represented at LIPG, reports provided and evidenced via the Minutes & attendance list
5.2	🟥	🟧	🟩	Action plan evidence provided for latest IP review (Ward 11) All IP action plans are now monitored via the LIPG
5.3	🟥	🟩	🟩	Plan on a Page for IP has been drafted and agreed for the forthcoming 12 months
	6. The site will ensure there is a sustainable improvement plan developed for areas that demonstrate repeated poor performance identified through the Medication Safety Audit with the appropriate support from Pharmacy and Corporate quality governance teams. This will be monitored via performance and improvement trajectories			
6.1	🟥	🟩	🟩	MM audits have now been reinstated and tabled at the Site Medicines management bi monthly meetings. Areas of poor compliance will have action plans drafted and monitored by the Directorate PSQ and Safer Meds group
6.2	🟥	🟧	🟧	ToR have been drafted for MM scrutiny meetings and agreed with HoNs (uploaded to evidence file) – this will be tabled for approval at next Site PSQ (July 21)
6.3	🟥	🟦	🟦	The MM SpN will be professionally line managed by the Site DoN
	7. The site will ensure there is a robust and auditable process regards the implementation of NICE guidance ensuring there is clear evidence of monitoring of and escalation where there is deviation from the agreed standards. This will be monitored via the clinical effectiveness framework			
7.1	🟥	🟧	🟩	The CEG has now been established on site evidenced via CEG minutes and attendance list. Compliance report for NICE audits now received and will be tracked via this improvement plan. There is a risk identified that there is no designated person leading on NICE which may affect achieving the actions within this recommendation
	8. The site will ensure the Health Board process for Mortality Reviews is in place, that it is monitored and there is evidence of learning and improvement actions in place and assurance is provided via the Health Board governance routes. This will be monitored via the Reducing Avoidable Mortality Review Group			
8.1	🟥	🟥	🟥	BCU plan awaited.
8.2	🟥	🟧	🟩	Numbers of MR to be undertaken is now established (in evidence file). The focus will be on Covid MRs in the first instance.
8.3	🟥	🟥	🟥	Meeting to be held between AMD Q&S and the Medical Director to discuss plan for trajectory.
	9. The site will co-produce with patients, staff and stakeholders a sustainable quality improvement plan focussed on improving the key quality underperformance across urgent and emergency care metrics			
9.1	🟥	🟩	🟩	Monthly Performance meetings now established

Ref				Description
9.2	Red	Red	Red	Trajectory for improvement required
9.3	Red	Red	Red	Formal review awaited
	10. The site will align its workforce plans with those of the strategic Health Board intent to provide a sustainable recruitment and retention plan, targeting key hotspot areas in the first instance			
10.1	Red	Amber	Amber	HR meetings undertaken – require trajectory and evidence
10.2	Red	Amber	Amber	HR meetings undertaken – require trajectory and evidence
10.3	Red	Amber	Amber	HR have a plan in conjunction with teams to triangulate available data to target hot spots
10.4	Red	Green	Green	Nominated lead assigned
10.4a	Red	Amber	Amber	HoN Medicine will bring the trajectory to the next Scrutiny meeting.
	11. The site will focus on its profile and engagement both internally and externally with staff, patients and the wider community, positioning itself as the local employer of choice			
11.1	Red	Amber	Amber	Initial discussion with PALS lead – meeting arranged and lead identified
11.2	Amber	Green	Green	Work already in progress
11.3	Red	Amber	Amber	Initial discussion with lead for site who will draft plan for taking this forward
11.4	Red	Red	Red	Awaiting HR response to take forward this action
11.5	Red	Red	Red	To be discussed as per 11.3
11.6	Red	Green	Green	Full engagement with recruitment drives but require evidence of sustaining
	12. The site will align its governance structure to that of the overarching Health Board, with a focus on timely intervention and escalation of key areas or issues of concern			
12.1	Red	Amber	Green	Key meetings for Site identified and aligned with HB governance structure. Individuals assigned to attend and attendance records/ minutes provided for assurance
12.2	Red	Green	Green	The AAA is used for all key governance meetings on Site
12.3	Red	Amber	Amber	ToR for Datix review meetings drafted with process for escalation of significant issues to include tracking of incidents requiring MIS to achieve the 72 hour standard. IP team engaged in the process
12.4	Red	Amber	Green	ToR for all harms review meetings drafted – with HoNs for approval
12.4.1	Red	Green	Green	TORs for all HARMS reviews drafted for ratification in July PSQ.
12.4.2	Red	Amber	Amber	Waiting for template via Governance Team.
12.4.3	Red	Red	Red	Matrons and Ward Managers meetings to be re-established.
	13. The site will address underperformance in areas such as complaints and incident compliance. The site must also ensure that assurance is obtained that lessons learned from complaints and incidents are embedded and sustained			
13.1	Red	Green	Green	Process for backlog review agreed.

13.2				Trajectory for backlog of INCs and COMs is in place and monitored via this plan, weekly divisional meetings and monthly scrutiny by DoN
13.3				Require starting and embedding within directorate PSQ
13.4				Plan for review as per corporate guidance to review COMs
	14. The site will review all Risk Registers ensuring that the registers reflect key issues and are reviewed and updated in line with Health Board policy. The HMT will be versed on all key risks and issues, cited on controls and gaps in assurance which are then escalated deescalated as necessary			
14.1				RM meetings embedded every 2 months. Attendance from directorates monitored by minutes and attendance records. ToR approved
14.2				Awaiting RM lead review and plan – aware this is required
14.3				All risks now allocated to the correct tier
14.4				The Risk manager is reviewing risks for Site and hosted services

RED	AMBER	GREEN	BLUE	IOS
Not yet started	In progress	Complete- need evidence of embedding	Completed	Issues of Significance

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 6th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Quality & Performance Report (Q&PR) to 31st May 2021
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mr Mark Wilkinson, Executive Director of Planning & Performance
Awdur yr Adroddiad **Report Author:**	Mrs Kamala Williams, Director of Performance Mr Ed Williams, Head of Performance Assurance
Craffu blaenorol: **Prior Scrutiny:**	The data and information in this report has been scrutinised by the Executive Director of Planning & Performance
Atodiadau **Appendices:**	None
Argymhelliad / Recommendation:	
It is recommended that the Committee discuss and receive 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	

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

It should be noted that publication of the NHS Wales Delivery Framework for 2021-22 has been delayed due to the ongoing consequences of the COVID-19 pandemic and changes to ministerial responsibility for Health and Social Care following the recent Senedd elections. Welsh Government have advised that Health Boards should continue to monitor performance in line with the measures included in the 2020-21 NHS Wales Delivery Framework until further notice.

The Committee are asked to note the following:
At the time of writing, further easing of restrictions are under consideration due to growing community transmission of COVID-19. Whilst we have restarted the recovery of our planned care services, we are continually monitoring COVID-19 rates and have plans in place to ensure that we can continue to deliver those services safely.

The COVID-19 vaccination programme continues apace, with over 853,000 vaccinations already given across North Wales, the highest number of all the Health Boards in Wales. The Health Board is now offering vaccinations to all adults of 18 years old and over.

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 4,

2020/21 at 95.4% of eligible children receiving 6 in 1 Hexavalent and 95.2% of eligible children receiving 2 doses of MMR vaccinations by age 5.

In comparison to the same period of 2020/21, there has been a fall in the number of most infection types across Wales and the Health Board. There has been a rise in the rate of C.Difficile infections across Wales. However, BCU currently has the lowest C.Difficile rate of all the Health Boards in Wales.

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

For Adult Mental Health there was a dip, as expected, in performance compared to last month, with percentage adults assessed within 28 days of referral at 61.99%. This was due to an increase in referrals in March and issues with capacity in East, which has a waiting list larger than West and Central combined. The number of patients starting therapy within 28 days of assessment remains above the 80% target at almost 80.9%.

Performance remains poor against the targets for the rate of children assessed within 28 days of referral, at 23.68%, and starting therapy within 28 days of assessment at 19.64%.

There has been a consistent and significant improvement in the percentage rate of adults waiting less than 26 weeks to start psychological therapy at 70.67% in May 2021 from a low of 20.1% in September 2020.

Whilst the number of patients experiencing delayed transfer of care (DToC) within our mental health has increased slightly at 15 in May 2021 (compared to 13 in March 2021), the length of stays has continued to fall at 565 (compared to 631 in April 2021). The service is working to resolve issues that lead to DToC, and it is expected that the number and length of DToCs will fall over the coming months.

Performance against the 26 week target or children awaiting neurodevelopment assessment remains poor at 26.84%, however it is a slight improvement on the 23.82% reported previously. It is expected that plans recently approved will enable us to increase capacity to see 120 children per month and this will translate to a much-improved performance.

There were 3 New Never Events reported in May 2021. These were a second dose of Methotrexate within 48 hours, A wrong side chest-drain insertion and a wrong side ankle-block. Investigations into all three incidents remain underway.

The percentage closure rate of complaints managed under Putting Things Right (PTR) < 30 working days (target 75%) - 57.39% May 2021. Whilst not reaching the set target the process is currently stable and delivering at around 60% compliance for the last 5 months. This is a sustained improvement compared to previous years, where performance has been as low as 30%.

Crude Mortality (under 75 years old has decreased to 1.01%. The mortality rate for BCU is lower than the Wales average of 1.13%.

Concern remains with regards the recording and monitoring of provision of Sepsis Six bundles both for our Inpatients and within our Emergency Departments and the Office of the Medical Director is currently reviewing this. It is expected that reporting will recommence by end of August 2021.

The Quality & Performance Report is currently being redesigned with a view to presenting a new Integrated Quality & Performance Report to the Health Board and its committees in Quarter 3 of 2021-22.

A Quality Surveillance Group (incorporating, performance, corporate, medical and nursing services) has been established (first meeting held on 14th June 2021) to review quality and identify hotspots and risks.

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 Q&PR 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
Not applicable

Impact Assessment
The Report has not been Equality Impact Assessed

Quality and Performance Report

Quality, Safety & Experience Committee

Performance to 31st May 2021 Presented on 6th July 2021

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It should be noted that publication of the NHS Wales Delivery Framework for 2021-22 has been delayed due to the ongoing consequences of the COVID-19 pandemic and changes to ministerial responsibility for Health and Social Care following the recent Senedd elections. Welsh Government have advised that Health Boards should continue to monitor performance in line with the measures included in the 2020-21 NHS Wales Delivery Framework until further notice.

Report Structure

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

Additional sections are added to reflect COVID-19 key performance indicators. In this month's report the indicators have been updated to align with those reported to each meeting of the Health Board in the COVID-19 and Vaccination Programme Report.

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

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

Performance Monitoring

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

Performance has improved over the last 6 months

Performance has got worse over the last 6 months

Performance remains the same

Ongoing development of the Report

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

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

Executive Summary

The Committee are asked to note the following:

COVID-19 Update
At the time of writing, further easing of restrictions are under consideration due to growing community transmission of COVID-19. Escalation plans require a balance with the restart and recovery of our planned care services.

The COVID-19 vaccination programme continues apace, with over 853,000 vaccinations already given across North Wales, the highest number of all the health boards in Wales. The Health Board is now offering vaccinations to all adults of 18 years old and over.

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 4, 2020/21 at 95.4% of eligible children receiving 6 in 1 Hexavalent and 95.2% of eligible children receiving 2 doses of MMR vaccinations by age 5.

Quadruple Aim 2: Infection Prevention
In comparison to the same period of 2020/21, there has been a fall in the number of most infection types across Wales and the Health Board. There has been a rise in the rate of C.difficile infections across Wales, however, BCU currently has the lowest C.Difficile rate of all health boards in Wales.

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

Quadruple Aim 2: Mental Health
For adult mental health services there was a dip, as expected, in performance compared to last month, with percentage adults assessed within 28 days of referral at 61.99%. This was due to an increase in referrals in March and issues with capacity in East, which has a waiting list larger than West and Central combined. The number of patients starting therapy within 28 days of assessment remains above the 80% target at almost 80.9%.

Performance remains poor against the targets for the rate of children assessed within 28 days of referral, at 23.68%, and starting therapy within 28 days of assessment at 19.64%.

There has been a consistent and significant improvement in the percentage rate of adults waiting less than 26 weeks to start psychological therapy at 70.67% in May 2021 from a low of 20.1% in September 2020.

Whilst the number of patients experiencing delayed transfer of care (DToC) within our mental health has increased slightly at 15 in May 2021 (compared to 13 in March 2021), the length of stays has continued to fall at 565 (compared to 631 in April 2021). The service is working to resolve issues that lead to DToC and it is expected that the number and length of DToC's will fall over the coming months.

Performance against the 26 Week target or children awaiting neurodevelopment assessment remains poor at 26.84%, however, it is a slight improvement on the 23.82% reported previously. It is expected that plans recently approved will enable us to increase capacity to see 120 children per month and this will translate to a much improved performance.

Quadruple Aim 3: Quality & Safety
There were 3 new Never Events reported in May 2021. These were giving a second dose of Methotrexate within 48 hours, A wrong side chest drain insertion and a wrong side ankle block. Investigations into all three incidents are underway.

The percentage closure rate of complaints managed under PTR < 30 working days (target 75%) - 57.39% May 2021. Whilst not reaching the set target the process is currently stable and delivering at around 60% compliance for the last 5 months. This is a sustained improvement compared to previous years, where performance has been as low as 30%. This reflects the learning from incidents and focus upon timely responses.

Quadruple Aim 4: Mortality and Timely Interventions
Crude Mortality (under 75 years old) has decreased to 1.01%. The mortality rate for BCU is lower than the Wales average of 1.13%.

Concern remains with regards the recording and monitoring of provision of Sepsis Six bundles both for our Inpatients and within our Emergency Departments. The Office of the Medical Director is currently reviewing this and it is expected that reporting will recommence by end of August 2021.

Performance management
The Quality & Performance Report is currently being redesigned with a view to presenting a new Integrated Quality & Performance Report to the Health Board and it's committees in at the latest Quarter 3 of 2021-22.

A Quality Surveillance Group (incorporating, performance, corporate, medical and nursing services) has been established (First meeting held on 14th June 2021) to review quality and identify hotspots and risks.

COVID-19

Key Messages

COVID-19 vaccination offered to all adults>18 years old

Pace of de-escalation of national alert levels is under review in light of increasing community transmission

Escalation plans need to be balanced with the restart and recovery of services

Measure	at 21st June 2021
Total number COVID-19 Vaccinations given BCU HB	833,888
Total Number who have received both 1st and 2nd doses of vaccine	336,052
Total number of tests for COVID-19 (last 7 days)	19,773
% Tests turned around within 24 Hours (Last 7 days)	100%
Average turnaround time (Last 7 days)	2 Hours
COVID-19 incidence per 100,000 population (last rolling 7 days)	55.7
% Prevalence of Positive Tests (last rolling 7 days)	3.9%
Number of (PHW) Deaths - Confirmed COVID-19* (last rolling 7 days)	0

Source: BCU IRIS Coronavirus Dashboard, accessed 21st June 2021
* PHW Coronavirus Dashboard Accessed 21st June 2021 data as at 20th June 2021

Data for **May 2021** (unless otherwise stated)
Presented on 6th July 2021

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- Incidence is increasing across all LA areas in North Wales. Four of our six counties have the highest incidence rates in Wales – cases per 100,000 over the last 7 days are at 91.3 for Conwy, 77.3 for Denbighshire, 73.7 for Flintshire and 47.8 for Wrexham (to 16 June.) Isle of Anglesey and Gwynedd currently remain below the Wales average at 20.0 and 12.0 cases per 100,000. The positivity rates reflect a similar positon with Flintshire exhibiting highest positivity rate over last 7 days to 16 June, at 6.1%; Conwy 4.6%; Denbighshire and Wrexham both at 4.2%.   Isle of Anglesey reported 1.8% positivity and Gwynedd 1.0%. These patterns are not unexpected given the proximity to the border areas and flow of citizens between the regions.

- The Delta variant is now accounting for the vast majority of cases across North Wales and is also the dominant variant across Wales.

- Highest volume of new positive results is amongst those under 50 years of age, with those under 29 accounting for more than half.

- Small numbers of community onset admissions have occurred over the last week or so, although still very low. There are currently no COVID-19 patients in critical care although each site has had one or two suspected or confirmed cases. There are concerns about capacity within hospitals if admissions for people with COVID-19 continue to increase, given the current high levels of unscheduled care pressures.

- A small number of care homes have staff or residents with positive tests and some awaiting results.

- Overall GP consultations remain generally flat although a very slight uptick seen in June.

- The vaccination programme continues to deliver well, with all adults over age 18 having been offered the vaccine. Initiatives are continuing to encourage uptake amongst groups that are to date underserved, and to reduce the numbers of people failing to attend for their appointments.

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

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

Key Messages

Childhood immunisations continue at a high rate despite COVID-19

As expected the smoking cessation rate is lower than same period last year as impacted by COVID-19

Timely provision of Care Treatment Plans for Adults and Children remains on or above target

Measures

Period	Measure	Target	Actual	Trend
Q4 20/21	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	>= 95%	95.40%	↓
Q4 20/21	Percentage of children who received 2 doses of the MMR vaccine by age 5	>= 95%	95.20%	↑
Q3 20/21	Percentage of adult smokers who make a quit attempt via smoking cessation services*	>= 5%	2.55%	↓
Apr 21	Percentage of health board residents in receipt of secondary mental health services who have a valid Care and Treatment Plan (aged under 18 years)	90%	90.50%	↓
Apr 21	Percentage of health board residents in receipt of secondary mental health services who have a valid Care and Treatment Plan (aged 18 years & over)	90%	92.10%	↑

* Performance compared to same quarter previous year

Data for **May 2021** (unless otherwise stated)
Presented on 6th July 2021

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

CAMHS struggling to meet demand and waiting times lengthening

Decrease in number of Mental Health beds days lost to Delayed Transfers of Care

Improved performance against Adult Psychology 26 weeks waits

Top Measures (based on movement up or down)

Period	Measure	Target	Actual	Trend
Q4 20/21	Percentage of children who received 2 doses of the MMR vaccine by age 5	>= 95%	95.20%	⬆
May 21	Number of New Never Events	0%	3	⬇
May 21	Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy	>= 80%	70.67%	⬆
Apr 21	Percentage of mental health (Adult) assessments undertaken within 28 days of referral	>= 80%	61.99%	⬇

Data for **May 2021** (unless otherwise stated)
Presented on 6th July 2021

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Quadruple Aim 2: Infection Control Measures

Period	Measure	Target	Actual
May 21	Cumulative rate of laboratory confirmed E-Coli cases per 100,000 population	<= 67	67.57
May 21	Cumulative number of laboratory confirmed E-Coli cases	N/A	79
May 21	Cumulative rate of laboratory confirmed S.Aureus cases per 100,000 population	<= 20	21.38
May 21	Cumulative number of laboratory confirmed S.Aureus cases	N/A	159
May 21	Cumulative number of laboratory confirmed C.Difficile cases	N/A	22

Period	Measure	Target	Actual
May 21	Cumulative rate of laboratory confirmed C.Difficile cases per 100,000 population	N/A	18.82
May 21	Cumulative numberof laboratory confirmed MRSA cases	0	0
May 21	Cumulative number of laboratory confirmed MSSA cases	<= 40	25
May 21	Cumulative number of laboratory confirmed Klebsiela cases	<= 38	21
May 21	Cumulative number of laboratory confirmed Aeruginsoa cases	<= 10	12

Comparison Charts to all Health Boards in Wales – May 2021
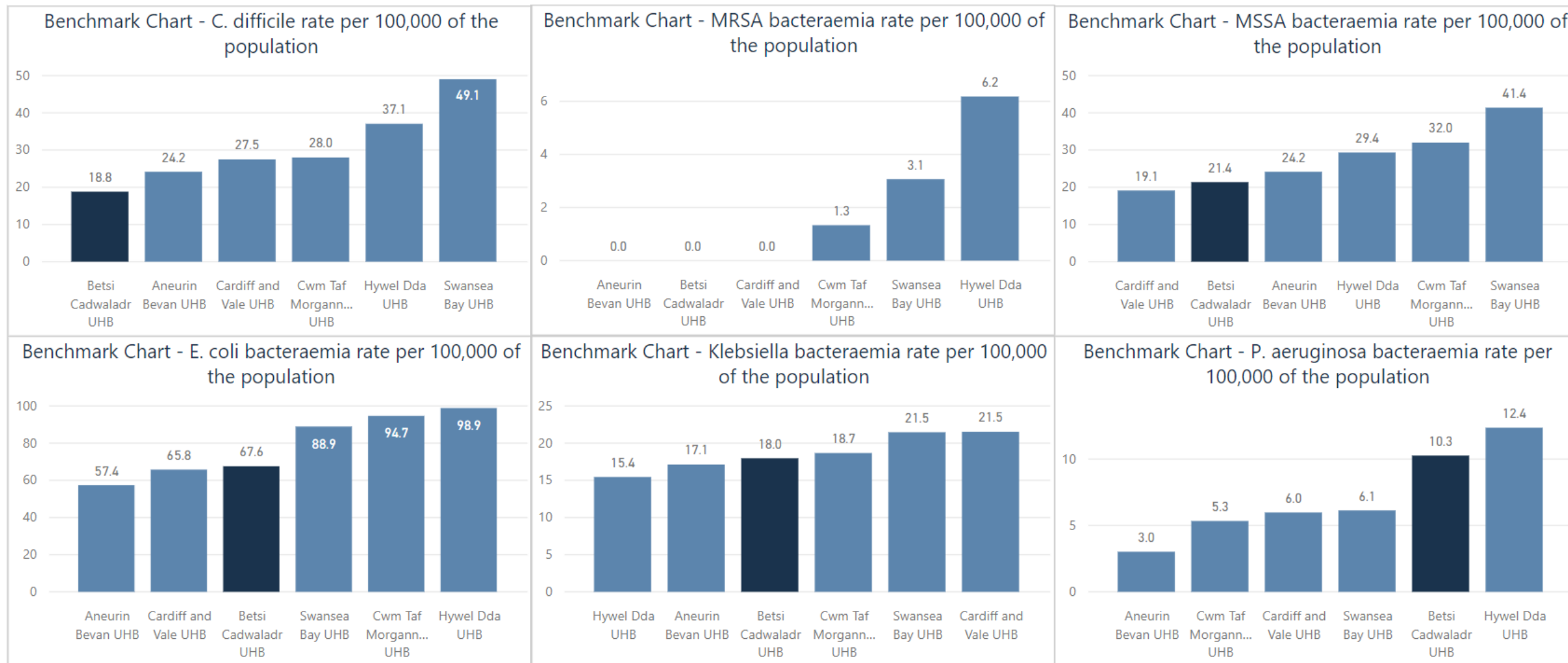
Rolling period refers to Cumulative April 2021 to Date (May 2021)

Quality and Performance Report
Quality, Safety & Experience Committee

Data for May 2021 (unless otherwise stated)
Presented on 6th July 2021

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Issues Affecting Performance

- Infection Prevention & Control Team requires a multidisciplinary Team (MDT) approach utilising expertise from Anti-Microbial Pharmacists (AMPs), senior qualified Infection Prevention & Control leads, project managers and quality improvement leads to provide the skillsets needed to support the frontline staff in reducing incidences, transmission, and risks of infections. Although funding for additional IPC staff was agreed several months ago, some vacancies remain un-recruited to, hindered by the by the complex nature of the recruitment processes.
- The increasing need to bring more people (patients and visitors) into hospital during a pandemic without expanding the facilities/redesigning how we deliver care.
- Isolation is the key control mechanism in infection prevention and control, this includes isolating suspected and know infected patients, physical distancing and sterile/effective fomite cleaning to stop the spread of infection.
    - We do not have enough appropriate facilities to provide rapid effective isolation for our suspected and confirmed infected patients.
    - We do not have enough people available to ensure effective fomite cleaning efficiently e.g. in between every contact.
    - How we use our facilities prevents us from maintaining enough physical distance to reduce the risk of infection transmission.
- Inability to find appropriate decant space to run a routine deep clean programme throughout our facilities.
- Inappropriate antimicrobial/PPI prescribing.
- Having the time to complete care bundle paperwork effectively upon insertion and maintenance of devices.
- Inability to have the information/intelligence needed at our fingertips to understand and minimise risk.
- Time it takes to get test results back - from test taken to results being acting upon. The national target is that tests be turned around within 12 hours and currently over 99% of tests meet this timeframe. However, we are proposing an ambitious project to significantly reduce the average test turnaround times. This work could form part of the improvement works of the laboratories and completion of the end-to-end process mapping of tests. The Executive Director for Public Health is overseeing the possibility of linking these two work-streams.

Actions and Outcomes

- Developing the Board Assurance Framework (BAF) to show short/medium and long term actions to drive performance improvement.
- Safe Clean Care Harm Free programme begin mobilised to support pan Health Board transformation and behavioural change, developing a bid for capacity and capability funding to provide full time support to drive improvements.
- Safe Clean Care Harm Free has six underpinning work streams Safe Place, Safe Space, Safe Action supported by Informatics, Communications and Staff Engagement to release time to deliver harm free care through mobilising the underpinning 38 projects.
- Second round of HARMs self assessment to see how the divisions are embedding the changes required to achieve the national IPC guidance and the remaining gaps.
- Accountable areas Infection Prevention Plans on a Page developed to set the road map for 2021/22 to reduce harms fostering an approach of zero tolerance to Health Care Associated Infections.

Timeline for delivery of improvement

April 2022

Risks and Mitigations

- Risks are set out on the corporate risk register and the Board Assurance Framework (BAF).
- New risk to flag is opening up our facilities to more visiting could significantly increase our risk of possible infection transmission and Health Care Associated Infections (HCAI).

Quadruple Aim 2: Mental Health Measures

Frequency	Measure	Target	Actual	Trend
Apr 21	Percentage of mental health (Adult) assessments undertaken within 28 days of referral	>= 80%	61.99%	🔻
Apr 21	Percentage of therapeutic interventions (Adult) within 28 days of assessment	>= 80%	80.90%	🔻
Apr 21	Percentage of mental health (CAMHS) assessments undertaken within 28 days of referral	>= 80%	23.68%	🔻
Apr 21	Percentage of therapeutic interventions (CAMHS) within 28 days of assessment	>= 80%	19.64%	🔺

Frequency	Measure	Target	Actual	Trend
May 21	Percentage of children and young people waiting less than 26 weeks for neurodevelopment assessment	>= 80%	26.84%	🔺
May 21	Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy	>= 80%	70.67%	🔺
May 21	Total Number of mental health delayed transfer of care (DToC) patients	Reduction	15	🔻
May 21	Total Number of mental health delayed transfer of care (DToC) bed days	Reduction	565	🔺

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

Issues Affecting Performance
- Increased referral numbers in last couple of months since return to schools.
- Children & Young People (C&YP) presenting with elevated acuity and complexity in Community teams and to Crisis teams, requiring additional capacity and support.
- Reduced efficacy of evidenced based treatments delivered remotely leading to increased new to follow up ratio.
- Reduced capacity within the teams – the current vacancy rate stands at 23.75%.
- Reduced physical capacity within CAMHS accommodation due to social distancing requirements.

Actions and Outcomes
- Targeted Interventions maturity matrix completed with 12 separate work streams. Leads identified for each work stream and Project Initiation Documents (PIDs) produced – priorities and timelines to be finalised.
- Regional infrastructure posts to support Performance delivery, governance and service development identified, to be recruited to.
- Bids submitted for Service Improvement funding for Eating Disorders, Psychological Therapies, Crisis services and Specialist CAMHS including Outreach team.
- Funding secured for roll-out of Schools In-Reach project, options appraisal to be finalised.
- Workforce plan to include recruitment strategy and training and development plan to be completed, additional HR support requested. Workshop to be arranged.
- Single Tender waivers for private providers to increase assessment and therapy submitted by each Area – awaiting approval with Contracting team.
- Tender for private provider for assessments and therapy to be renewed, Ministerial approval being sought by Procurement colleagues.
- Health Education & Improvement Wales (HEIW) allocated one training number for commencement in August 2021 and a further two training numbers for commencement in August 2022, BCU support in Annual Plan.
- Attend Anywhere being utilised in all teams – video contacts constituted 17.22% of total attendances in April 2021.
- Ongoing discussions regarding access to additional accommodation for clinical contacts including discussions with schools to support remote appointments.

Timeline for delivery of improvement
- Targeted Intervention priorities and timelines to be agreed by July 2021.
- Workforce plan to be finalised, timeframe to be confirmed. Workshop to be held late June/early July 2021.
- Tender process to be completed with contract in place by December 2021.
- Single tender waiver arrangements to be made by respective teams by end of June 2021, dependent on approval to proceed received.

Risks and Mitigations
- Current vacancies and additional posts cannot be recruited to - to be supported by workforce plan.
- Demand for services and acuity and complexity increases – Service Development funding to target.
- Non-delivery on Mental health Measures (MHM) targets included on service risk register – reviewed regularly at local meetings and CAMHS Service Improvement Group.

Key Drivers of performance
- Current waiting list 2,110 a slight decrease of 54 on the March 2021 position. There are currently 1,634 children waiting over 26 weeks.
- Referrals into the service remain slightly lower than pre-COVID-19 activity, however, this is starting to see an increase following pre-COVID-19 trends
- Activity from within establishment remains below trajectory.

Actions being taken
- Waiting list validation exercise commencing at the end of June 2021.
- External provider remains on target with current trajectory. Discussions taking place with regards to increasing the trajectory. Early indications show that the provider could deliver 1,104 assessments by end of March 2022.
- Private Provider has offered to deliver between 1,500 and 1,700 assessments by year end, however, which will require further investment/funding and a remodelling of MDT's due to the internal capacity that the model will require. Work is underway on this.

Timelines
- Internal capacity to undertake assessments expected to be at pre COVID-19 level by Quarter 2 2021/22.

Risks
- Internal staffing capacity will present a risk to increased levels of internal activity if projections are revised as it will currently require work in addition to current job plans which may then negatively impact upon other assessments and interventions offered by the service.
- Additional activity from external providers will require additional funding, as well as confirming that they can provide that activity, which is a fluctuating situation.
- If staffing levels decrease internally, including clinical/admin, this may place external contract could be placed at risk due to the collaborative and interwoven approach between external and internal provision, e.g. with joint Multidisciplinary Teams (MDTs).
- Future demand following full opening of all schools may see referrals increase. We are working with Local Authorities (LAs) and schools to improve clarity regarding expectation and appropriateness of referrals.

Quadruple Aim 2: Adult Mental Health Delayed Transfers of Care

Since February the MH&LD DToC performance has improved significantly on a weekly basis both in patient numbers and bed days lost and we expect this to be our regular position aside from some issues out of our control, such as, the availability of low secure beds across the UK and nursing homes being red due to COVID-19. The current performance is where we expected for April and May 2021, and if the recommendations from the DToC Review report are progressed and implemented there should be further improvements.

Issues Affecting Performance
*   Continuation of weekly divisional scrutiny panel, supported by Heads of Nursing (HON's) and senior staff, Community Health Council (CHC) and Finance.
*   Analysis of weekly figures, barriers to change, appropriate coding of registration, actions and reduction/ increase in DToC for that period.
*   National database updated and all related training given, this is now single source of DToC information, to allow parity and consistency across division.
*   EDD requested for all registrations to allow monitoring of process and appropriate actions.

Actions and Outcomes
*   Policy and process reviewed to ensure accuracy and consistency across BCUHB Mental Health & Learning Disabilities (MH&LD) Division.
*   Divisional scrutiny panel weekly data considered, barriers identified and support and guidance offered by panel members.
*   Delayed Transfer of Care Review Report presented to MH&LD, Speech & Language Therapy (SLT) with recommendations.
          Significant reduction in registered DToC's since scrutiny process enabled- **Overall reduction 83%** since inception of process.
*   Since the review commenced **reduced bed days lost to DToC from 3,000 to 498** – a further reduction of 38% since March report completed.

Timeline for delivery of improvement
*   National database updated for weekly scrutiny and recommendations. Process enabled 5.2.21 and ongoing.
*   Scrutiny panel supported by HONs, CHC and Finance, continues weekly to date.
*   Weekly report to Gold Command on progress with recommendations, and highlighting good/effective practice in planning.
*   Delayed Transfer of Care Report completed April 2021, awaiting implementation of recommendations.

Risks and Mitigations (What are the key risks to improving performance and have they been escalated? If so where to?)
*   All risks managed through weekly scrutiny panel review and reported to divisional leads, with mitigation plans. Timelines, and Estimated Discharge Dates.
*   All significant barriers identified and reported to Command meeting, where additional senior support is identified as a need to ensure timely resolution.

Issues Affecting Performance
• Capacity/demand mismatch.
• Sickness and vacancy.
• COVID-19 restrictions.

Actions and Outcomes
• Stepped Care Initiative support to offer input during maternity leave of clinician in Wrexham (now returned April 2021).
• Stepped Care Initiative supported increased provision from MDTs (as per Matrics Cymru) through supervision & training.
• Digital adaptations increasing online clinician supported delivery of CBT, DBT, and Coping Skills group and individuals.
• External support waiting list initiative (now ended) in Wrexham has increased compliance significantly.
• Compliance significantly improved over last year due to combination of above actions.

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
May 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%	57.39%	⬇
May 21	Number New Never Events	0	3	⬇
May 21	Doctor Appraisal / revalidation rate*	95%	77.33%	⬆

Failure to complete an appraisal due to COVID-19 issues will be logged as an approved missed appraisal. Everyone who has not completed an appraisal so far in 2020 is entitled to an approved missed appraisal. The adjusted figures should read 100% for all areas.

Serious Incidents (Welsh Government Reportable)

Key Drivers of performance
- Key performance indicators set by Welsh Government (criteria narrowed as of 5th January 2021 due to conflicting pressures of COVID -19).
- BCUHB core values: Putting Patients First.
- Putting Things Right (PTR) Regulations.

Actions being taken and timelines
- Daily incident review meeting in place inclusive of moderate incidents.
- Local daily safety huddles remain in place.
- New incident management will commence June 2021; current systems aligned in preparation.
- Serious Incident Learning Panel reviews undertaken each week to discuss quality and content of Concise and Comprehensive investigations.
- Introduction of new incident investigation skills passport – launch to be confirmed.
- New Datix system planned for implementation – launch to be confirmed; patient safety team involved in national discussion re incident management module.
- Implementation of new national incident reporting framework (from 14 June 2021).

Impact upon performance should be visible by
- Reduction in time taken to report to Delivery Unit (DU)/ Welsh Government (WG) reported within 24 hours: May performance = 11.11% (target = 90%). The corporate teams now manage the submission of reportable incidents to the DU/WG via the daily review; as the new process is embedded in June 2021 improvement is expected.
- Improvement in completion time of SI investigations completed within 60 working days: May performance = 25% (42 open incidents, 31 of which are overdue).

Risk
- The quality of investigations is variable – investigating officer training will mitigate this risk.
- The timeliness of investigation is below target – the new process will mitigate this risk.
- The level of patient and family involvement in investigations is variable - the training and new process will mitigate this risk.

Falls, HAPU and medication errors reported as serious incidents

Key Drivers of performance
Key performance indicators set by Welsh Government (criteria narrowed as of 5th January 2021 due to conflicting pressures of COVID -19).
BCUHB core values: Putting Patients First.
Putting Things Right (PTR) Regulations.

Actions being taken and timelines
Local daily safety huddles in place.
Daily Incident review meetings in place.
Falls and Hospital Acquired Pressure Ulcers (HAPU) dashboards in place to provide local access to data and trends.
Strategic Falls Group re-commenced with a focus on accurate and consistent data and reporting to support identification of themes and areas for improvement.
New falls action plan being developed building on work of the falls collaborative.
All Wales Review Tool for Pressure Ulcers now available on Datix and being tested to provide easier data collection and theming – launched 01 April.
Serious Incidents (SI) investigations for all falls/HAPUs and Medication Errors which will be scrutinised at the new SI Learning Panel rolled out in April 2021.

Risk
Prior to the introduction of the Datix All Wales Review Tool for Pressure Ulcers, forms were completed manually on paper and filed locally.

HAPU Data
177 pressure ulcers Grade 3, 4 and unstageable reported in May 2021. Of the 177 incidents, 113 incidents have been closed and 7 were deemed as avoidable pressure ulcers.

Falls Data
11 patient falls with harm were reported in May 2021 (6 East Acute, 4 Central Acute, 1 West Area).

Medication Error Data
1 Serious Medication error was reported as an SI and Never Event in May (YGC) relating to the overdose of methotrexate for non-cancer treatment.

Key Drivers of performance
Key performance indicators set by Welsh Government (criteria narrowed as of 5th January 2021 due to conflicting pressures of COVID- 19).
BCUHB core values: Putting Patients First.
Putting Things Right (PTR) Regulations.

Actions being taken and timelines
Weekly PTR meetings in place across services.
Improved joint working between Complaints Team and PALS to address complaints through Early Resolution.
Pilot of a Matron Helpline being setup and tested at WMH.
Phased testing and implementation of new process for complaints.
Introduction of new complaint handling/investigation skills passport – first two modules now available.
Ombudsman delivered training rolling out.
New Datix system planned for implementation.

Impact upon performance should be visible by:
% of formal complaints acknowledged in 2 working days (target 90%) – 92.71% May 2021.
% of complaints managed under PTR < 30 working days (target 75%) - 57.39% May 2021.
Whilst not reaching the set target the process is currently stable and delivering at around 60% compliance for the last 5 months. This is a sustained improvement compared to previous years, where performance has been as low as 30%. This reflects the learning from incidents and focus upon timely responses.

Risk
Services continue to report issues identifying staff as Investigating Officers causing delays in commencement of investigation.
The quality and timeliness of investigations is variable.
The level of patient and family involvement in investigations is variable .
The recent COVID-19 second wave has created a backlog of overdue complaints (126 as of May 2021).

Top 3 reasons (primary subjects) identified:

1.   Consent, confidentiality or communication;
2.   Access, appointment, admission, transfer, discharge;
3.   Treatment, procedure.

Never Events

There were 3 Never Events reported in May 2021. Investigations remain underway, however, immediate actions are as follows:

Second dose of Methotrexate within 2 days of previous dose.
Actions:
Methotrexate Policy and Patient Safety Alert circulated across the Health Board.
Cross reference to previous learning from 2018 as part of the investigation.
Yellow Methotrexate Alerts to be visible and in place within the clinical environment.

Wrong side insertion of chest drain.
Actions:
BCUHB Local Safety Standards for Invasive Procedures (LocSSIPs) library launched 14 June 2021 – LocSSIPs to be used for any invasive procedure.
Mandated nursing staff in attendance when undertaking chest drain insertion.
Internal auditing of LocSSIP compliance within clinical areas underway.

Wrong side ankle block.
Actions:
'Stop Before you Block' posters and protocols reinforced to all staff across Health Board.
Anaesthetist to verbalise 'Stop Before you Block' prior to administering a block.
Reinforcing staff responsibility to speak-up and raise concerns.
'Stop Before you Block' stickers now in place on nerve stimulators and ultrasound machines.
Safety Alert distributed across Health Board.

In addition, a report is being presented to the Patient Safety and Quality Group outlining the findings of work to assess the external review of a Never Event in urology against the action plan put in place, to identify any further actions needed.

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.

Key Messages

| Mortality Rate at 1.01% remains below peer average | Increased system working to link Health and Social Care Data | Work underway to resume reporting of Sepsis Six Bundle |

Measures

Period	Measure	Target	Actual	Trend
Apr 21	Crude hospital mortality rate (74 years of age or less)*	Reduction	1.01%	⬆
May 21	Percentage of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	Improve	No Data	
May 21	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	No Data	
Apr 21	Percentage of patients (age 60 years and over) who presented with a hip fracture that received an orthogeriatrician assessment within 72 hours *	>= 75%	62.00%	⬆
May 21	Percentage of episodes clinically coded within one reporting month post episode discharge end date	>= 95%	92.00%	⬇

* Reported 1 month in arrears

Data for **May 2021** (unless otherwise stated)
Presented on 6th July 2021

22
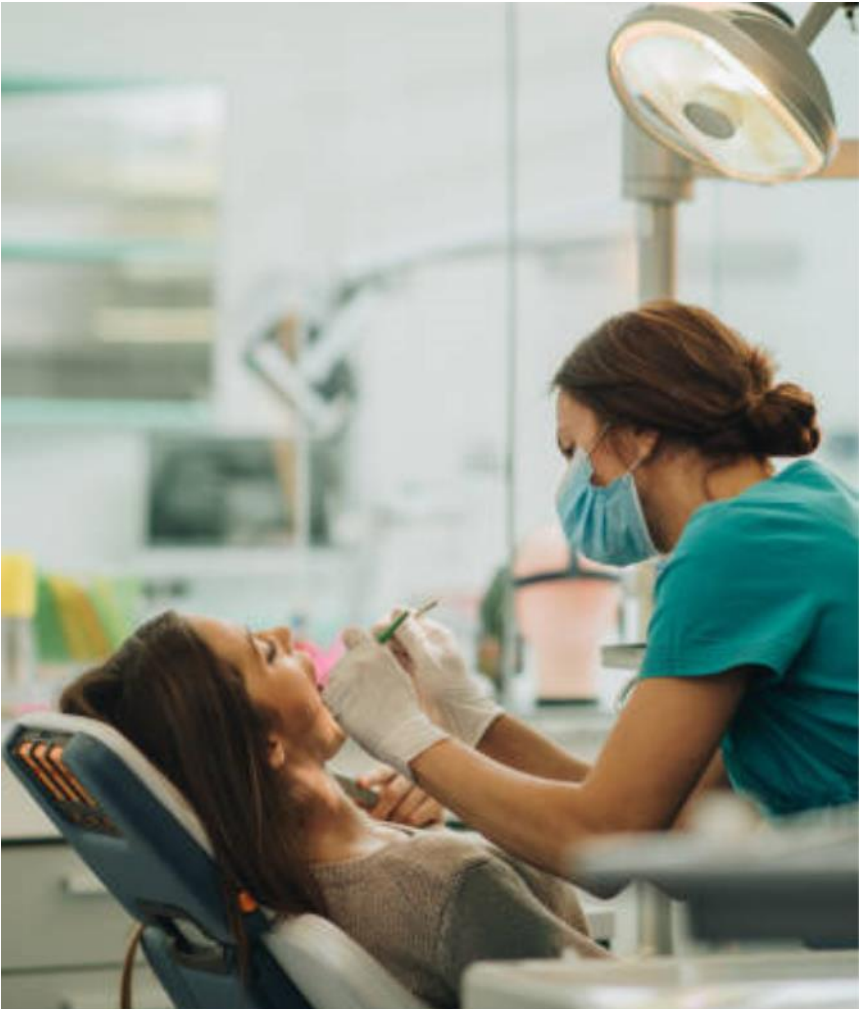
Quadruple Aim 4: Narrative - Mortality

The 12 month rolling crude mortality rate for ages 75 years and under is below the peer group (1.01% v 1.13% (Other Welsh HBs ex Powys) to April 2021). This has reduced during the last quarter as the second COVID-19 surge has receded. The highest number of deaths was in those patients admitted with COVID-19 (136) , Sepsis (82) and unspecified pneumonia (74).

Key Drivers of performance (for year to April 2021 against other Welsh health boards excluding Powys reported by CHKS)
- Crude mortality- overall (2.33% v 2.65%) this is similar to the pre second surge level.
- Mortality- sepsis (18.2% v 20.4%) remains below the peer; however, this has increased compared to the previous years crude rate.
- Mortality- cerebrovascular disease incl. stroke (12.3% v 13.3%) variation seen over the past year is common cause with mortality "as expected" overall.

Actions being taken
- Implementation of DATIX mortality module to support learning from deaths has been delayed due to reduced training capacity within the team. However, this has recommended and DATIX is being used across all sites
- The roll out of the Medical Examiner continues to be delayed until we can provide scanned notes; funding has been agreed and the recruitment process has started. This will support our decision to undertake further review and highlight any emergent themes for action. Processes have been piloted at Wrexham and Bangor to ensure smooth introduction to the service.
- Hospital Acquired COVID-19 reviews are continuing. Additional support has been agreed in principle as part of the wider review process and a paper has been developed to support this.
- BCUHB clinical mortality lead to work with OMD to increase local ownership and enhance learning –advertised 18/06/21.
- Supporting Delivery Unit with developing All Wales Learning from Deaths Framework and the mortality process review. Visits and discussions have been taking place with other services within and external to Wales to inform our developing policy.

Timelines
- DATIX mortality module – aim to be paperless for in-patients by April 2022. Acute site roll out complete by August 2021; Community beds by April 2022.
- Medical Examiners– aim all deaths on acute sites will be scanned by August 2021.
- HCAI COVID-19 deaths - Sites have lists of all deaths for review; process in place to update monthly. Review process has started to roll out on all sites. Completion date will depend on resources available and cannot be confirmed at this time. YG will have completed death reviews by the end of June 2021.
- Clinical Mortality Lead - Job description written and funding agreed – aim to be appointed by July 2021.
- Learning from Deaths Policy – on hold pending the appointment of the Clinical Lead.

Risk
- The COVID-19 pandemic has reduced the capacity for staff to undertake routine mortality reviews. This, together with the need to complete HCAI death reviews has led to a backlog of stage 2 reviews. Nursing colleagues have been identified on all sites to support mortality reviews. Additional resources are required to ensure these are completed. Other health boards in Wales are in a similar position. Failure to complete these in a timely way may impede safety and also cause reputational damage to the Health Board. A proposal document has been written for Executive review.
- Lack of agreed mortality review process across all acute sites may result on the three areas working differently. Mitigation - all sites are using the same tools.

Quadruple Aim 4: Narrative – Timely Interventions - Sepsis

Issues Affecting Performance
- There has been a significant reduction in data collection across all sites since the COVID-19 pandemic. This is in absolute numbers of patients audited and the completion of the bundle data such that the levels of compliance are unreliable.
- YG have noted delays in doctor reviews; seeking second checker for antibiotics; ambulance waits and the introduction of Symphony as contributing to this.

Actions and Outcomes
- All sites are aware of this issue and it has been escalated to Secondary Care division and corporate Clinical Effectiveness Group (CEG).
- YG ongoing unscheduled care improvement work stream will address some process delays; reminding staff to note if entries in Symphony are retrospective and explore whether a prompt can be introduced in to Symphony.
- YGC has identified a new Sepsis lead for the site who is developing a plan.
- YWM has identified sepsis champions for all clinical areas that will start to support a programme led by Acute Intervention Team; sepsis bundle included in local teaching with additional targeted education focussing on new starters.

Timeline for delivery of improvement
- YG by end of August they will define the denominator to enable real time monitoring and reinforcement.
- YWM above actions now in place; improvement is anticipated by September 2021.
- Secondary care have been asked to provide an improvement plan; this will be followed up at secondary care CEG in June 2021.

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

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

Ortho-geriatrician Review within 72 Hours – Performance is in line with national average.

Issues Affecting Performance

YG - Performance is in line with national average at 87% for April 2021 - Lack of Ortho-Geriatric cover due to consultant shielding and sickness; Potentially non standard reporting mechanisms (versus South Wales) where reported compliance is higher despite no dedicated Ortho-geriatric Physicians.

YGC – Performance is in line with the national average at 87%. There is a full time physician in this role and a dedicated Physicians Associate attached to Ortho-Geriatrics.

YWM- Ortho-geriatrician is available on site with 4 planned ward rounds per week. There is no cover for leave.

Actions and Outcomes

YG - Limited sessional cover secured for planned annual leave (10 sessions/year of Care of the Elderly COTE).

YGC – no additional actions.

Timeline for delivery of improvement

Plans pre-COVID-19 for Delivery Unit (DU) led National Networking Group needs to be re-established – Action held by DU.

YG - Establish Health Board working group – within next quarter – Action Directorate General Manager Surgical and Critical Care (DGM SACC); Draft business case completed for additional COTE sessions and to be submitted to site Finance & Performance meeting by end of July – Action DGM SACC.

Risks and Mitigations

The risk is that patients' health is not maximised before surgery and comorbidities not managed well peri-operatively with the potential for avoidable morbidity and mortality. Performance has improved over the past 3 years across the Health Board with additional resources. However, these are not consistent across the sites and in YG a business case is being developed as above.

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

Additional Information

Quadruple Aim 2: Charts Adult Mental Health

Percentage Mental Health Assessments (Adult) within 28 days of Referral (April 2021)

Legend: 2019/20, 2020/21, 2021/22, Target

Figure 1: May 2021 Target Compliance BCUHB

BCU at 70.67%

Apr-21

Percentage Mental Health Theraputic Interventions (Adult) within 28 days of Assessment (April 2021)

Legend: 2019/20, 2020/21, 2021/22, Target

Figure 2: Target Compliance BCUHB May 2019, 2020 & 2021

May-19: 22.37
May-20: 50
May-21: 70.67

BCU
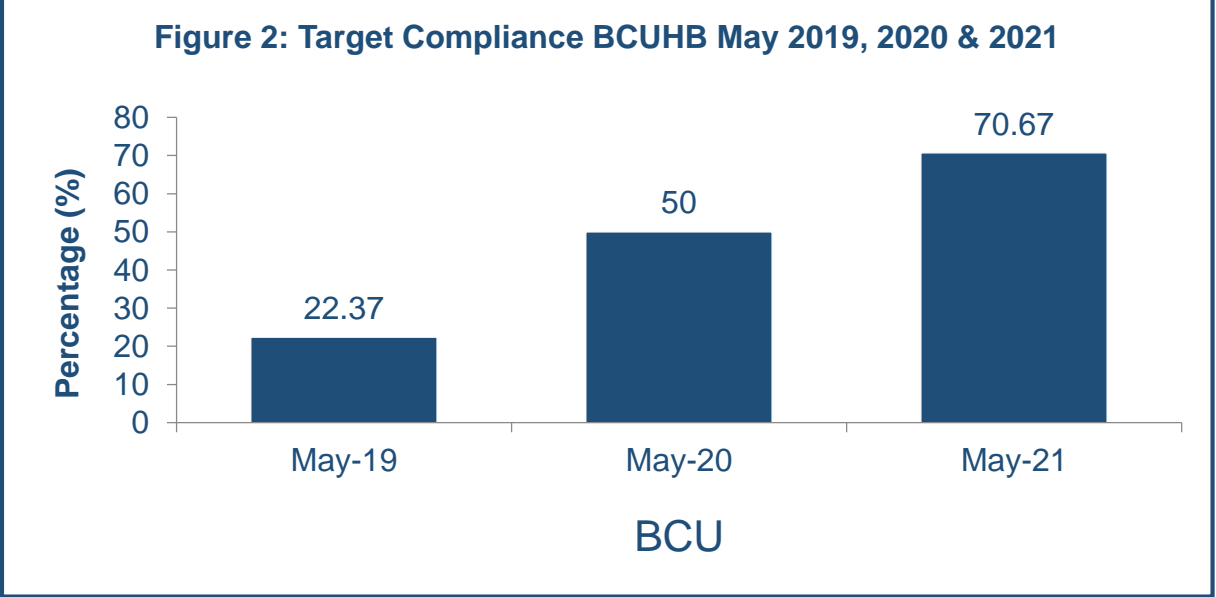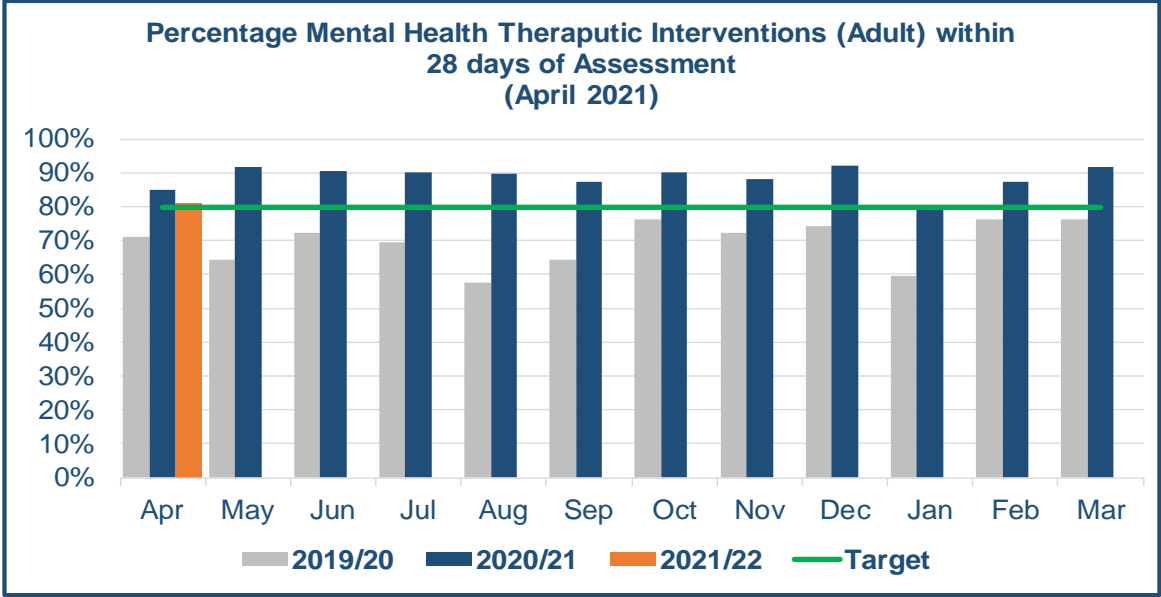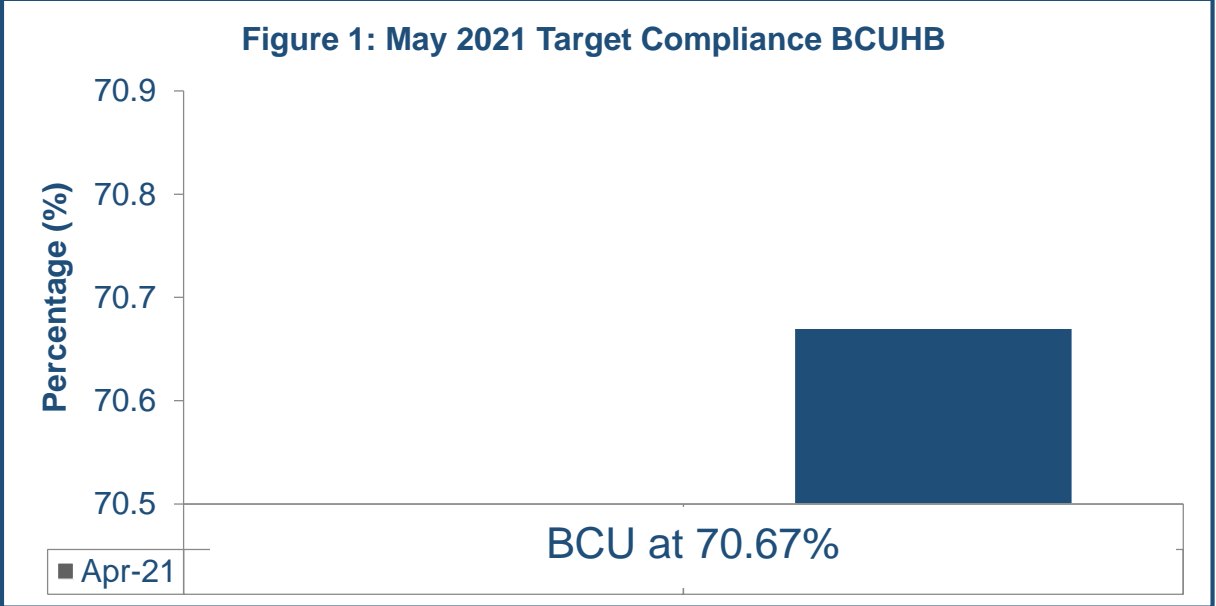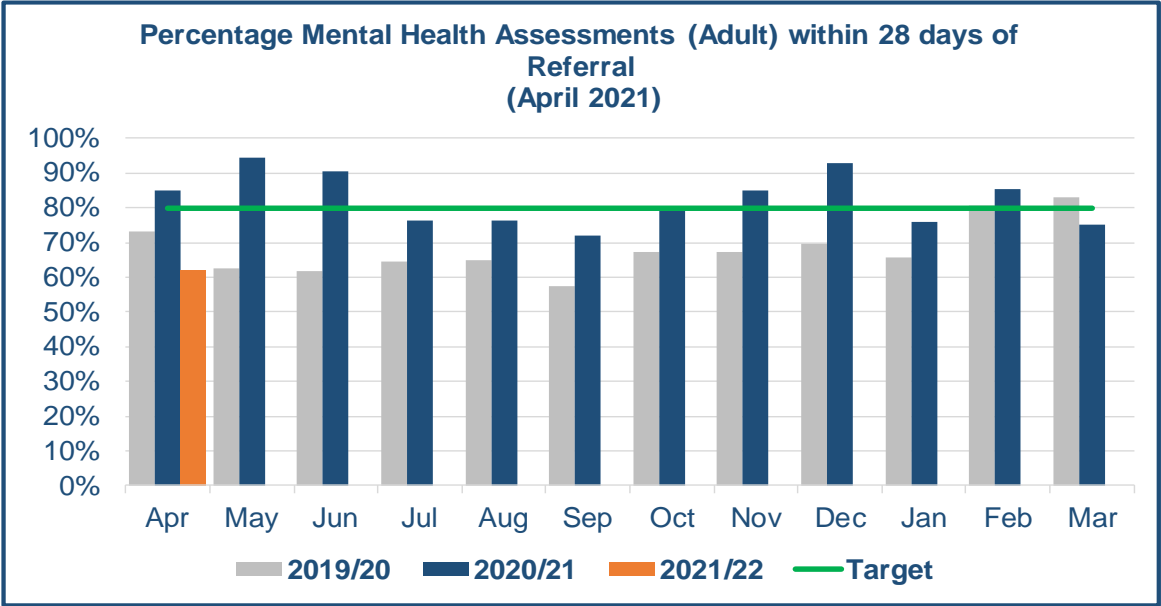
Percentage Mental Health Assessments (CAMHS) within 28 days of Referral (April 2021)
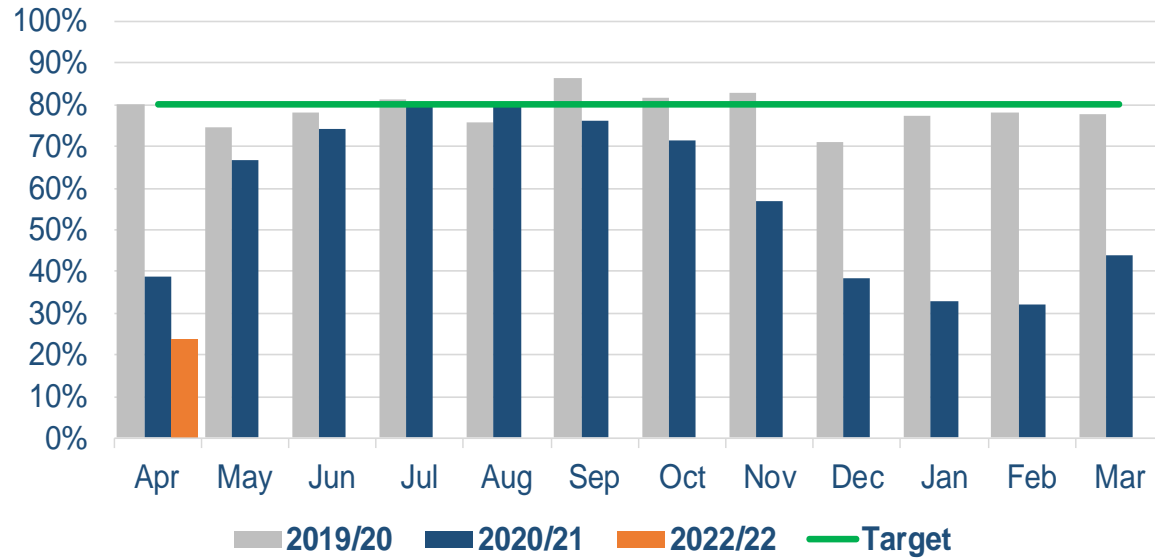
Percentage Mental Health Theraputic Interventions (CAMHS) within 28 days of Assessment (April 2021)
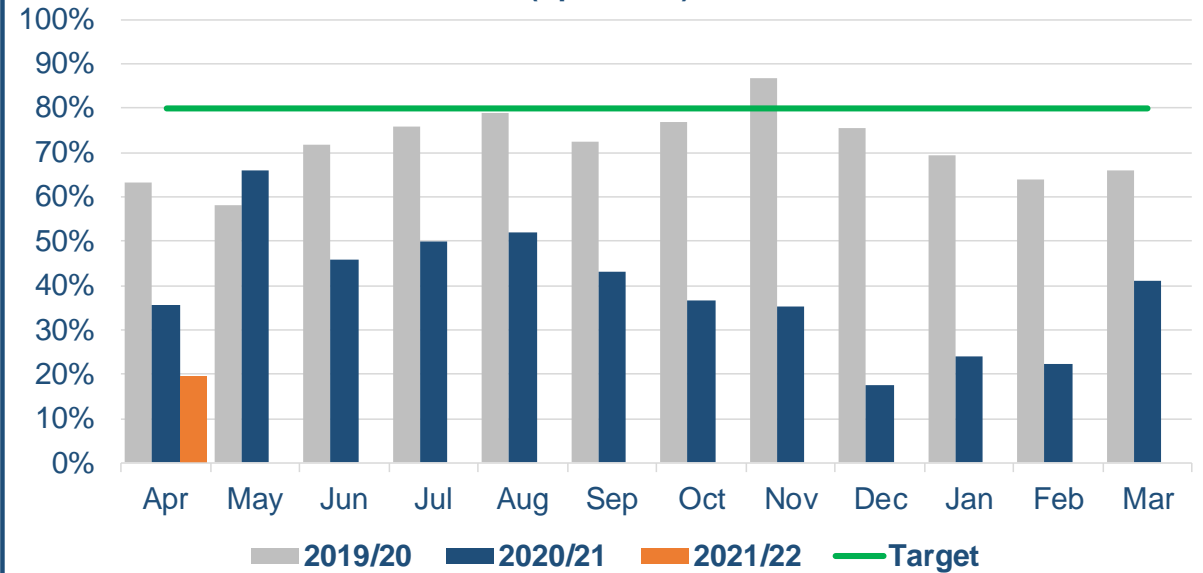
Data is reported 1 month in arrears

Quadruple Aim 2: MH Delayed Transfers of Care

Number of Delayed Patients (BCU Mental Health)
2021/22 comparison to 2020/21 and 2019/20
May 2021
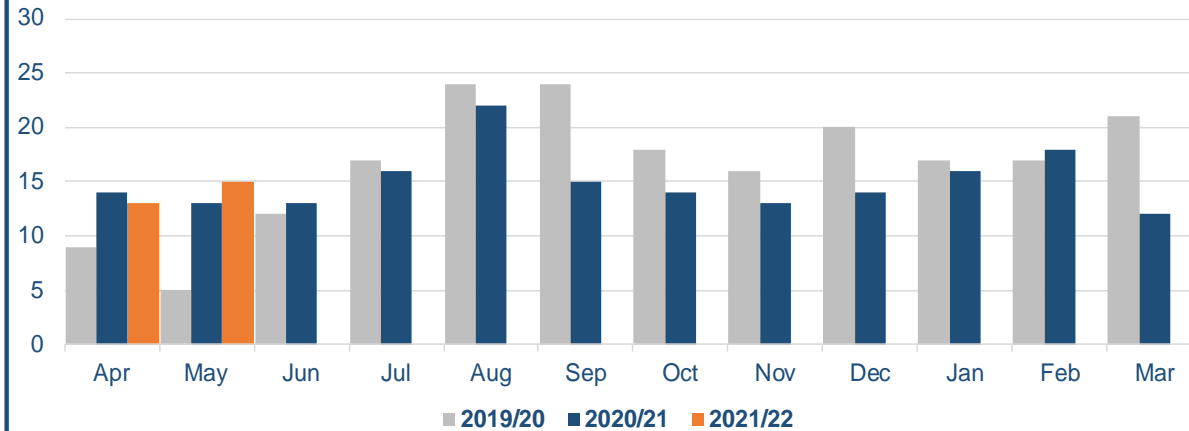
Number of Delayed Bed Days (BCU Mental Health)
2021/22 comparison to 2020/21 and 2019/20
May 2021
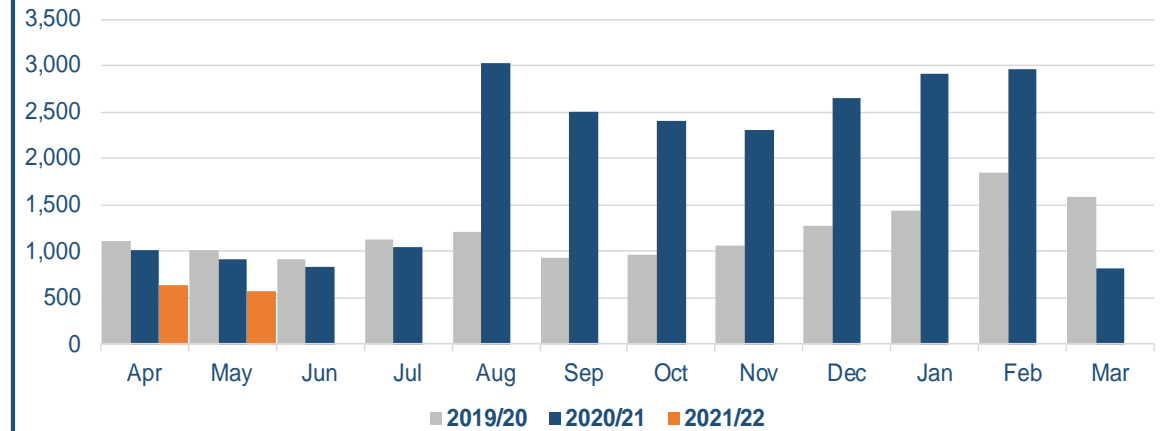
Legend: 2019/20, 2020/21, 2021/22

Impact of Covid-19 Pandemic on Unscheduled Care

ED & MIU Attendances and 4 Hr Performance
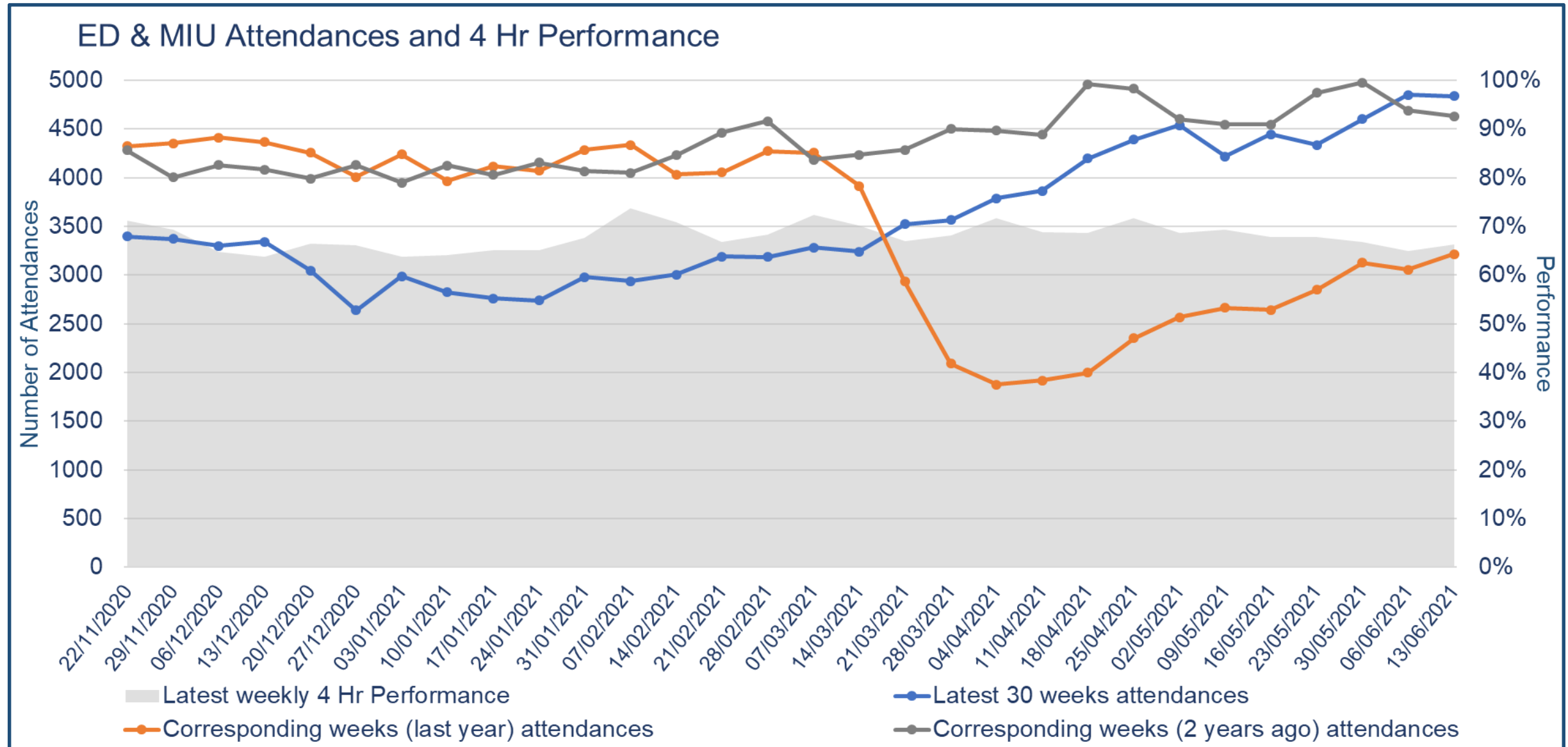
Impact of Covid-19 Pandemic on Unscheduled Care

Unscheduled Care Performance by Site
7th June - 13th June 2021

Measure	West	Centre	East	BCU
ED&MIU Number of Attendances	1438	1850	1550	4838
ED&MIU 4 Hour Performance	72.32%	67.19%	59.81%	66.35%
ED Number of Attendances	1087	1317	1354	3758
ED 4 Hour Performance	64.03%	54.06%	54.21%	57.00%
ED 12 Hour Performance	123	174	141	438
*1 Hour Ambulance Handover Breaches	87	136	17	240
Red 8 Minute Ambulances	27	57	54	138
Red 8 Minute Performance	62.96%	59.65%	59.26%	60.14%

*Please note: WAST Handover data is 1 day in arrears so the data shows 6th June to 12th June 2021

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

Sources: Red 8 Minute - WAST Health Board Area Report; ED and Handover - IRIS, accessed 14/06/2021

Impact of Covid-19 Pandemic on Referral Rates
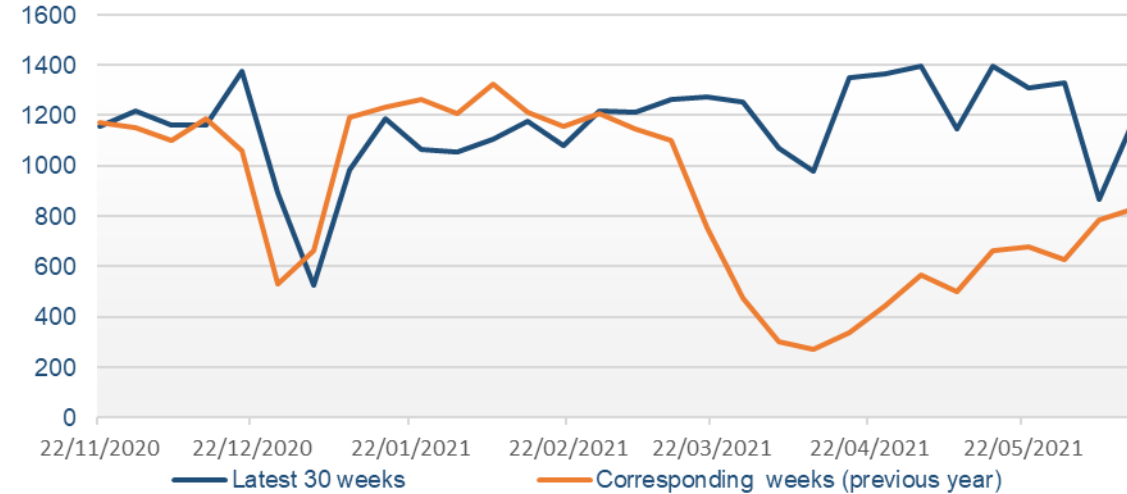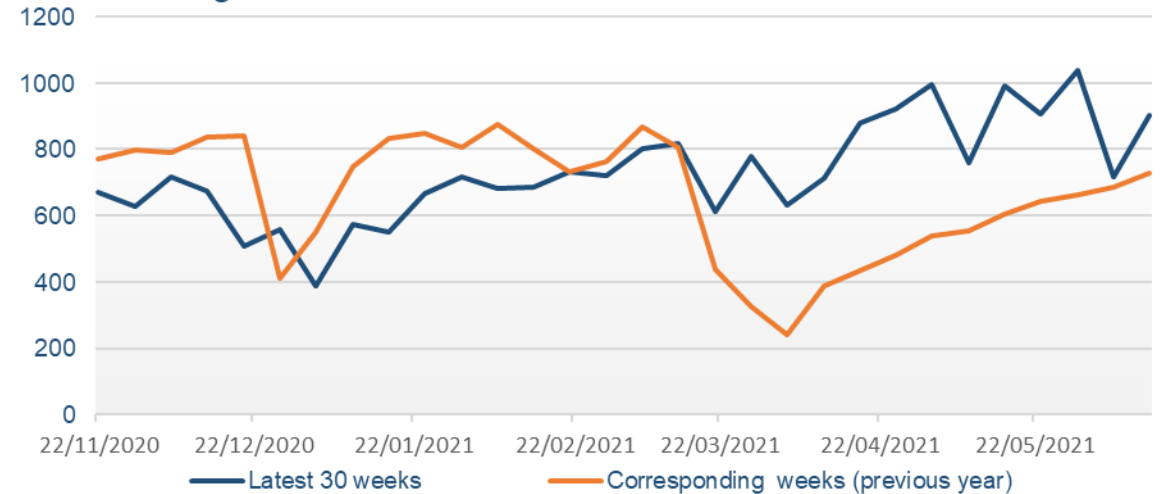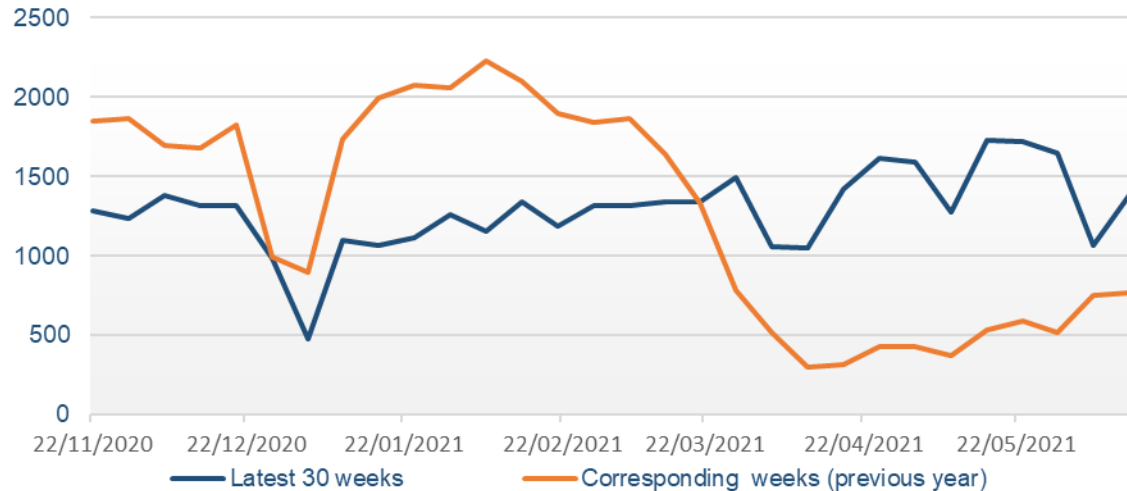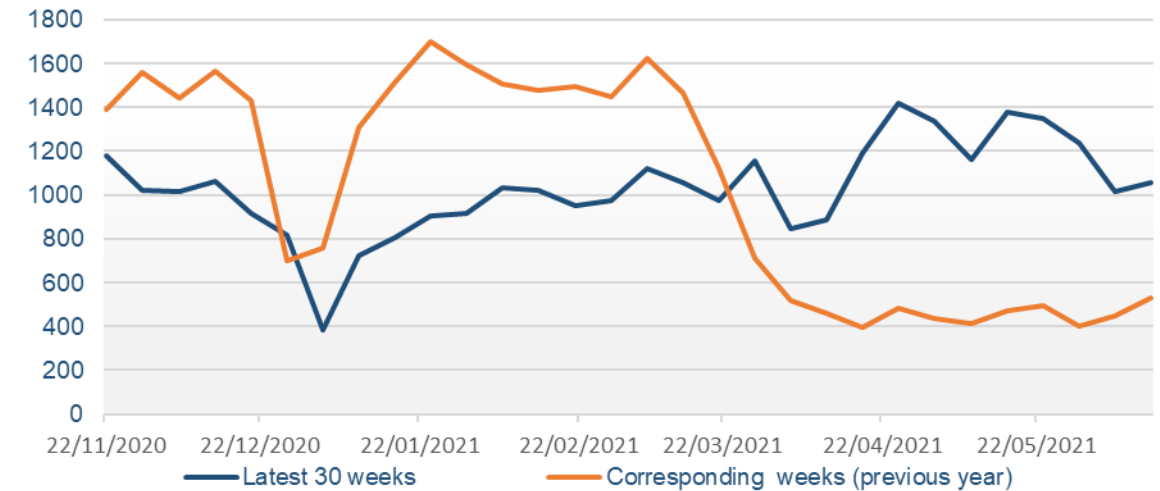
Impact of Covid-19 Pandemic on Planned Activity

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

Core Outpatient Activity

Latest 30 weeks — Corresponding weeks (previous year)
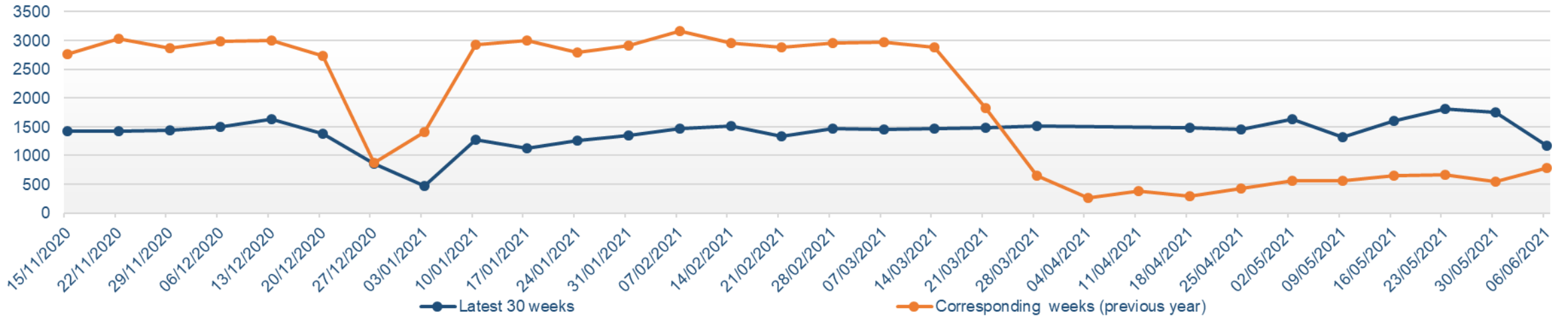
Theatre Procedures (Inpatient and Daycase): Completed Elective Cases in Planned Elective Lists by Week

Data labels: 248, 244, 161, 114, 167, 136, 132, 102, 129, 112, 133, 114, 118, 119, 126, 154, 150, 161, 289, 244, 291, 249, 299, 386, 372, 268
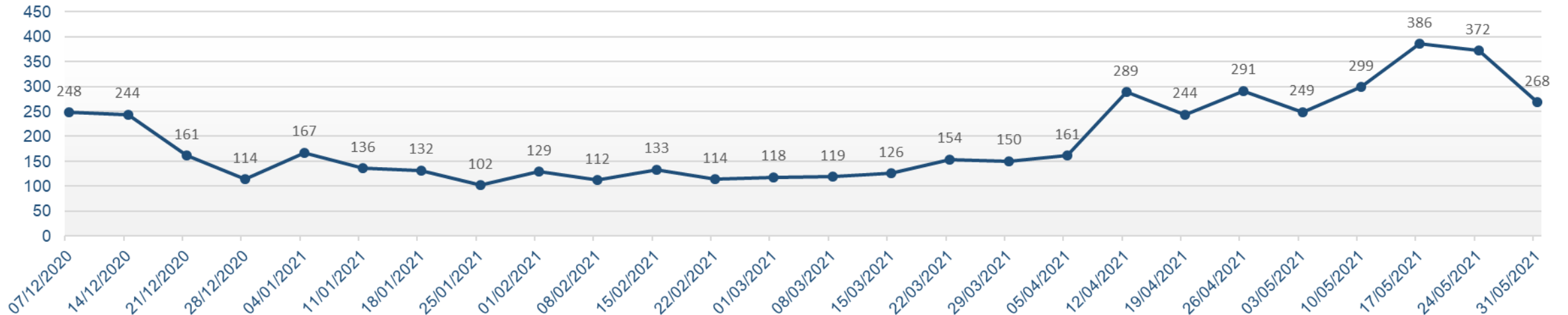
Further information is available from the office of the Director of Performance which includes:

- 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 (QSE) Committee 6 July 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Board Assurance Framework (BAF)
Cyfarwyddwr Cyfrifol: Responsible Director:	Louise Brereton, Board Secretary
Awdur yr Adroddiad Report Author:	Dawn Sharp, Assistant Director: Deputy Board Secretary
Craffu blaenorol: Prior Scrutiny:	Executive Team meeting on 23 June 2021
Atodiadau Appendices:	Appendix 1 – BAF Report Appendix 2 - Remapping of BAF risks to Annual Plan Appendix 3 – Key field guidance (updated)

Argymhelliad / Recommendation:
That the Committee review and note the progress on the Principal Risks as set out in the Board Assurance Framework (BAF).

Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion	✔	Ar gyfer sicrwydd For Assurance	✔	Er gwybodaeth For Information	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	

Sefyllfa / Situation:
The revised Risk Management Strategy and Policy was implemented on the 1st October 2020, and on the 21st January 2021, the Board approved the implementation of the revised Board Assurance Framework (BAF) template reporting arrangements. The BAF seeks to bring together in one place all of the relevant information on the risks to the Board's strategic priorities. The new template design reflects the work undertaken by the Board to support the effective management of the agreed principal risks that could affect the achievement of its agreed priorities. Each BAF risk has since been reviewed and updated. **Appendix 1** highlights the Board Assurance Framework risks assigned to this Committee. **Appendix 2** explains the remapping of the BAF risks to the Annual Plan.

Appendix 3 provides details of the updated key field guidance.

Cefndir / Background:

The design of the new BAF and Corporate Risk Register (CRR) emphasises their distinctive roles in underpinning the effective management of both strategic and operational risks respectively, but also highlights their symbiotic relationship as both mechanisms inform and feed off one another. This includes the evaluation, monitoring and review of progress, accountability and oversight of the principal risks and also the high level operational risks which could affect the achievement of the Health Board's agreed priorities. These are being monitored by regular review with respective leads and oversight by the Risk Management Group and Executive Team.

Board Assurance Framework

Oversight and co-ordination of the BAF process has transferred from the Corporate Risk Management Team to the Office of the Board Secretary, with the risk management system and process continuing to be managed by the Corporate Risk Team. Reports are provided separately.

Ownership of the BAF rests with the Board, with individual Executives being responsible for the management of their respective risks, and the Board Secretary holding responsibility for managing the underpinning process. Joint working between the Office of the Board Secretary and risk leads continues to progress well. Work is ongoing to refine the BAF as a tool to ensure that strategic risks are visible to the Board and committees.

The Board has updated its strategic priorities as set out within the 2021-22 Annual Plan. As a result, some principal risks do not lend themselves to direct mapping, and have subsequently been mapped to an 'enabler' rather than a priority. The remapped BAF risks were endorsed by the Audit Committee on 10th June 2021 and are attached at Appendix 2. The new identifiers have been applied to the BAF risk sheet as presented.

It is recognised that in respect of a number of risks, the target risk score is above the Board's risk appetite. The reviewed Risk Management Strategy including revised risk appetite will be presented for approval at the July Health Board meeting. Following this, risk appetite scoring will then be remapped to the individual risks and the position reviewed with each risk lead. This updated position will be reviewed by the August Risk Management Group.

The BAF is a 'live' document that evolves through engagement and support from the Board. This approach will continue as the Health Board refreshes *'Byw'n iach, Aros yn iach/Living Healthier, Staying Well'(LHSW)* and its underpinning strategies. This refresh will necessitate a greater focus on strategic risks in the BAF as the Health Board looks to the future in delivering its strategies. A further revision of the BAF will be required to reflect the refreshed objectives as defined in LHSW. Operational BAF risks will be managed as part of the Corporate Risk Register going forward.

Key progress on the BAF risks assigned to the QSE Committee are detailed below (this information is also reflected within the relevant BAF risk sheet at Appendix 1):-

- **BAF21-01 – Safe and Effective Management of Unscheduled Care (USC) (formerly titled Emergency Care Review Recommendations)**

Key progress since the last review relates to the action concerning a scoping review to develop a strategic blueprint solution for USC – this has now been moved into the mitigation column. At the beginning of June 2021, Executives have commissioned further work by Kendall Bluck, to build an acute medical model into the Emergency Department workforce plan, taking into account improved pathways currently being progressed through the USC improvement plan. This is designed to ensure that the Health Board funds and recruits to a robust and sustainable model for urgent care. The USC BAF risk is currently subject to review, which involves longer-term action planning and mitigation linked to the winter plan, to include partners such as the Red Cross.

- **BAF 21-04 – Timely Access to Planned Care (reporting to both Finance & Performance [F&P] Committee and QSE)**

Key progress since the last review relates to mitigations, gaps and actions updated to reflect current developments, including extension to some timelines. Further actions have been added which include additional internal activity above core being mobilised via the recovery plan, development of a business case for an orthopaedic modular ward and theatre on each site, outsourcing of orthopaedic activity being investigated with the Independent Sector, and capacity planning to understand the clearance times for the over 52 week backlog. Current estimates are that it will take approximately 3-4 years to clear the backlog - orthopaedics being the most significant driver for this lengthy timescale. For this reason, the current scoring is maintained. It is considered that the further actions listed above, as well as the review of the Ophthalmology business case in light of Welsh Government cataract centres strategy, will have the most material impact on the planned care BAF risk.

- **BAF21-06 – Safe and Effective Mental Health Service Delivery**

Key progress since the last review relates to action and timelines in respect of work ongoing to address interim roles in the management structure. An appointment has now been made to a Head of Psychology role, with a start date of 1 July 2021. The stability of the other interim roles within the senior leadership team is also being addressed. Delivery of Targeted Intervention outcomes for Mental Health will also be key going forward, and ensuring the effective functioning of the Together for Mental Health Project Board will have the most material impact on this risk.

- **BAF21-07 – Mental Health Leadership Model**

Key progress since the last iteration relates to the Governance Structures Review, now completed and shown as mitigation. A new action has been added in respect of a cycle of business to support effective reporting through the revised governance structure. It is considered that the stability of the leadership team will have the most material impact on this risk.

- **BAF21-08 – Mental Health Service Delivery During Pandemic Management**

Key progress since the last review relates to completion of the action to procure additional IT equipment for Attend Anywhere. A further action has been added, as this project was initially a proof of concept exercise which has demonstrated benefits and is therefore supported by the

Division for wider roll out. This project is also aligned to Information Management and Technology (IM&T) implementation. It is considered that the collective impact of the actions to be taken will mitigate the risk.

- **BAF21-09 – Infection Prevention and Control (IPC)**

Key progress since the last review relates to additional actions identified. These include ensuring that the most effective control measures are being monitored at a local level with assurance reporting to the QSE Committee, the requirement for Safe Clean Care programme support, development of a real time information platform to focus improvement actions, and also the substantive appointment of an IPC Director of Nursing. It is considered that the action to build or purchase more isolation facilities would have the most material impact on this risk. This risk was the subject of a deep dive at the Risk Management Group meeting on 15 June. At its next review the narrative will be expanded to include more long term strategic controls, to further reduce the rating over the coming months.

- **BAF21-10 – Listening and Learning**

Key changes since the last review relates to the updating of target action dates, acknowledging the delay in roll out of the new Datix system. The action in relation to the Quality Dashboard is now shown as complete.

- **BAF21-11 – Culture / Staff Engagement**

Key changes since the last review relates to the go live date for the new Speak Out Safely process being extended to ensure all supporting actions are in place. It is considered that the collective impact of the actions relating to Raising Concerns will mitigate the risk.

- **BAF21-12 – Security Services**

Key changes since the last review relates to target action dates for line one being updated to June 2021 from May 2021. Scoring remains static. The review of mitigations highlighted the action regarding the commitment from Estates to upgrade CCTV systems on a number of premises. The reference to the temporary hospitals in the control column has been updated to reflect an extension of the requirement to maintain premises during de-commissioning. It is considered that the actions relating to the case for investment to improve capacity and quality of the security service, together with implementation of the gap analysis findings, will have the most material impact on the risk. This risk will be subject to a deep-dive review at the August Risk Management Group.

- **BAF21-13 – Health and Safety**

Key progress since the last review relates to an update on the position as regards the IOSH Managing Safely and Leading Safely training programme for senior leadership, which will be implemented subject to a business case. Welsh Government is likely to provide additional funding for this as a result of the new Fire Bill, in light of the Grenfell disaster. It is considered that this training programme is the action that will have the most material impact on the risk. This risk will be subject to a deep-dive review at the August Risk Management Group.

- **BAF21-14 – Pandemic Exposure**

  Key progress since the last review relates to Planning and Estates improvement plans being approved by Board and currently with Welsh Government awaiting approval, and also ensuring that fit testing becomes business as usual to be kept under continuous review by the Health & Safety Group. It is considered that the purchase or construction of more isolation facilities would have the most material impact on this risk.

- **BAF21-19 – Impact of COVID-19**

  Key changes since the last review relate to updated controls, mitigations, actions and timeframes to reflect the current situation. The risk score remains unchanged in light of the potential risks posed by the variants of concern. It is considered that the collective impact of the actions listed will mitigate the risk. Executive Lead responsibility for COVID-19 has transferred to the Deputy Chief Executive/Executive Director of Nursing & Midwifery, from the Executive Director of Primary and Community Care.

Below is a heat map representation of the current BAF risk scores for the QSE Committee:

Current Risk Level		Impact				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5					BAF21-04
	Likely - 4				BAF21-01 BAF21-11	BAF21-06 BAF21-09 BAF21-10 BAF21-12 BAF21-13 BAF21-14
	Possible - 3			BAF21-08	BAF21-19	BAF21-07
	Unlikely - 2					
	Rare - 1					

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol /Strategy Implications
The implementation of the Board Assurance Framework and the revised Risk Management Strategy and Policy aligns with the Health Board`s strategy to embed effective risk management. The aim is to foster a culture of safety and learning, to support continuous improvements and an enhanced patient experience.

Opsiynau a ystyriwyd / Options considered
Not applicable.

Goblygiadau Ariannol / Financial Implications
The effective mitigation and management of risks has the potential to deliver a positive financial dividend for the Health Board, through better integration of risk management with business planning and decision-making. It will also shape how care is delivered to patients, leading to better quality, less waste and a reduction in claims.

Due to the improved and increased reporting frequency arrangements, the management of the BAF is resource intensive and so additional resources may be required.

Dadansoddiad Risk / Risk Analysis
The individual risks at Appendix 1 include details of the related risk implications.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
There are no legal and compliance issues associated with the delivery of the Board Assurance Framework or the Risk Management Strategy and Policy.

Asesiad Effaith / Impact Assessment
No specific or separate EqIA has been carried out for this report, as a full EqIA has been completed in relation to the new Risk Management Strategy and Policy, to which the BAF and CRR reports are aligned. Due regard of any potential equality/quality and data governance issues has been factored into the writing of this report.

Strategic Priority 5: Improved Unscheduled Care Pathways

Risk Reference: BAF21-01			Risk Rating	Impact		Likelihood		Score		Appetite	

Safe and Effective Management of Unscheduled Care (formerly titled Emergency Care Review Recommendations)

There is a risk that the Health Board may not be able to deliver safe and effective care due to being unable to commit support processes. This could negatively impact on the quality of patient care provided.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	4 ↔		4 ↔		16 ↔		
		Target Risk	4		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Unscheduled Care Improvement Group in place to oversee the improvement programme of work and monitor performance which provides regular reports to the Finance & Performance.	2	1) Ysbyty Glan Clwyd (YGC) improvement plans in place and approved by Executive Team for ambulance handover and flow including EDQDF. 2) Emergency Department (ED) dashboard established which monitors performance. 3) Established Tactical Control Centres in place. 4) Standardised SITREP / escalation reports submitted 3 x day. 5) Primary Care Urgent Treatment (PCUT) Centre established in East	2	1) Roll out of YGC improvement plan to other sites as appropriate. National support agreed. 2) Identify improvement and project support for delivery of the objectives. 3) In line with Welsh Government (WG) directive, implement Phone First programme that will ensure patients are seen by the right person, in the right place, first time. 4) In line with the agreed standards implement a uniform model for patient access to and from EDs. 5)Fully implement across NWales the following to require maximising impact Same Day Emergency Care (SDEC) - currently in place in YG and YGC but further work required in East. SDEC is part of USC continuous improvement programme. 6) D2R&A (discharge to rehabilitate and assess) - in progress; 7)111 - on track to implement by June 2021 and PCUT to be established in Centre and West.	30 June 2021 30 June 2021 30 June 2021 30 June 2021 30 Setember 2021 31 December 2021 30 June 2021
Annual Plan in place and agreed by the Board, with monthly monitoring and review through the Unscheduled Care (USC) Improvement Group.	2	1)Monthly USC Improvement Group meetings Chaired by the Chief Operating Officer. 2) USC scoping review undertaken to develop strategic blueprint solution for unscheduled care	1	1) Implement recommendations of Kendal Bluck Emergency Department workforce review related to unscheduled care. 2) Update as of beginning June 2021 - Executives have commissioned further work by Kendal Bluck to build in acute medical model on to the Emergency Department workforce plan, taking into account improved unscheduled care pathways currently being worked through the unscheduled care improvement plan. This will ensure that the Health Board funds and recruits to a robust and sustainable model for urgent care.	30 June 2021 30 June 2021
Interim COO / Interim Director of USC overseeing the Annual plan in respect of USC and variance to the plan with regular reporting to the Finance and Performance Committee.	2	Bi-monthly report to Finance & Performance Committee to provide assurance on unscheduled care strategic developments.	2	Establish permanent substantive posts currently covered on an interim basis, providing continuity and sustained leadership for unscheduled care.	30 June 2021

Review comments since last report: Action in relation to USC scoping review to develop strategic blueprint solution for unscheduled care now moved into mitigation column. Update as of beginning June 2021 - Executives have commissioned further work by Kendal Bluck to build in acute medical model on to the Emergency Department workforce plan, taking into account improved unscheduled care pathways currently being worked through the unscheduled care improvement plan. This will ensure that the Health Board funds and recruits to a robust and sustainable model for urgent care. It is considered that it is the collective impact of the actions that will mitigate the risk.		
Executive Lead: Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery	**Board / Committee:** Quality, Safety and Experience Committee	**Review Date:** **1 June 2021**
Linked to Operational Corporate Risks:		

Board Assurance Framework 2021/22

Strategic Priority 2: Recovering access to timely planned care pathways

Risk Reference: BAF21-04			Risk Rating	Impact		Likelihood	Score		Appetite	
Timely Access to Planned Care										

	Risk Rating	Impact	Likelihood	Score	Appetite
There is a risk that the Health Board may be unable to deliver timely access to Planned Care due a mismatch between demand and capacity and Covid-19, which could result in a significant backlog and potential clinical deterioration in some patient conditions.	Inherent Risk	5	5	25	Low 1 - 6
	Current Risk	5 ↔	5 ↔	25 ↔	
	Target Risk	5	3	15	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps (actions to achieve target risk score)	Date
Manual validation being conducted across all three sites on a daily and end of month basis.	2	Revised Monthly meetings to focus solely on planned care performance chaired by the Interim Director of Performance, aligns to Finance and Performance Committee. Introduction of further validation staff in Q3/4 non recurring complete.	2	1)Scoping of Artificial Intelligence approach to validation requires IT infrastructure and engagement of Informatics to ensure the inclusion of the scheme within the Informatics Business Plan. 2)Validation staff being recruited on a fixed term basis to continue with validation work. 3)Subject matter expert reviewing validation exercises for planned care.	31 July 2021
Implemented risk stratification system and process for stage 4 patients providing clinical priority with regular monitoring by local Primary targeting list (PTL) and access group.	1	1)Ensure the waiting list size is continually validated and patients appropriately communicated with. 2)Waiting list initiatives introduced in Q3/4, Business case for Insourcing to support long waiting patients approved via Single Tender Waiver.	1	1) Introduce a system that allows patients to "opt in" for treatment. allowing a communication strategy to support the Q1/Q2 plan. 2) Introduce risk stratification for stages 1-3 (outpatients and diagnostics). Work currently ongoing with Welsh Government. 3) Sites and areas are completing backlog clearance plans to ensure the pre-Covid backlog is cleared by March 2022.	20 June 2021 31 July 2021 31 May 2021
Head of Planned Care overseeing the plan with variance to the plan with monthly reporting to the Chief Operating Officer and bi-monthly reporting to the Finance and Performance Committee.	2	Bi-monthly report to Finance and Performance Committee to provide assurance on planned care strategic and tactical developments.	2	Introduce substantive post into the organisation, currently covered on an interim solution. Thus providing continuity and sustained leadership for planned care. Shortlisted candidates, interviews mid May.	31 July 2021
Once for North Wales approach introduced to standardise and ensure consistent delivery of general surgery, orthopaedics, Ophthalmology (Stage 4), Urology and Endoscopy to reduce health inequalities.	2	1)Weekly operational group with Divisional general Managers (DGM's) to ensure operational co-ordination of the once for north wales approach. 2)Scoping of new strategic model of care known as the diagnostic and treatment centre approach for planned care. Strategic outline case to be presented to Board and Welsh Government. 3) Insourcing for ophthamology introduced in February. 4) Over 52 week recovery plan for the 2019/20 end of March co-hort as first phase agreed.	1	1) Introduction of insourcing into the organisation to undertake activity that supports P2-3 activity and over 52 week waiters, therefore reducing the overall waiting times 2) Agree a strategy for planned care over the next 3 years that will improve the business process and reduce long waiting patients. 3) Review of Opthamology Business Case in light of Welsh Government Strategy re Cataract Centres. 4) Additional internal activity above core is being mobilised via recovery plan. 5) Business case being developed for orthopaedic modular ward and theatre on each site. 6) Outsourcing of orthopaedic activity is currently being investigated with the Independent Sector.	31 July 2021 31 May 2021 20 June 2021 31 July 2021 20 June 2021 20 June 2021

Review comments since last report: Mitigations and Gaps/Actions updated to reflect current developments including extension to some timelines. Further actions added which include:- additional internal activity above core being mobilised via recovery plan; business case being developed for orthopaedic modular ward and theatre on each site; outsourcing of orthopaedic activity being investigated with the Independent Sector; and capacity planning undertaken to understand the clearance times for the over 52 week backlogs. It is estimated to be approximately 3-4 years to clear this activity, orthopaedics being the most significant driver for this length of time. These are the reasons for retaining the current scoring. It is considered that the following actions will have the most material impact on the risk:- Review of Ophthalmology Business Case in light of Welsh Government Strategy re Cataract Centres; Additional internal activity above core is being mobilised via recovery plan; Business case being developed for orthopaedic modular ward and theatre on each site; and Outsourcing of orthopaedic activity is currently being investigated with the Independent Sector.

Executive Lead: Mark Wilkinson, Executive Director of Planning and Performance	Board / Committee: Finance and Performance Committee and Quality, Safety and Experience Committee	Review Date: 7 May 2021
Linked to Operational Corporate Risks:		

Board Assurance Framework 2021/22

Strategic Priority 6: Integration and Improvement of Mental Health Services

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

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps (actions to achieve target risk score)	Date
Mental Health and Learning Disabilities Divisional Governance Structure is in place and aligned to corporate governance requirements, providing consistent approach across the Division.	1	1) Key divisional roles in governance and safety are in the process of aligning to corporate reporting from the 1.11.20. 2) Formal reporting and financial transfer of budget complete to ensure the alignment of governance and associated roles to BCUHB corporate.	2		
Partnership and assurance structures are in place. These are: Together for Mental Health Partnership Board (T4MHPB), Local Authority Scrutiny meetings, Local Implementation Teams (LIT), North Wales Adult Safeguarding Board is in place and the division is in attendance. All meetings are formerly minuted and reported with membership regularly reviewed according to their Terms of Reference. The East Local Implementation Team has been re-established; work is ongoing to re-establish in the other Areas. There has been a review of the Terms of Reference of the T4MHPB)	1	Partnership working and reporting assures flow of information and raising of any concerns over delivery or equity. North Wales Community Health Council have held a number of formal stakeholder listening events for the division and a report from the CHC has now been received. The Director of Mental Health meets formally with the 6 local authority directors.	1	1) The T4MH Partnership Board is now meeting regularly (last met on 9 April 2021). Interim Deputy Director leading this key partnership agenda.	31 December 2021
The Mental Health Learning Disabilities Divisions Senior Leadership Team in place with regular cycle of business meetings. This is a control for the delivery of safe and effective services. Regular reports are presented to the appropriate governance body.	1	1)The Mental Health Learning Disability Division has an agreed management structure (2019). It provides timely reports to the agreed Committees of the Board and the Executive Team and is held to account by them for delivery of a safe and effective Mental Health and Learning Disability Service. 2) Divisional triumvirate in place (albeit interim cover is currently in place through to September 2021). The division has created 2 additional Deputy Directors in post reporting to the Director of Mental health to fill operating gaps in partnership and strategy development.	2	1. Work is ongoing to address interim roles in the management structure. There is a "Head of Psychology" role now appointed to, with a start date of 1 July 2021. Work is ongoing to address the stability of the other interim roles within the senior leadership team. 2. Delivery of Targeted Intervention Framework outcomes for Mental Health.	01/09/2021

31 March 2022 |

Review comments since last report: Action and timelines reviewed which include:- 1. Work ongoing to address interim roles in the management structure. There is a "Head of Psychology" role now appointed to, with a start date of 1 July 2021. Work is ongoing to address the stability of the other interim roles within the senior leadership team.
2. Delivery of Targeted Intervention Framework outcomes for Mental Health - aligned to all TIIF Measures. Ensuring the effective working of the T4MHPB will have the most material impact on this risk.

Executive Lead: Teresa Owen, Executive Director of Public Health	Board / Committee: Quality, Safety and Experience Committee	Review Date:18 June 2021
Linked to Operational Corporate Risks:		

Board Assurance Framework 2021/22

Strategic Priority 6: Integration and Improvement of Mental Health Services

Risk Reference: BAF21-07		Risk Rating	Impact		Likelihood		Score		Appetite
Mental Health Leadership Model									

		Risk Rating	Impact		Likelihood		Score		Appetite
There is a risk that the leadership model is ineffective and unstable. This may be caused by temporary staffing, unattractive recruitment and high turnover of staff. This could lead to an unstable team structure, poor performance, a lack of assurance and governance, and ineffective service delivery.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	3	↔	15	↔	
		Target Risk	4		2		8		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps (actions to achieve target risk score)	Date
Interim Senior Leaders in place and working within division. This is alongside other key posts; Interim Director of Nursing and Interim Deputy Directors x2. Each lead specific programmes and will further support and develop leadership, governance and management.	1	Interim Leadership changes are regularly reviewed by the Executive Director to ensure the model is effective in discharging it's roles and responsibilities.	2	Stabilise Senior Management with substantive posts. Sustainability needs to reviewed as a matter of priority to ensure continuity.	1 September 2021
Strategy approved and regular updates reported via Targetted Intervention to Welsh Government.	2	All key actions will be further developed and underpins the required work to have a well developed, fully integrated, Integrated Medium Term Plan (IMTP), which will further strengthen and support an effective model. Oversight will be via the Clinical Advisory Group (CAG).	2	Review Mental Health Structure to ensure fit for purpose and reflects new clinical pathways. There is on-going work to agree plan for 21/22	1 December 2021
		Engagement has been re-established through the Pathway Development Groups (e.g. Rehab / OPMH) with regular and consistent attendance with Regional Partners and stakeholders via North Wales leadership groups.	2	Implement the Mental Health Strategy in a consistent manner across the Health Board.	1 December 2021
		Pathway groups are clinically led and partners working to deliver the strategy, patients groups are members of those groups. All pathway groups report via the Division Clinical Advisory Group.	2	Evaluate regional management and pathway structure approach to delivery of strategy via a pilot and report findings to the Executive Team.	1 December 2021
		Business Case developed with additional funding from Welsh Government secured. Scrutiny of financial governance monitored by Head of Finance.	1		
Business Continuity Plan including essential service sustainability in place, with engagement from the Corporate Business Continuity Team.	2	Business Continuity Plans are updated within the Area with final scrutiny and approval at the Divisional monthly Finance and Performance Meeting.	1	Finalise all 4 service areas draft Business Continuity Plans for implementation.	01 September 2021
Divisional Quality, Safety and Experience Group meeting monthly, chaired by the Interim Director of Nursing to oversee Divisional governance arrangements and reporting, with oversight at the QSE Board Committee.	1	Division has actively worked to ensure that the Divisions Governance Structure more accurately reflect and is coherent with BCUHB's governance structure		Need to introduce a cycle of business to support effective reporting to the revised governance structure	1 September 2021

Review comments since last report: Actions reviewed and updated to reflect the current position with target dates amended. Action in relation to review of Governance Structures now completed and shown as mitigation. New action in respect of cycle of business to support effective reporting to the revised governance structure. Actions were reviewed and it is considered that the stability of the leadership team will have the most material impact on the risk.

Executive Lead: Teresa Owen, Executive Director of Public Health	Board / Committee: Quality, Safety and Experience Committee	Review Date: **18 June 2021**
Linked to Operational Corporate Risks:		

Board Assurance Framework 2021/22

Strategic Priority 6: Integration and Improvement of Mental Health Services

Risk Reference: BAF21-08		Risk Rating	Impact		Likelihood		Score		Appetite	
Mental Health Service Delivery During Pandemic Management										

	Impact		Likelihood		Score		Appetite
Inherent Risk	4		4		16		Low
Current Risk	3	↔	3	↔	9	↔	1 - 6
Target Risk	3		2		6		

There is a risk to the safe and effective delivery of MHLD services. This could be due to the consequences of the COVID-19 pandemic. This could lead to changing type and level of demand across the region, a lack of appropriate staff and resources, poorer outcomes for our population.

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps (actions to achieve target risk score)	Date
MH&LD Covid19 Lead has been identified, and reports into the Divisional Governance meetings, Covid19 Divisional meetings and Covid19 Corporate meetings. Weekly Establishment Control meetings. Monthly operational accountability meetings.	1	1) MH&LD Covid19 Winter Plan discussed and agreed in both the Divisional and Corporate Clinical Advisory Group (CAG). 2) MH&LD Operational Covid19 Winter Plan fully implemented. (All patient transfers now progressed back to localities, although direct admission to Bryn Hesketh are being worked through due to outstanding estates works)	2		
MH&LD Covid19 Winter Plan approved in both the Divisional Covid19 CAG meeting 3.11.20, and Corporate CAG meeting 6.11.20. Gaps in recruitment have been assessed and recruitment plan established as part of ESR.	1	MH&LD Engagement and Communication Plan in place to ensure effective and efficient communication across the MHLD Division and also to all key stakeholders, both external and internal. This includes sharing the MH&LD Covid19 Winter plan. Monthly reporting against ESR and the divisional actions to scrutinise them through Senior Leadership Team.	2	Recruitment to vacancies identified as part of each area agreed establishment plan to be progressed.	30 August 2021
Wellness, Work and Us Strategy launched in October 2020, to ensure staff are supported. Approved by the MH&LD Divisional Directors within the Divisional Business meeting September 2020.	1	1) Engagement sessions held across the MH&LD Division regarding the Wellness, Work and Us Strategies. Reviewed Year One priorities aligned to Covid19, ongoing implementation. 2)Approval by Corporate Business Continuity Lead for quality checking, and final sign of by the Divisional SLT at the appropriate Governance meeting of Business Continuity Plans and MH&LD Covid19 Action Cards. (East Business Continuity plan received Divisional sign off)	1		
Business Impact Analysis, Business Continuity Plans and MH&LD Covid19 Action Cards implemented November 2020.	1	1) Support being delivered by Corporate Business Continuity Lead to quality check the MH&LD Business Continuity Plans. 2)Revisit and assess gaps in recruitment processes to support additional staff requirements. 3)Heddfan Establishment review undertaken and discussed in Gold Command meeting, 5.2.21	2	Having assessed the gaps in the recruitment processes it has been agreed that a full establishment review should be undertaken to clarify future needs and resource requirements.	30 September 2021
MH&LD Divisional PPE Task and Finish Group in place, reporting into MH&LD Divisional daily SITREP call, MH&LD Covid19 Briefing meeting and Corporate PPE Task and Finish Group.	2	1) Monitoring and reviewing PPE availability, MH&LD Divisional plan developed and monitored to ensure all staff are appropriately FIT testing as part of key mitigation, feeds into Corporate PPE Task and Finish Group. Also reports to the Corporate FIT testing Steering Group. 2) Process to ensure continuous mapping of staff to enable redeployment decisions.	2		
Clinical Patient Pathway, approved by Clinical Advisory Group, monitored and reviewed by the MH&LD Clinical Pathway Group and changes made aligned to the Covid19 Winter Plan.	1	MH&LD SITREPS completed daily, with oversight by Covid MH&LD Lead. MH&LD SITREPS sent daily to Executive Nurse Director. Staffing pressures reviewed in daily SITREPS and Divisional Safety Huddle, any issue escalated to Corporate Staff Redeployment meeting.	1		
Covid 19 Training in place with compliance monitored and reviewed through Workforce Work stream.	2	MH&LD Covid19 Senior Leadership Team briefing meeting in place, currently meeting twice weekly, but flexible and responsive to need, which reports into the Corporate Covid19 meetings.	2		
MH&LD Divisional Workforce meeting, currently meeting fortnightly to review workforce plan, reports into MH&LD Covid19 briefing meeting and the Divisional Governance meetings.	1	1) MH&LD Covid-19 Command Structure SOP developed 21st December 2020. 2) MH&LD Covid-19 Command Structure SOP operationalised	1		
Attend Anywhere in operation across the MH&LD Division to provide a virtual consultation platform to allow the continuation of appropriate services, approved by the Divisional Clinical Advisory Group and is part of the MH&LD Winter Plan.	1	Divisional prioritisation of IT equipment requirements completed and forwarded to IT.	1	1)To source and procure additional IT equipment, primarily laptops, to increase the roll out of Attend Anywhere across the MH&LD Division. All Priority 1 laptops delivered across the MH&LD Division, priority 2 laptops delivery roll out planned ongoing. 2)This project was initially progressed as a proof of concept which has been beneficial and is therefore support by the Division for wider roll out - this project is also aligned to Information Management and Technology (IM&T) implementation.	Complete 31 December 2021

Review comments since last report: Procurement of additional IT equipment action now shown as complete with a further action added as this project was initially progressed as a proof of concept which has been beneficial and is therefore support by the Division for wider roll out - this project is also aligned to Information Management and Technology (IM&T). All action dates reviewed and updated. Actions reviewed in terms of which would have the most material impact on the risk. It is considered that it is the collective impact of the actions that will mitigate the risk.

Executive Lead: Teresa Owen, Executive Director of Public Health	Board / Committee: Quality, Safety and Experience Committee	Review Date: 18 June 2021
Linked to Operational Corporate Risks:		

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-09			Risk Rating	Impact		Likelihood		Score		Appetite	
Infection Prevention and Control											
There is a risk that Health Board may not be able to deliver appropriate care to patients and they may suffer harm due to healthcare associated infection. This may be caused by a failure to put in place systems, processes and practices that would prevent avoidable infection. The impact of this may increase morbidity and mortality, increase admissions and longer length of stay, increase treatment costs, reputational damage and loss of public confidence.			Inherent Risk	5		5		25		Low	
			Current Risk	5	↔	4	↔	20	↔	1 - 6	
			Target Risk	5		3		15			

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps (actions to achieve target risk score)	Date
New leadership in place with revised governance arrangements supporting Infection Prevention.	2	Business case approved and recruitment commenced to increase IPC team/resource. Risk register monitored and escalated via IPSG and Patient Safety & Quality Group. Safe, clean care harm free programme commenced.	2	1) Analysis to be undertaken to ensure that there is the right leadership in place across Directorates/Divisions/Teams who understand infection prevention and the appropriate escalation arrangments in place across the Health Board. 2) Finalise recruitment to increase IPC Team resource. 3) To develop the leadership to influence culture and behaviours to ensure that infection prevention becomes habit. This is an integral part of the safe, clean care harm free programme. 4) IT solution and information leadership required to ensure that the right data is captured which can then be tranformed into intelligence, so that people delivering care can see that they are delivering safe practice (real time system). 5) Safe clean care programme support required to support and manage and assure delivery. 6) Substantively recruit into the Director of Nursing IPC role	31 December 2021 30 September 2021 31 December 2021 31 December 2021 31 July 2021 30 September 2021
Infection Prevention Sub Group in place providing regular oversight and gaining assurance that the key controls are in place and effective, reporting into Quality, Safety and Experience Committee (QSE).	2	Monitoring of performance and risk in place by Public Health Wales and Welsh Government.	3	1) Identify decant facilities on all clinical sites to ensure an effective deep cleaning programme (Hydrogen Peroxide Vapour {HPV}) 2) To build or purchase more isolation facilities to ensure all infected patients can be isolated within two hours. 3) Development of a real time information platform to focus improvement actions	31 October 2021 31 October 2021 31 October 2021
Major Outbreak policy (IPO5) currently in place for managing Covid 19 infections.	2	Work, policy and risk register review programmes in place. Microbiology and Antimicrobial stewardship activity overseen by Infection Prevention Sub Group (IPSG), Audit Committee/ Patient Safety & Quality Group and Quality and Safety Executive.	2	1) Strengthening of effective reporting arrangements through outbreak control groups and IPSG. 2) Ensuring that the most effective control measures are being monitored at a local level and assurance reporting to QSE Committee.	30 September 2021 30 August 2021

Review comments since last report: Additional actions identified including ensuring that the most effective control measures are being monitored at a local level with assurance reporting to QSE Committee; safe clean care programme support required to support and manage and assure delivery; development of a real time information platform to focus improvement actions; and to substantively recruit into the Director of Nursing IPC role. Actions reviewed in terms of which would have the most material impact on the risk. It is considered that the action to build or purchase more isolation facilities would have the most material impact on this risk.

Executive Lead: Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	Board / Committee: Quality, Safety and Experience Committee	Review Date:14 June 2021
Linked to Operational Corporate Risks:		

Strategic Priority 2: Strengthen our Wellbeing focus

Risk Reference: BAF21-10			Risk Rating	Impact	Likelihood	Score	Appetite
Listening and Learning							

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

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps (actions to achieve target risk score)	Date
Incident reporting and investigation procedure, systems and processes in place - includes lessons learning learned being shared and actions tracked with reporting to Patient Safety and Quality Group (PSQ) and Quality, Safety and Experience Committee (QSE).	2	Training programme implemented for staff involved in investigations and sharing of learning.	2	Implementation of new procedures and processes for incidents, complaints, claims, redress, safety alerts and inquests - new processes will focus on learning and improvement, with improved use of technology. This will address aspects 1, 2 and 3 of the risk.	30 September 2021
Complaint reporting and investigation procedure, systems and processes in place - includes lessons learned being shared and actions tracked and fed back to patients, families and carers with reporting to PSQ and QSE.	2	Use of the Datix concerns management system to track events, investigations and actions with reporting to PSQ and QSE.	2	Implementation of the new Datix IQ Cloud system for incidents, complaints, redress, claims and mortality reviews - new system will improve the quality of information (including across Wales) and the ability to triangulate information better. This will address aspects 1, 2 and 3 of the risk.	31 October 2021
Safety alerts procedure, systems and processes (both national and local alerts) - includes actions being tracked and WG Compliance Returns completed with reporting to PSQ and QSE.	3	Reporting on patient safety and patient and carer experience to local, divisional and Health Board groups and committees.	2	Implementation of a new skills pathway and passport for those involved in investigations and sharing of learning. This will address aspects 2 and 3 of the risk.	30 June 2021
Claims and redress investigation procedure, systems and processes - includes completion of Welsh Risk Pool (WRP) Learning from Events Reports evidencing learning which are reviewed by the WRP Committee with reporting to PSQ and QSE.	3	Dashboards and information available at local, divisional and Health Board level to provide oversight of quality and safety indicators.	2	Implementation of a new digital learning library to bring together the access, cascade, and sharing of lessons learned. This will address aspects 2 and 3 of the risk.	30 September 2021
Learning from deaths procedure, systems and processes including mortality reviews, inquest coordination and interaction with Medical Examiners in place with reporting to CEG and QSE.	2			Implementation of safety culture initiatives including development of a human factors community of practice, embedding of just culture principles into processes, embedding of Safety II considerations, learning from excellence reporting, annual safety culture survey, and safety culture promotion initiatives. This will address aspects 1, 2 and 3 of the risk.	31 March 2022
Local and organisation-wide safety culture and quality improvement initiatives based on identified themes, trends and areas of concern with reporting to PSQ and QSE.	2			Implementation of a new Quality Strategy (developed with patients, partners and staff) containing organisational improvement priorities and enabling measures aligned to the organisational strategy. This will address aspects 2 and 3 of the risk.	31 March 2022
				Implementation of an organisation-wide integrated Quality Dashboard. This will address aspects 2 and 3 of the risk.	Complete
				Implementation of a new Speak out Safely process for staff to raise concerns. This will address aspects 1, 2 and 3 of the risk.	30 June 2021

Review comments since last report: Target action dates reviewed and updated, acknowledging the delay in roll out of the new Datix system. Action in relation to the Quality Dashboard now shown as complete. Actions reviewed in terms of which would have the most material impact on the risk. It is considered that it is the collective impact of the actions that will mitigate the risk.		
Executive Lead: Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery	Board / Committee: Quality, Safety and Experience Committee	Review Date: 2 June 2021
Linked to Operational Corporate Risks:		

Board Assurance Framework 2021/22

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-11			Risk Rating	Impact	Likelihood		Score	Appetite	
Culture - Staff Engagement									

	Risk Rating	Impact	Likelihood	Score	Appetite
There is a risk that the Health Board loses the engagement and empowerment of its workforce as a result of staff not feeling that it is safe and/or worthwhile highlighting concerns due to: Lack of clear mechanisms for raising concerns at any and every level, lack of a clear, effective and transparent mechanism for listening, reviewing, addressing, sharing learning and feedback, lack of trust and confidence regarding the reception of and impact of raising concerns, lack of support and guidance for all parties involved. This could lead to an impact on the organisation being able to learn from experience or improve services, which could result in poor staff morale, leading to poor outcomes impacting on the delivery of safe and sustainable services and the reputation of the Health Board.	Inherent Risk	4	5	20	Low 1 - 6
	Current Risk	4 ↔	4 ↔	16 ↔	
	Target Risk	4	3	12	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Key Policies: 1.Raising Concerns Policy 2.Safehaven Guidance	2	Revised new Speak Out Safely process agreed by Remuneration and Terms of Service Committee 1st February 2021. Implementation Plan in place, key elements being: 1. External platform commissioned - Work in Confidence - to replace Safe Haven to enable staff to engage in, dependent on preference, anonymous and/or two way dialogue with Speak Out Safely Guardian and/or members of wider Multi-disciplinary Team. 2. Role outline for Speak Out Safely Guardian completed, Guardian will report directly to CEO, with an independent board member now also identified to support and scrutinise Guardian role and new Multi-Disciplinary Team being established, the role of which will be to review concerns raised, agree actions required; and, monitor themes to identify learning; 3. Role outline for Speak Out Safely Champions has been refreshed and network of champions being created 4. Communications and promotion strategy under development with support of corporate communications; 5. WP4a policy (Raising Concerns) has been revised to reflect the transition to the new process	1	1. Launch of Work in Confidence platform now anticipated to be early July 2021, having received approval of DPIA (received Friday 11th June) 2. Advert has been placed to appoint first Speak Out Safely Guardian, closing date of 25th June and interviews during first 2 weeks of July; 3. Full membership of MDT now agreed with first meeting arranged for 29th June; 4. Overarching SOP in development, inclusive of agreed role outlines for Guardian, Speak out Safely Champions and independent member and terms of reference for MDT, with process map for Speak out Safely to be completed to support completion of SOP; 5 Communications strategy includes development of intranet pages. 6. WP4a policy (Raising Concerns) revised to reflect new process; 7. Evaluation metrics to monitor impact of new process under development. 8. On-going concerns raised through Safehaven process being managed to ensure they are not 'lost' during transition phase	31st July 2021
3. Dignity at Work Policy - Now Respect and Resolution Policy 4. Grievance Policy	2	Assessment of cases upon submission to determine most appropriate process undertaken. Case management review takes place monthly. Thematic review in place at operational level.	1	1. Dignity at Work Policy under review at All Wales level. 2. Triangulation of themes to be included within the reporting outlined in Raising concerns review. 3. Simplified Guidance to be developed for managers and staff to follow to promote early resolution. 4. Current training to be reviewed to align to revised approach.	30 September 2021
5.Performance & Development Review Policy	2	Monthly analysis and reporting at operational level undertaken (as well as strategic level) to enable managers to identify areas with low compliance with PADR. Staff Engagement, Organisational Development and HR Teams work with challenged areas to support and improve in terms of engagement/feedback/recognition/development.	2	1. Identify improvements to the process and documentation to support specific areas/teams. 2. Develop a programme for "Dip testing" of quality of PADRS against key metrics/feedback. 3. Utilise the survey function of the system implemented for Speak out safely to support identification of examples of outstanding/good and requires improvement. 4. Build "role contribution" into Strategic OD programme specification. 5. Review feedback from NHS Staff Survey and update divisional improvement plans.	30 September 2021

Review comments since last report: Go live date for new Speak Out Safely process has been extended to ensure all supporting actions in place as outlined above. It is considered that the collective impact of the actions for Raising Concerns will mitigate the risk.

Executive Lead: Sue Green, Executive Director of Workforce and Organisational Development	Board / Committee: Quality, Safety and Experience Committee	Review Date: 14th June 2021
Linked to Operational Corporate Risks:		

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-12			Risk Rating	Impact		Likelihood		Score		Appetite	
Security Services											

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

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps (actions to achieve target risk score)	Date
1)There is Security provision at the three main hospital sites with 24/7 Security staff present. The Field Hospitals have adequate external security contract in place and reviewed to support the change of use of the sites until the end of June 2021 to ensure appropriate to needs of staff, landlord and patients. The external contractor is responsible for Patient Safety & Visitors and Estates Building Management. This has been increased to support Covid safe environments. 2) New Security Contractor appointed from 1.4.21 who will undertake enhanced DBS assessments of all security staff on the DGH sites.	1	Staff Training is in place in certain service areas. Risk Assessments on some areas looking at physical security. V&A Case Manager to support staff when taking criminal action against assailant. Additional Bank staff employed to support Covid vaccination centre work and security review.	2	1) A review of Security was undertaken in August 2019 and identified a number of shortfalls in the systems management and staffing of the current security provision for BCUHB. BCUHB requires copies of Security Industry Authority licences. Limited capacity within the H&S Team to implement safe system of work. Clarity on roles required to describe an effectively managed security contract and safe systems of work in areas such as lone working, restraint training, lockdown and CCTV. Resources to facilitate and support V&A Security are looking at being secured, with recruitment of Bank/Agency staff until permanent post agreed. 2) Business case under further review to identify gold standard approach. 3) Ligature assessments require additional support to ensure safe systems of working are in place in all service areas.	30 June 2021 30 June 2021 30 June 2021
There is a Security Group established to review workstreams. Specific restraint training is provided in specific areas such as mental health. General Violence and Aggression (V&A) training is provided by the Manual Handling Team.	1	Data capture and reporting systems for V&A. A V&A Case Manager is in post to support staff when criminal action is taken. The Obligatory Response to Crime has had a combined training event with North Wales Police.	1	The lack of Policies staffing and structures poses a significant risk to staff, patients and visitors from V&A cases and security related activity. To control the risks a full review of Security services including, training particularly in restraint and restrictive practices is required. To ensure appropriate care, this particular aspect is delivered by competent staff. A full Security review was undertaken in September 2019 and previous reviews in 2017 by Professor Lepping and to date none of the recommendations have been implemented due to lack of appropriate resourcing. There is a lack of compliance with the NHS Wales Security Management Framework (NHS in Wales 2005) and Obligatory Response to Violence etc. The Manual Handling Team require competency training in order to be able to deliver appropriate V&A training.	30 September 2021
There are some up to date maintained CCTV systems in place. Staff in some areas have had training on use and licencing requirements. IG aware of issues in relation to data and management of CCTV.	1	There is a system for gathering data when an incident occurs if the equipment is working effectively. A task and finish group has been established to review the current systems with a view to working up a scheme to centralise the CCTV system and improve current compliance.	2	There is a lack of a structured approach to CCTV management and control. The systems are different in many service areas. A central Policy is being developed but requires significant investment to centrally control all systems. This is likely to result in a breach of the Data Protection Act if not appropriately managed. There is often limited maintenance on CCTV systems. A full review of all systems is required. Estates have committed to upgrade CCTV systems in a number of premises.	30 September 2021

Review comments since last report: Scoring reviewed and remains static. Target action dates in relation to line one have been updated to June 2021 from May 2021.
Reference also made to an action regarding Estates, who have committed to upgrade CCTV systems in a number of premises. Additionally the reference in the 'Control' column to the Field Hospitals has been updated to reflect an extension of the requirement to maintain premises during de-commissioning.
- It is considered that the following actions will have the most material impact on the risk: Support for the case for investment and change to improve capacity and quality of the security service and management and Implementation of the gap analysis findings.

Executive Lead: Sue Green, Executive Director of Workforce and Organisational Development	Board / Committee: Quality, Safety and Experience Committee	Review Date: 26 May 2021
Linked to Operational Corporate Risks:		

Strategic Priority 2: Strengthen our Wellbeing Focus

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

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps (actions to achieve target risk score)	Date
Health and Safety Leadership and Management Training Programme in place across the Health Board, with regular monitoring reported to Strategic H&S group.	1	Competence in training in service areas has been reviewed. Plan in place through business case to establish robust Safety Competence and leadership training programme. There is a three year strategy that requires implementing to support the Strategic Objectives of BCUHB.	2	1)The gap analysis of 31 pieces of legislation,117 site specific inspections including Acute, Mental Health Community Services GP and Wrexham HMP. Identified significant areas of none compliance. The OHS team continues to have significant support from our trade union partners. Further evaluation of H&S systems has been led by Internal Audit. A clear plan and framework for action to firstly identify hazards and place suitable controls in place has been developed. Covid support has significantly effected the delivery of the action plan. 2) IOSH Managing Safely and Leading Safely Modules for Senior Leadership to be implemented subject to business case approval.	30 September 2021 31 October 2021
Policies and Sub groups have been established including Asbestos, Water Safety, Fire Electrical Safety etc. to monitor and report into the Strategic Occupational Health & Safety Group and escalate via Quarterly Reports to QSE.	1	Clearly identified objectives for the Annual plan to achieve and transfer of risk ownership for a number of high level risks to E/F as duty holder for asbestos, legionella, contractor management and control, Electricity and Fire.	1	1) Clearly identified issues escalated to Board via business case to be reviewed. Gaps in Fire safety for a number of premises including YG working with North Wales Fire and Rescue service on action plans. (Welsh Government are likely to be providing additional support post 'Grenfell' to support the new Fire Bill.) Close working relationship with HSE to ensure key risks and information required is provided in a timely manner. HSE are scrutinising work activity in many areas, likely to Audit BCUHB for Asbestos and Violence at work shortly. 2)Actions arising from the Legionella review to be implemented.	30 September 2021 31 October 2021
Lessons Learnt analysis from COVID reported to Executive Team, Through Covid Group and with action to progressed to appropriate Executives. Clear strategy from Board to deal with PPE and suitable control measures to minimise risk of transmission of Covid through risk assessment, safe distancing advice, FAQ's, ICT Audits, guidance and standard operating procedures.	2	RIDDOR reporting in place with robust timeline and tracking through outbreak groups of Datix 72 hour reviews a total of 820 RIDDOR investigations undertaken since April 2020. PPE steering group has weekly meetings and a 'triple A' assurance report is provided to QSG and key issues escalated via QSE. Over 200 site safety visits undertaken by the H&S Team to review Covid safe environments. Action cards in place to ensure movement of staff effectively managed during outbreak.	3	HSE have identified gaps in COSHH Regulations specifically fit testing which requires fit2fit training programme to be in place. Improvement Notice from HSE against BCUHB provided on 24th October was lifted at the beginning of April. There has been significant investment with fit testing equipment with further plans in place to continue fit testing on new masks. There will be a requirement to release fit testers and staff to comply with legal compliance required within all service areas. Full time fit testing staff are required as the current arrangement is predicated on temporary staffing.	30 September 2021
Executive Team understand the range and types of risks identified through Annual Report and Gap analysis. Gaps in safety including areas of inefficiency to be addressed. Internal Audit have reviewed structure of meetings and Governance procedures.	1	Strategic OHS Group established to monitor performance and workshop with OD support has looked at leadership styles and developing a positive culture with partners from finance, procurement, Estates and Facilities and Occupational Health.	2	Robust action plan with clear objectives for Team difficult to deal with all elements of legislative compliance with limited capacity. Action: Recommending specialist support to review key areas of risk and attendance at operational groups to further understand significant risks.	30 September 2021

Review comments since last report: Actions updated to reference IOSH Managing Safely and Leading Safely Modules for Senior Leadership to be implemented **subject to a business case** and that Welsh Government are likely to be providing additional support post 'Grenfell' to support the new Fire Bill. It is considered that the action that will have the most material impact on the risk is the Competence and leadership training programme including IOSH Managing Safely and Leading Safely Modules for Senior Leadership and it is anticipated that the necessary funding will therefore be made available.

Executive Lead: Sue Green, Executive Director of Workforce and Organisational Development	Board / Committee: Quality, Safety and Experience Committee	Review Date: 26 May 2021

Linked to Operational Corporate Risks:
CRR20-01 - Asbestos Management and Control
CRR20-02 - Contractor Management and Control
CRR20-03 - Legionella Management and Control

CRR20-04 - Non-Compliance of Fire Safety Systems

Strategic Priority 1: Covid 19 response

Risk Reference: BAF21-14			Risk Rating	Impact		Likelihood		Score		Appetite	
Pandemic Exposure											
There is risk that patients, staff or visitors are exposed to COVID-19 due to inadequate/inappropriate resources, lack of compliance with prevention/protection measures across all settings, lack of understanding, skills, ownership of responsibilities, lack of systems and/or capacity and/or capability to identify, analyse, adapt, address immediate themes arising from intelligence both internal and external in a dynamic way. This could impact or effect avoidable harm caused to our patients, staff, visitors, increase in demand/length of stay/risk to other patients, reduction in availability of staff to support the delivery of safe care and services. This could led to prosecution for breach of statutory/legal duty and reputational damage to trust and confidence.			Inherent Risk	5		5		25		Low 1 - 6	
			Current Risk	5	↔	4	↔	20	↔		
			Target Risk	5		3		15			

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps (actions to achieve target risk score)	Date
PPE monitoring and management in place with regular reporting to the Patient Safety and Quality Group and reporting through to Quality, Safety and Experience Committee.	1	PPE steering group (PPESG) and reporting into Infection Prevention Sub Group, Patient Safety & Quality Group with governance structure in place. In addition the formation of the Safe Clean Care Harm Free Group which now reports to Quality,Safety and Experience Committee.	2	Continuous supply is not secure, training availability limited due to staffing resource in PPE and IPC teams. BCUHB to approve second admission screen.	30 September 2021
Fit testing in place to prevent avoidable infection. This is monitored via IPSG and OH&SG.	1	Fit testing programme, Accreditation training and business case in place to increase assurance monitored by PPESG.	2	To ensure fit testing becomes business as usual and is kept under continuous review by the Health & Safety Group	30 September 2021
Review of all buildings has taken place against new regulations/guidance in relation to what the clinical environment should look like with regard to infection prevention, with a schedule of improvements identified.	1	Ventilation and Environmental groups reporting into Infection Prevention Sub Group and Patient Safety & Quality Group with governance structure in place. Implementation of segregation and screening to clinical areas.	1	1) Review and risk assess the improvement plans in order to address the environmental considerations necessary to meet new guidance in relation to the built environment. Some buildings are a risk due to infrastructure (dialysis and community hospitals). Improvement plans in place via Planning and Estates, approved by Board and currently with Welsh Government awaiting approval. 2) To build or purchase more isolation facilities to ensure all infected patients can be isolated within two hours.	30 September 2021 31 December 2021

Review comments since last report: Actions reviewed and updated:- Improvement plans in place via Planning and Estates, approved by Board and currently with Welsh Government awaiting approval; and ensuring fit testing becomes business as usual and is kept under continuous review by the Health & Safety Group. Actions reviewed in terms of which would have the most material impact on the risk. It is considered that the purchase/building of more isolation facilities will have the most material impact on this risk.

Executive Lead: Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	Board / Committee: Quality, Safety and Experience Committee	Review Date: **8 June 2021**
Linked to Operational Corporate Risks:		

Board Assurance Framework 2021/22

Strategic Priority 1: Covid 19 response

Risk Reference: BAF21-19		Risk Rating	Impact	Likelihood	Score	Appetite
Impact of COVID-19						

	Risk Rating	Impact	Likelihood	Score	Appetite
There is a risk that the ongoing Covid-19 pandemic will lead to the HB being overwhelmed and unable to respond to Covid healthcare needs and/or carry out its core functions due to the spread and impact of Covid-19 in North Wales. This could lead to reduced staff numbers available for work, increased demand on services (including acute, community, mental health and primary care), and suspension of planned services. This could negatively affect patient safety and quality of care, patient outcomes; delivery of the mass vaccination programme and TTP; and the Health Board's ability to deliver its plans and corporate priorities.	Inherent Risk	5	4	20	Low 1 - 6
	Current Risk	4 ↔	3 ↔	12 ↔	
	Target Risk	4	2	8	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps (actions to achieve target risk score)	Date
Divisional operational management teams' Covid response arrangements are in place and meeting regularly. Any issues requiring escalation are reported into Executive Team or the Executive Incident Management Team (EIMT) as appropriate. EIMT is now phasing down (now meeting fortnightly) as business as usual returns.	2	Contingency and escalation plans are in place and operational measures taken to support the response to Covid-19 including amended care pathways; provision of PPE; remote or prioritised assessment pathways; prioritisation of treatment; escalation plans and surge capacity. De-escalation and decommissioning plans are being implemented. Surge plans/winter resilience plans are being tracked against modelling predictions. Revised modelling is being used to inform capacity and re-escalation plans.	2	1) Updating of business continuity and escalation plans. 2) Decommission Ysbytai Enfys in Bangor and Llandudno. 3) Deeside to be retained as local vaccination centre and for surge capacity.	30 June 2021 31 July 2021 31 March 2022
Covid-19 response programmes established to plan and deliver specific targeted response including Test, Trace and Protect programme; Vaccination Delivery Programme; PPE group; Operational Delivery Group for outbreak management; Ysbyty Enfys Assurance Group now stood down but reporting continues through EIMT for significant decisions.	2	1)Detailed programme plans in place for each programme area; performance indicators identified to enable monitoring and evaluation; governance structures in place to enable oversight and decision-making. 2) Strengthening of reporting processes into and from EIMT and/or Executive Team in place. 3) Establishment of clear regularised reporting structures around established workstreams.	2	1) Updating of programme plans and development of new plans in response to new Welsh Government guidance as it arises. 2) Prevention and response plan to be refreshed with partners.	31 July 2021 30 June 2021
Clinical Pathways Group established to scrutinise clinical response to the pandemic and approve amended pathways and reporting into the Clinical Effectiveness Sub-Group.	2	1) Clinical approval for service delivery proposals; approved pathways published on the BCU intranet; reporting to Executive Team and EIMT. 2) Programme and links into ET/EIMT reviewed.	2		
Coronavirus Co-ordination Unit established to support programme reporting and strategic co-ordination, working closely with the Business Intelligence Unit (BIU) and Covid Intelligence Hub to ensure timely and accurate analysis of data and modelling of trajectories.	2	Covid dashboards to facilitate up to date review of performance; weekly reporting to executive team and IMs; monitoring of reporting to WG including SitReps, outbreak reporting, unscheduled care and hoc reports. Dashboard now consistently linked for BIU users. Mechanisms in place for ongoing surveillance, analysis and modelling after current pandemic peak.	2	1) Ensure readiness for further escalation as required in the event of further waves of Covid pandemic.	30 September 2021
Executive Incident Management Team has been established and is meeting as required (frequecy dropped since original inception), with formal reporting to the Board as appropriate.	2	Recording of actions and decisions via daily updates to logs; regular briefing to IMs via Board briefings; escalation of matters requiring Board approval.	2	Ongoing work to ensure all records captured and indexed.	30 September 2021
North Wales LRF Strategic Co-ordinating Group has stood down. Recovery Co-ordinating Group remains in place and is continuing surveillance and managing recovery. SCG will be reconvened as and when required.	3	Risk assessment, escalation of sub-regional and regional issues, whole system response; and reporting to WG on an escalation basis.Mechanisms in place through RCG for ongoing collaborative arrangements for monitoring transition into recovery.	3	1) Prevention response plan to set out remobilisation.	30 June 2021

Review comments since last report: Control, mitigations and action together with timeframes updated to reflect the current position of the pandemic. Current risk score reviewed but remains unchanged in light of the potential risks posed by the Variants of Concern. It is considered that the collective impact of the actions listed will mitigate the risk. Executive Lead transferred to Gill Harris from Chris Stockport.

Executive Lead: Gill Harris, Deputy Chief Executive and Executive Director of Nursing and Midwifery	Board / Committee: Quality, Safety and Patient Experience Committee	Review Date: 28 May 2021
Linked to Operational Corporate Risks:		

- Remapping of BAF risks to the revised strategic priorities and enablers as set out within the Draft Annual Plan for 2021-22: -
    - **Priorities**
        - 1 Covid19 response
        - 2 Strengthen our wellbeing focus
        - 3 Primary and community care
        - 4 Recovering access to timely planned care pathways
        - 5 Improved USC pathways
        - 6 Integration and improvement of MH Services
    - **Key enablers:-**
        - Making effective and sustainable use of resources
        - Transformation for improvement
        - Effective alignment of our people

Remapped BAF Risks

New BAF Ref.	New priority alignment	20-21 Plan Priority	Previous BAF Ref.	Title
N/A Archived	5 Improved USC Pathways	1 Safe USC	20-01	Surge/ Winter Plan
21-01	**5** **Improved USC Pathways**	**1** **Safe USC**	**20-02**	**Safe and Effective Management of Unscheduled Care (formerly titled Emergency Care Review Recommendations)**
21-02	2 Strengthen our wellbeing focus	2 Essential Services and Planned Care	20-03	Sustainable Key Health Services
21-03	3 Primary and Community Care	2 Essential Services and Planned Care	20-04	Primary Care Sustainable Health Services
21-04	**4** **Recovering access to timely planned care pathways**	**2** **Essential Services and Planned Care**	**20-05**	**Timely Access to Planned Care**

New BAF Ref.	New priority alignment	20-21 Plan Priority	BAF Ref.	Title
21-05	**6** **Integration and Improvement of MH Services**	**3** **Mental Health Services**	**20-07**	**Effective Stakeholder Relationships**
21-06	6 Integration and Improvement of MH Services	3 Mental Health Services	20-08	Safe and Effective Mental Health Delivery
21-07	6 Integration and Improvement of MH Services	3 Mental Health Services	20-09	Mental Health Leadership Model
21-08	6 Integration and Improvement of MH Services	3 Mental Health Services	20-10	Mental Health Service Delivery During Pandemic Management
21-09	**2** **Strengthen our wellbeing focus**	**4** **Safe and Secure Environment**	**20-11**	**Infection Prevention and Control**
21-10	**2** **Strengthen our Wellbeing focus**	**4** **Safe and Secure Environment**	**20-12**	**Listening and Learning**

New BAF Ref.	New priority alignment	20-21 Plan Priority	Prev. BAF Ref.	Title
21-11	2 Strengthen our wellbeing focus	4 Safe and Secure Environment	20-13	Culture – Staff Engagement
21-12	2 Strengthen our wellbeing focus	4 Safe and Secure Environment	20-14	Security Services
21-13	2 Strengthen our wellbeing focus	4 Safe and Secure Environment	20-15	Health and Safety
21-14	1 Covid 19 response	4 Safe and Secure Environment	20-16	Pandemic Exposure
21-15	NB aligned to key enabler – Making effective and sustainable use of resources	5 Effective Use of Resources	20-17	Value Based Improvement Programme
21-16	NB aligned to key enabler – Transformation for Improvement	5 Effective Use of Resources	20-18	Digital Estate and Assets

New BAF Ref.	New priority alignment	20-21 Plan Priority	BAF Ref.	Title
21-17	NB aligned to key enabler – Making effective and sustainable use of resources	5 Effective Use of Resources	20-20	Estates and Assets Development
21-18	NB aligned to key enabler – Effective alignment of our people	5 Effective Use of Resources	20-21	Workforce Optimisation
21-19	1 Covid 19 response	2 Essential Services and Planned Care	20-25	Impact of COVID-19
21-20	NB aligned to key enabler – Making effective and sustainable use of resources	5 Effective Use of Resources	20-26	Development of Annual Operational Plan 2021-22
21-21	NB aligned to key enabler – Making effective and sustainable use of resources	5 Effective Use of Resources	20-27	Delivery of a Planned Annual Budget
21-22	NB aligned to key enabler – Making effective and sustainable use of resources	5 Effective Use of Resources	20-28	Estates and Assets

Board Assurance Framework Key field guidance/ definitions of assurance levels

BAF Template Item		Please refer to the Risk Management Strategy and Policy for further detailed explanations
Risk Reference		Board Assurance Framework reference number, allocated by the Board Secretary
Risk Description		An uncertainty that something could or may happen that will have an impact on the achievement of the Health Board's Priority. There are 3 main components to include when articulating the risk description (cause, event and effect):
		- There is a risk of / if ….
		- This may be caused by ….
		- Which could lead to an impact / effect on ……
Risk Ratings	Inherent	Without taking into consideration any controls which may be in place to manage this risk, what is the likelihood that this risk will be realised, and if it did, what would be the consequence
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed.
Risk Impact		The consequence (or how bad) if the risk were to be realised, in line with the NPSA Grading Matrix an impact of 1 is a Negligible (very low), with a 5 as Catastrophic (very high)
Risk Likelihood		The probability that the risk will be realised. In line with the NPSA Grading Matrix a likelihood of 1 is this will probably never happen / recur, with a 5 being that it will undoubtedly happen, recur, possibly frequently
Score		Impact x Likelihood of the risk happening
Appetite	Definition	Is defined as the amount and level of risk that the Health Board is willing to tolerate or accept in order to achieve its priorities.
	Low	Cautious with a preference for safe delivery options (Score 1 to 6)
	Moderate	Prepared to take on, pursue or retain some risks as a result of the Health Board taking opportunities to improve quality and safety of services (Score 8 to 10)
	High	Open or willing to take on, pursue or retain risks associated with innovation, research and development consistent with the Health Board's Priorities (Score 12-15)

Board Assurance Framework Key field guidance/ definitions of assurance levels

Control	Definition	These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised. A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise and ensure that care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management] A measure that maintains and/or modifies risk (ISO 31000:2018(en))
	Examples include, but are not limited to:	- People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklist in place and being implemented which ensures the delivery of an objective - Training in place, monitored and assurance reported - Compliance audits - Business Continuity plans in place, up to date, tested and effectively monitored - Contract Management in place, up to date and regularly monitored
Mitigation	Definition	This refers to the process of reducing risk exposure and minimising its likelihood and/or lessening or making less severe its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity).
	Examples include, but are not limited to:	- A redesigned and implemented service or redesigned and implemented pathway - Business Case ~~Development~~ agreed and implemented - Trained staff - Insurance procured
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the data is available
	2	The second level of assurance comes from other functions in the Health Board who have internally verified the data, for example quality, finance and H/R assurance
	3	The third level of assurance comes from assurance provided from outside the Health Board, for example WG, HIW, HSE, and Internal/External Audit etc.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience (QSE) Committee 6th July 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Corporate Risk Register Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Simon Evans-Evans, Interim Director of Governance
Awdur yr Adroddiad Report Author:	Justine Parry, Assistant Director: Information Governance and Risk
Craffu blaenorol: Prior Scrutiny:	Risk Management Group on the 15th June 2021 Executive Team meeting on the 23rd June 2021
Atodiadau Appendices:	Appendix 1 – QSE Corporate Tier 1 Operational Risk Report Appendix 2 – QSE Operational Risk for Escalation
Argymhelliad / Recommendation:	

That the Committee:-

1. Review and note the progress on the Corporate Tier 1 Operational Risk Register Report as set out below:

CRR20-01:
a) **Note** the Risk Management Group recognise the progress in completing and implementing actions and noted some of these were completed ahead of their deadline date, but were unable to support a change in the current risk rating until further discussions and clarification is received from the Risk Lead Officer.
b) **Approve** the reduction in the target risk rating score from 10 to 8. The Asbestos Management Group is making significant progress to reduce the risk identified through audits and independent inspections. Progress is reported through the Strategic Occupational Health and Safety, which then reports to the QSE Committee. Therefore with this progress being made the Director of Estates and Facilities has recommended a change in the target risk score following the achievement of the completed actions to bring it in line with the Risk Appetite of the Health Board and in line with the realistic target risk date.
c) **Note** the completion of the actions 12241, 12242, 12244, 12245, 12246, 12247, 12249, 12250 and 15032 so they can be archived and removed from the next report, recognising that their implementation will be captured as part of the controls within the next iteration of the risk.

CRR20-02:
a) **Note** the Risk Management Group recognise the progress in completing and implementing actions, but were unable to support a change in the current risk rating until further discussions and clarification is received from the Risk Lead Officer.
b) **Approve** the reduction in the target risk rating score from 10 to 8. The Estates and Facilities Department is working through the actions to address the risk identified with the implementation of systems and processes to support the control of contractors. Progress updates are reported to the Strategic Occupational Health and Safety Group, which reports to the QSE Committee. Therefore with this progress being made the Director of Estates and Facilities has recommended

a change in the target risk score following the achievement of the completed actions to bring it in line with the Risk Appetite of the Health Board and in line with the realistic target risk date.

c) **Note** the completion of the actions 12251, 12253 and 12553 so they can be archived and removed from the next report, recognising that their implementation will be captured as part of the controls within the next iteration of the risk.

CRR20-03:

a) **Note** the Risk Management Group recognise the progress in completing and implementing actions, but were unable to support a change in the current risk rating until further discussions and clarification is received from the Risk Lead Officer.

b) **Approve** the reduction in the target risk rating score from 10 to 8. The Estates and Facilities Department is working through the actions to address the risk identified which is being monitored by the Water Safety Group. Items of escalation are reported to the Strategic Occupational Health and Safety Group which reports to the QSE Committee. Therefore with this progress being made the Director of Estates and Facilities has recommended a change in the target risk score following the achievement of the completed actions to bring it in line with the Risk Appetite of the Health Board and in line with the realistic target risk date.

CRR20-05:

a) **Note** the Risk Management Group recognise the progress in completing and implementing actions, but were unable to support a change in the current risk rating until further discussions and clarification is received from the Risk Lead Officer.

b) **Approve** the reduction in the target risk rating score from 12 to 9. Processes have been reviewed and updated with partners in the Local Authorities and have now become part of business as usual and a cycle of improvement. A report has been provided to the Regional Leadership Group that will go to the Regional Partnership Group Board. Care Homes have been part of the Executive Incident Management Team and are being provided with regular updates on the situation. This has enabled the Care Homes cells to be stepped down and we have now reverted to Business As Usual (BAU). The Continuing Health Care (CHC) Associate Chief of Staff – Operations has therefore recommended a change in the target risk score following the achievement of completed actions to bring it in line with the Risk Appetite of the Health Board and in line with the realistic target risk date.

c) **Note** the completion of the actions 14936, 14937, 14938, 14941, 14944, 14945, 14946, 14947, 14952, 15272 and 15273 so that they can be archived and removed from the next report, recognising that their implementation will be captured as part of the controls within the next iteration of the risk.

CRR20-08:

a) Note (risk ID – **3628 - Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients**) which was approved by the QSE in March 2021 and which has been added onto the CRR and Tier 1.

b) Approve the new risk ID1976 being presented for escalation onto the Tier 1 Operational Risk Register.

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

Y/N to indicate whether the Equality/SED duty is applicable
N

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

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

Each Corporate Risk has been reviewed and updated. The full CRR will go to the Board in July 2021.

Cefndir / Background:

The implementation of the revised Risk Management Strategy underlines the Health Board's commitment to placing effective risk management at the heart of everything it does while embedding a risk-based approach into its core business processes, objective setting, strategy design and better decision making. This includes the evaluation, monitoring and review of progress, accountability and oversight of the Principal Risks and the high-level operational risks that could affect the achievement of the Health Board's agreed Priorities.

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

Corporate Risk Register:
The Corporate Risk Management Team continue to deliver the RM03 - Risk Management Training Plan for 2021/22 that commenced, in line with the plan in April. This training includes the management of risk in line with the Risk Management Strategy for managers and also practical training for developing, managing and reporting risks for risk handlers. Following the delivery of the training in April, feedback will be collated and used to influence further training from June 2021 onwards.

In addition to the above, the Corporate Risk Management Team also attend existing meetings and networks in place to deliver the training, for example: Junior Doctors meetings or Consultant's meetings.

The current tier 1 risks for QSE Committee oversight are (full details of the risks and progress can be found in Appendix 1):

Risk Title	Inherent risk rating	Current risk rating	Target risk rating	Movement*
CURRENT RISKS – appendix 1				
CRR20-01 - Asbestos Management and Control	20	20	8	Unchanged
CRR20-02 - Contractor Management and Control	20	20	8	Unchanged

CRR20-03 – Legionella Management and Control	20	20	8	Unchanged
CRR20-04 - Non-Compliance of Fire Safety Systems	20	20	8	Unchanged
CRR20-05 – Timely access to Care Homes	25	20	9	Unchanged
CRR20-08 – Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	25	20	6	Unchanged
ESCALATED RISKS – appendix 2				
1976 – Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	20	16	6	New Risk

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

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

Current Risk Level		Impact				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5				CRR20-03 CRR20-04	
	Likely - 4				1976	CRR20-01 CRR20-02 CRR20-05 CRR20-08
	Possible - 3					
	Unlikely - 2					
	Rare - 1					

Asesiad / Assessment & Analysis

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

Options considered
Continuing with Corporate Risk Register.

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

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

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

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

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

Appendix 1 - QSE Corporate Tier 1 Operational Risk Report

CRR20-01	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 21 June 2021
	Risk: Asbestos Management and Control	**Date of Committee Review:** 02 March 2021
		Target Risk Date: 31 March 2022

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

	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level*)	4	2	8
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	Assurances
1. Asbestos Policy in place (refer to further action 12242). 2. A number of surveys undertaken (refer to further action 12241). 3. Asbestos management plan in place. 4. Asbestos register available (refer to further action 12250). 5. Targeted surveys where capital work is planned or decommissioning work undertaken. 6. Training for operatives in Estates. 7. Air monitoring undertaken in premises where there is limited clarity on asbestos condition (refer to further action 15032).	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources Safe, secure & healthy environment for our people	BAF21-13 BAF21-17

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12241	Undertaking a re-survey of 10-15 premises to determine if the original Asbestos surveys are valid. This is problematic as finances are not available for this work, increasing the risk of exposure to staff and contractors.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed - 14/04/2021. Re-survey of existing asbestos surveys, sample 10 – complete and assurance provided that surveys are robust. Resampling will be included with the updated management plan as an ongoing compliance work stream. 14.04.2021 (DT, updates from RT/GB) Completion of this action was reported to the asbestos management group in Jan 2021.	Complete
	12242	Update and review the Asbestos Policy and Management Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed - 14/04/2021. This updated policy and plan will ensure consistency across the Health Board in the management of Asbestos and support the mitigation of the risk should it materialise.	Complete

	12243	Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	This action will help us to identify the areas of asbestos and thus better mitigate and manage any potential impact by enabling to a web supported system to access records remotely.	On Track
	12244	Ensure priority assessments are undertaken and highest risk escalated.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/21. Priority assessments and risk reviews – Actions complete and removal / management plan in place.	Complete
	12245	Evaluate how contractors are provided with information and instruction on asbestos within their work environment. Ensure work is monitored.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/21. Contractor management and control – actions complete with updated permit to work system and contractor control framework	Complete
	12246	Ensure all asbestos surveys are available at all sites and there is a lead allocated for premises.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed - 14/04/2021. Asbestos surveys – all site have access to site-specific registers (hard copy). Following the roll out of the asbestos management modal within MICAD, all sites will have access to digital register which will improve management and oversight in support of managing the likelihood of the risk materialising.	Complete

	12247	Annual asbestos surveys to be tracked and monitor for actions providing positive assurance of actions taken to mitigate risks.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/21. - Annual re-inspections – Asbestos Management Group providing oversight and governance with escalation to SOH&SG. Appointed Independent Asbestos Consultants.	Complete
	12248	Update intranet pages and raise awareness with staff who may be affected by asbestos.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Creating staff awareness of the presence of asbestos thus reducing may potential impact.	On Track
	12249	QR Code identification to be provided on all areas of work with identified asbestos signage in non-public areas.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed - 14/04/2021. Action should be closed as not required as there is no legal requirement none one on grounds of best practice.	Complete
	12250	Lack of completed asbestos registers on all sites picked up in H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/21. Corporate Health and Gap analysis – Action plan updated and progress against actions recorded and included within escalation report to SOH&SG.	Complete
	15032	Air Monitoring in all premises where there is limited clarity on asbestos condition.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed - 14/04/2021. Improve safety and ongoing compliance with the Regulations. Action completed.	Complete

CRR20-02	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 21 June 2021
	Risk: Contractor Management and Control	**Date of Committee Review:** 02 March 2021
		Target Risk Date: 30 September 2022

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

	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level*)	4	2	8
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	Assurances
1. Control of contractors procedure in place (refer to further action 12260). 2. Induction process being delivered to new contractors. 3. Permit to work paper systems in place across the Health Board. 4. Pre-contract meetings 5. Externally appointed CDMC Coordinator (Construction, Design and Management Regulations) in place. 6. Procurement through NHS Shared Services Procurement market test and ensure contractor compliance obligation.	1.Health and Safety Leads Group. 2.Strategic Occupational Health and Safety Group. 3.Quality, Safety and Experience Committee.

Links to	
Strategic Priorities	**Principal Risks**

Safe, secure & healthy environment for our people	BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12251	Identify current guidance documents and ensure they are fit for purpose.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021	Action Closed - 31/03/2021. The Control of Contractors Guidance Document is currently being reviewed and updated.	Complete
	12252	Identify service Lead on each site to take responsibility for Contractors and H&S Management within H&S Policy).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for additional staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the Operational Estates geographical areas to manage COSHH and Inspection process to ensure compliance.	On Track
	12253	Draft and implement a Control of Contractors Policy that all adhere to including IT and other services who work on BCUHB premises.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021	Action Closed - 31/03/2021. The Control of Contractors Policy Document is currently being drafted.	Complete

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

					includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	On Track
	12258	Identify responsible person to review RA's and signs off Method Statements (RAMS), skills, knowledge and understanding to be competent to assess documents (Pathology, Radiology, IT etc.).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	On Track
	12259	Identify the current Permit To Work processes to determine whether is it fit for purpose and implemented on a pan BCUHB basis.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A Permit to Work system will be adopted as part of implementation of SHE software.	On Track
	12260	Lack of consistency and standardisation in implementation of contractor management procedure picked up in H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board	On Track

					includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	
	12552	Induction process to be completed by all contractors who have not yet already undertaken.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for addition staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the Operational Estates geographical areas to manage COSHH and Inspection process to ensure compliance.	On Track
	12553	Evaluation of standing orders and assessment under Construction Design and Management Regulations.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021	Action Closed - 31/03/2021. The Control of Contractors Guidance Document is currently being reviewed and updated.	Complete

CRR20-03	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 21 June 2021
	Risk: Legionella Management and Control.	**Date of Committee Review:** 02 March 2021
		Target Risk Date: 30 September 2022

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

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score (Risk Appetite – *low level*)	2	4	8
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	Assurances
1. Legionella and Water Safety Policy in place (refer to further action 12270). 2. Risk assessment undertaken by clear water. 3. High risk engineering work completed in line with clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonis. 6. Authorising Engineer water safety in place who provides annual report. 7. Annual Review of the H&S Self Assessments undertaken by the Corporate H&S Team. 8. Water safety Group has been established to better provide monitoring, oversight and escalation. 9. Internal audit of compliance checks for water safety management regularly undertaken.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Experience Committee.

Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources Safe, secure & healthy environment for our people	BAF21-13 BAF21-17

Risk Response Plan Actions being implemented to achieve target risk score	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
	12262	Ensure that engineering schematics are in place for all departments and kept up to date under Estates control. Implement MiCAD/database system to ensure all schematics are up to date and deadlegs easily identified.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	MiCAD (IT) system being rolled out on a phased basis and work has commenced on polylining site drawings (digital site drawings) for migration to MiCAD. Schematic drawings for all sites for water safety being reviewed as part of the new Water Safety Maintenance Contract, which has been approved by the Health Board in January 2021.	On Track
	12263	Departments to have information on all outlets and deadlegs, identification of high risk areas within their services to ensure they can be effectively managed	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	All water outlets within managed departments have outlets run as part of the cleaning schedule undertaken by domestic services. Deadlegs are removed on identification and assessment of risk.	On Track
	12264	Departments to have a flushing and testing regime in place, defined in a Standard Operating Procedure, with designated responsibilities and recording mechanism Ward Manager or site responsible person.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A policy for the Management of Safe Water Systems in place to ensure water safety compliance. A programme of flushing of little use outlets in place for un-occupied areas and recorded by Operational Estates for each site.	On Track

	12265	Water quality testing results and flushing to be logged on single system and shared with or accessible by departments/services - potential for dashboard/logging system (Public Health Wales).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Pseudomonas and Legionella sample testing carried out within augmented care areas, exception reports are presented at the Water Safety Group in an excel format. All water testing across BCUHB is undertaken by Operational Estates through Public Health Wales.	On Track
	12266	Standardised result tracking, escalation and notification procedure in place, with appropriate escalation route for exception reporting.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Escalation and notification process is contained within Policy for the Management of Safe Water Systems (Appendix B).	On Track
	12267	Awareness and training programme in place to ensure all staff aware. Departmental Induction Checklist.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A training and development structure for Operational Estates is being reviewed as part of new Water Safety Contract, which has just been approved by the Health Board.	On Track
	12268	BCUHB Policy and Procedure in place and ratified, along with any department-level templates for SOPs and check sheets.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A policy for water safety management is currently in place – A consultant has been appointed to review current procedural documents for each area with the objective to develop one policy document.	On Track
	12269	Water Safety Group provides assurance that the Policy is being effectively implemented across all sites, this requires appropriate clinical and microbiology support to be effective	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Water Safety Group provides assurance that the Policy is being effectively implemented across all sites; this requires appropriate clinical and microbiology support to be effective. The Water Safety Groups reports issues of significance and	On Track

					assurance to the Infection Prevention Sub-Group (IPSG) and Strategic Occupational Health and Safety Group (SOH&SG).	
	12270	Lack of consistency and standardisation in the implementation of the Legionella and Water Safety Policy picked up in the H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Independent Consultant appointed to review the current procedural documents for each area with the objective to develop one policy document.	On Track

CRR20-04	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 02 June 2021
	Risk: Non-Compliance of Fire Safety Systems	**Date of Committee Review:** 02 March 2021
		Target Risk Date: 30 September 2022

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

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score (Risk Appetite – *low level*)	4	2	8
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	Assurances
1. Fire risk assessments in place (refer to further action 15036). 2. Evacuation routes Identified and evaluation drills established and implemented. 3. Fire Safety Policy established and implemented. 4. Fire Engineer regularly monitor Fire Safety Systems. 5. Fire Safety Mandatory Training and Awareness session regularly delivered to BCUH Staff. 6. Fire Warden Mandatory Training established and being delivered to Nominated Fire Warden.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Committee.

Links to	
Strategic Priorities	**Principal Risks**

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Effective use of our resources	BAF21-13
Safe, secure & healthy environment for our people	BAF21-17

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12273	Review Internal Audit Fire findings and ensure all actions are taken.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Governance actions completed and operational elements are captured within the gap analysis areas below.	On Track
	12274	Identify how actions identified in the site FRA are escalated to senior staff and effectively implemented.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Complete with escalation through Hospital Management Teams, Area Terms and MH&LD management teams with site responsible persons.	On Track
	12275	Identify how site specific fire information and training is conducted and recorded.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Database located within the fire safety files, managed and updated by the fire safety trainer.	On Track
	12276	Consider how bariatric evacuation training - is undertaken define current plans for evacuation and how this is achieved?	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Work in progress. To be included in site specific manual and training developed with Manual Handling team.	On Track

	12279	AlbaMat training - is required in all service areas a specific training package is required with Fire and Manual Handling Team involved.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Albac mat training is undertaken as part of the induction programme for clinical staff and as part of the refresher-training programme delivered by the Manual Handling team.	On Track
	12554	Commission independent shared services audits.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Independent, Shared Services (Specialist Estates Services) audits commissioned on an annual basis to ensure the appropriate fire safety measures, process and procedures are in place within Acute and Community hospital sites.	On Track
	12555	Information from unwanted fire alarms and actual fires is collated and reviewed as part of the fire risk assessment process.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Unwanted Fire signals (Uwfs) and fire safety data collated within an All-Wales management system and annual report collated and published. Details shared with the SOH&SG and escalated to QSE as necessary. Information reviewed as part of the annual Fire Risk Assessment process and appropriate action taken.	On Track
	15036	Fire Risk Assessments in place Pan BCUHB	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Improve safety and compliance with the Order.	On Track

CRR20-05	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 11 May 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 21 June 2021
	Risk: Timely access to care homes	**Date of Committee Review:** 02 March 2021
		Target Risk Date: 31 December 2021

There is a risk that there will be a delay in residents accessing placements in care homes and other community closed care settings. This is caused by the need to protect these vulnerable communities from the transmission of the virus during the pandemic. This could lead to individual harm, debilitation and delay in hospital discharges impacting on quality of care, wider capacity and patient flow.

	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level*)	3	3	9
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

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

decision making on hospital discharge, transfer between care homes and admissions from home. 10. Regular formal communication channels with care homes at a local level and across BCU.	

Links to	
Strategic Priorities	**Principal Risks**
Continuing to provide care under 'essential' services & safe stepping up planned care	BAF21-03

Risk Response Plan Actions being implemented to achieve target risk score	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
	14936	Establish separate discharge cell.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed - 02/06/2021. This will help eradicate delays in discharge through better co-ordination.	Complete
	14937	Develop a BCU wide approach to primary care support and intervention, including GPOOH.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed - 02/06/2021. This will improve communication and support direct admission to care homes.	Complete
	14938	Develop electronic daily reporting metrics.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed - 02/06/2021. This will help eradicate delays in discharge through better co-ordination.	Complete

	14939	Complete and implement a North Wales care home escalation and support tool.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14940	Ensure that all new national guidance on testing for care home staff and residents is widely communicated and implemented.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Ongoing weekly reviews will ensure that regular guidance is shared and implemented to reduce the risk likelihood of the risk re-occurring.	On Track
	14941	Embed the new ways of working in all home first bureau.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed - 02/06/2021. This will help eradicate delays in discharge through better co-ordination.	Complete
	14942	Develop communication with care homes at a local level and across North Wales.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14943	Deliver a revised financial support package for care homes.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This action will support access to care homes.	On Track

	14944	Adopt care home DES for primary care.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed - 02/06/2021. This will support the quality of provision in care homes and reduce demand on unscheduled care.	Complete
	14945	Increasing the frequency for multiagency care home cell.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed - 02/06/2021. This will improve communication and support direct admission to care homes.	Complete
	14946	Update the 2020 care home monitoring levels and escalation framework.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed -28/05/2021. This will support the quality of provision in care homes and reduce demand on unscheduled care.	Complete
	14947	Development of proactive risk triggers.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed - 02/06/2021. This will support the quality of provision in care homes and reduce demand on unscheduled care.	Complete
	14948	Diversion of CHC priorities.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track

	14949	Development of resources support capacity and demand for care homes.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14951	Increase MDT Care Home group to weekly or as the need arises due to C-19 pressures.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14952	Implementation of reactive support to in crisis care homes.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed - 02/06/2021. This will support the quality of provision in care homes and reduce demand on unscheduled care.	Complete
	14954	Contribute to the development and implementation of national guidance.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will support the quality of provision in care homes and reduce demand on unscheduled care.	On Track
	15272	Infection Prevention and Control.	Ms Jane Trowman, Associate Chief of Staff - Operations	04/01/2021	Action Closed 25/02/2021. Identify outbreaks in care homes at an earlier stage and prevent escalation. Develop triggers which identify which homes are most at risk	Complete

| Complete | 15273 | Vaccination of Care Home Staff. | Ms Jane Trowman, Associate Chief of Staff - Operations | 30/04/2021 | Action Closed 25/02/2021.

High uptake of the vaccination will reduce the spread of covid within the care home, if staff are positive then vaccination will reduce the severity of the illness relieving staffing pressures. Process for new staff to access the vaccine in a timely way | Complete |

	Director Lead: Executive Director of Nursing and Midwifery	Date Opened: 14 September 2020
CRR20-08	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 02 June 2021
	Risk: Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	Date of Committee Review: 02 March 2021
		Target Risk Date: 28 February 2022

There is a risk that patients may come to harm of permanent vision loss. This may be caused by reduced capacity resulting from Covid-19 and increase in waiting times for clinic review as clinics have been cancelled.

This may negatively impact on patients through untreated proliferative diabetic retinopathy, untreated glaucoma, untreated age related macular degeneration, prolonged suffering and may result in falls from impaired vision due to lack of cataract secondary capacity due to prolonged surgical capacity reduction during the pandemic. This could negatively also impact on patient safety and experience, the quality of care, finance through claims, and the reputation of the Health Board.

	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level*)	3	2	6
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	Assurances
1. Reviewing list of patients affected to get fast-track or book those who may deteriorate to clinics. 2. Cataract - All cataracts have been stratified in order of visual impairment, to deal with the most clinically pressing cases first. 3. Once surgery resumes across all sites patients who are already clinically prioritised may be shared across all three units in North Wales to ensure equity of access as part of the 'Once for North Wales' process. 4. More clinic slots are being made available to accommodate clinically pressing patients.	1. Risk is regularly reviewed at local Quality and Safety meetings.

Links to	
Strategic Priorities	**Principal Risks**
Continuing to provide care under 'essential' services & safe stepping up planned care	BAF21-02 BAF21-04

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	14907	Age related macular degeneration – A business case is awaiting approval to increase staffing and treatment capacity. The resources have been identified in the HBs Annual Business Plan for 2021/22 and is being progressed to final approval stages.	Mr Eoin Guerin, Consultant Ophthalmologist	31/12/2021	This action will enable the service to robustly mitigate and manage this risk to its target score.	On Track
	14908	The retinal cameras have been procured as part of a larger equipment replacement scheme and are expected to be commissioned soon. Date awaited from internal sources.	Mr Eoin Guerin, Consultant Ophthalmologist	31/12/2021	This action will enable the service to effectively mitigate and manage this risk so as to achieve its target score.	On Track
	15662	Proliferative diabetic retinopathy – Pan BCUHB pathway has been initiated to get optometry review of the backlog. Referrals are being sent out from secondary care to primary care optometrists and are at various stages of progression but positive progress.	Mr Eoin Guerin, Consultant Ophthalmologist	31/12/2021	This action will enable the service to appropriately mitigate and manage this risk in attaining its target score.	On Track

Appendix 2 – QSE Operational Risk for Escalation

Nurse Staffing Risk 1976 Escalation

Argymhelliad / Recommendation:
The Nurse staffing risk 1976 has been reviewed and updated resulting in a revised score of 16, inherent of 20 with a target grade of 6. The Executive Team are asked to note the controls and actions advised and support this increased score ahead of presentation to the Quality Safety Experience Committee in July 2021.
Sefyllfa / Situation:
The revised score has taken into account the long standing impact of COVID 19 on an existing backdrop of vacancies. We are becoming more aware Nationally of the increasing impact on Mental Health and resilience on our nursing workforce. There is concern that we will be seeing an increasing number of staff seeking retirement again against a backdrop of an increasing age profile that already exists. Staff alternatively looking to reduce hours (60% nationally work part time) or seek alternative employment; any further decrease will place additional constraints on an existing challenged position. Although there are a number of controls in place there remains a heavy reliance on temporary workforce solutions which are exposed to the same impact to that of our substantive staff. Equally there are a number of actions underway, however it should be noted that there is a lead in time and a momentum to be gained for these actions to make significant impact on the current vacancy numbers.
Cefndir / Background:
The Health Board has remained in deficit position for Nurse Vacancies for a number of years and arguably reflective of the National picture compounded by challenges associated with Health Board status directly. It should be noted that a number of initiatives have been undertaken over time and continue to do so. However the number of Nurses attracted has not been sufficient to meet the turnover demands. Recruitment and Retention requires a joint focus to both aid retention and support attraction.
Asesiad / Assessment & Analysis
Goblygiadau Strategol / Strategy Implications The focus of the Recruitment and Retention strategy underpinning work programmes is aimed at bringing both arms together. Greater analysis of data and information is being utilised to both inform and target improvement work and interventions ensuring they are outcome driven. A more focussed collaborative working arrangement between the Office of the Nurse Director and Workforce and OD dept. to combine intelligence and expertise is designed to ensure they remain outcome focussed with accountability being maintained. All of these will be supported with the appropriate level of resource to aid pace and deliver on outcomes.
Opsiynau a ystyriwyd / Options considered Control measures are reviewed in line with the Health Boards Risk Management strategy, with actions monitored via the Recruitment and Retention Group whereby options analysis has been undertaken.

Goblygiadau Ariannol / Financial Implications

Current overspend associated with temporary workforce, Agency Spend and the spend associated with double running impact whilst we recruit to substantive positions and maintain patient safety.
Business case in development to resource the increased demand and throughput.

Dadansoddiad Risk / Risk Analysis

As per Risk attached.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Potential Non adherence with the Nurse Staffing Act (2016) Wales

Asesiad Effaith / Impact Assessment

Nurse Staffing Act (2016) Wales Harm Review process reported via QSE

1976	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 07 December 2017
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 20 May 2021
	Risk: Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	**Date of Committee Review:** New Risk
		Target Risk Date: 30 December 2022

There is a risk to the provision of high quality safe and effective nursing care due to the number of nursing vacancies across the Health Board.
This may be caused by the increasing age profile within the nursing workforce, difficulties with recruitment and retention of nursing staff across the Health Board, geographical challenge and competition with other hospitals across the borders. There is also the precarious position of Bank & Agency staffing in terms of continuity of supply and the impact this has on skill mix and patient experience. This has been further exacerbated by the impact on the resilience of the workforce due to the ongoing Covid 19 pandemic.
This could lead to negative impact on the safe delivery of highly quality, timely patient-centred care and enhanced experience, financial loss due to reduction in business/operational activities and potential reputational damage to the Health Board.

		Impact	Likelihood	Score
To be populated following approval	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	4	16
	Target Risk Score (Risk Appetite – *low*)	3	2	6
	Movement in Current Risk Rating Since last presented to the Board in - *To be populated following approval*.	New Risk		

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

10. Annual Commissioning requirements calculated triangulating service development / staffing review and national planning information.
11. International Nurse recruitment programme in place informed by data analysis.
12. Clinical Fellows for Nursing programme being rolled out.
13. AND appointment to lead and support nurse recruitment.
14. Workforce/Service planning process to triangulate requirements.
15. Introduction of new roles to support e.g. Band 4 roles across the HB where applicable.
16. Daily redeployment meeting with Senior Nursing Leadership chair during pandemic surge.
17. MDT staffing support across the Health Board during surge due to inability to respond to demand.
18. Objective setting via the PADR process to ensure staff are working to 'top of license' and have opportunity.

Links to	
Strategic Priorities	**Principal Risks**
Continuing to provide care under 'essential' services & safe stepping up planned care Effective use of our resources Safe unscheduled care	BAF21-02 BAF21-09 BAF21-11 BAF21-18

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	15633	Analysis of current vacancy, turnover and recruitment data to better inform recruitment intentions.	Mrs Alison Griffiths, Associate Director of Nursing Workforce	31/05/2021	Gain a clear understanding of the current position which will help drive the way forwards in terms of mitigating the risk. A new suite of metrics have been developed that better inform our current vacancies, but also enable us to forecast future trends taking planned recruitment activity into account. In having this information, we can monitor performance on our recruitment campaigns and take timely action when necessary.	Complete

	15634	Development of a clinical fellowship model for nursing.	Mrs Alison Griffiths, Associate Director of Nursing Workforce	31/05/2021	This action will assist to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise. This is a further pipeline for staff into the organisation, it is an attraction method which in turn will also support retention.	Complete
	15635	Development of a recruitment and resourcing business case to go to Executives.	Mr Nick Graham, Associate Director of Workforce Planning & Performance	01/07/2021	This action will assist to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise. This will increase the ability to expedite recruitment and increase volume. The individual benefits and KPIs of the business case are linked to the relevant sections of our corporate risk register.	On Track
	15636	Extension of the International Nurse Programme.	Mr Nick Graham, Associate Director of Workforce Planning & Performance	01/07/2021	The pipeline of international recruits has been developed and strong links with overseas partners have been created. The anticipated approval of extending this programme will see new recruits joining each month through to spring 2022, offering a consistent and manageable number of nurses to integrate into our workforce. This action will assist to create a sustainable workforce in the longer term whilst continuing to recruit nationally.	On Track
	15637	Put in place a targeted specialist recruitment campaign Band 5 nurses.	Mr Nick Graham, Associate Director of Workforce Planning & Performance	31/07/2021	We have enlisted the support of a specialist company to run a comprehensive marketing campaign. To date, the marketing material has been created and the campaign is due to launch in the early July. A further campaign has been initiated for Mental Health and Learning Disability division, which includes CAMHS, to increase our numbers of mental health trained staff, across a range of staff groups. A key factor in this is that a new team will	On Track

					be established which can be mobilised to respond to situations more readily. This action will assist with creating and delivering an innovative, digital attraction strategy and help limit the over-reliance on temporary agency staff. To assist this campaign, a new SharePoint site of online guidance and material has been created that supports our recruiting managers. Moreover, a series of proposals to streamline the recruitment process have been taken forward which will shorten the time it takes to recruit, but also reduce the admin burden on Ward managers.	
	15638	Introduce targeted monitoring across rosters, through KPI management to reduce agency expenditure and maximise substantive staff usage.	Mrs Alison Griffiths, Associate Director of Nursing Workforce	31/07/2021	A new suite of metrics are in development to provide a clearer picture of how rosters are being managed, which in turn will enable us to monitor staffing levels for patient safety and staff wellbeing. These metrics will link roster data together with recruitment and temporary staffing information to provide a rounded picture of wards in difficulty. This action will put in place a formal Review and Approve process to maximise e-Rostering efficiency and support the creation of safe and effective rosters in line with Health Board KPIs.	On Track
	15639	Introduction of leadership development programmes commencing with Matrons which will extend to include Ward Managers, Heads of Nursing and subsequently aspirant programmes.	Sian Knapper	31/3/2022	This action will support retention with providing developing opportunities but also aid delivery of the Quality & Safety strategy within the Nursing workforce.	On Track

	15640	Review of band 4 roles across the HB as to maximising opportunity.	Mrs Alison Griffiths, Associate Director of Nursing Workforce	31/8/2021	This action will continue to further develop career pathway opportunities and aid stability within the current workforce.	On Track

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Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 6th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Infection Prevention Steering Group (IPSG) Update
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Deputy Chief Executive/Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Sally Batley, Interim Associate Director of Nursing, Infection Prevention & Control (IPC)
Craffu blaenorol: **Prior Scrutiny:**	Infection Prevention Steering Group 15/05/2021 Safe Clean Care Steering Group 02/06/21
Atodiadau **Appendices:**	1. IPSG Presentation slides

Argymhelliad / Recommendation:
The committee is asked to note the content of the report.

Ticiwch fel bo'n briodol / Please tick as appropriate						
Ar gyfer penderfyniad /cymeradwyaeth **For Decision/** **Approval**		**Ar gyfer Trafodaeth** **For** **Discussion**		**Ar gyfer sicrwydd** **For** **Assurance**	X	**Er gwybodaeth** **For** **Information**	X

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

Sefyllfa / Situation:
The accompanying slide set provides an update on Infection Prevention performance across the Health Board and an All Wales position. The Infection Prevention Annual Report 2020/21 was presented and scrutinised at the May 2021 Health Board in public session.

Cefndir / Background:
The Infection Prevention steering Group (IPSG) is a reporting group for QSE and Patient Safety and Quality Group (PSQ) providing scrutiny and assurance that accountable areas are managing their Infection Prevention and Controls risks to achieve the aims of the Board, by: 1. Evidencing Infection Prevention Control measures that the Health Board have in place to improve infection rates. 2. Overseeing the risks and mitigating actions, escalating as required 3. Informing Infection Prevention elements on the Board Assurance Framework (BAF) As part of the pandemic response Welsh Government issued guidance for COVID-19 and wider Infection Prevention and Control requirements. This informed a self-assessment, which the accountable areas completed in March 2021, and are about to reassess. The results from this shaped their 2021/22 plan on a page and the Safe Clean Care Harm Free Programme's underpinning work streams Safe Place, Safe Space and Safe Action with three enabling work streams Communications, Staff Ambassadors and Informatics.

The overarching Safe Clean Care Harm Free Transformation Programme to support the accountable areas to deliver sustainable change required to prevent infection transmission in our staff and patients commenced at pace utilising existing resource and skills, which due a variety of reasons is at risk for the medium to long term delivery of the programme and maintain pace. These resource implications are currently being considered.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

Infection Prevention and Control is essential to the delivery of the Health Board's strategic objectives and is everybody's business.

A review of options to increase our isolation capacity and physical distancing measures before the winter is key to managing the risk of infection prevention and control. In addition to this identifying decant facilities so we can operate a regular deep clean programme throughout our Hospitals is a requirement for our future success.

Opsiynau a ystyriwyd / Options considered

No options needed for this paper.

Goblygiadau Ariannol / Financial Implications

Scoping of additional measures to support the:
1. Infection Prevention compliance as outlined in the revised cleaning standards
2. Social Distancing measures required to minimise transmission

Dadansoddiad Risk / Risk Analysis

Risks mitigations are highlighted within the reports.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Statutory compliance with Infection Prevention and Health and Safety Standards.

Asesiad Effaith / Impact Assessment

No impact assessment required for this paper.

Infection Prevention Performance April 2021 Update

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- Welsh Government trajectories have not yet been set for 2021/22 – for the moment the number of cases are being measured alongside the trajectories for 2019/20, which were the last trajectories set by WG. In comparison with other Welsh Health Boards, BCUHB is not an outlier for 5 of the 6 organisms, where our position is either 1st or 3rd when looking at April '21 data. We are currently an outlier with Pseudomonas aeruginosa bacteraemia – 5th position.

- During April 2021 we saw 8 cases of CDI - East 4 (below trajectory of 5), Central 4 (equal to trajectory of 4) and West 0 (below trajectory of 3). This is approximately 53% fewer than the equivalent period in 2020-21 and is currently the lowest rate per 100,000 of the population of the 6 Welsh Health Boards. This is the lowest monthly number of CDI in BCUHB since January 2020.

- There were no cases of Methicillin Resistant Staphylococcus Aureus (MRSA) during April 2021, which is the same as during April 2020. BCUHB therefore has a rate of 0 cases per 100,000 along with 3 other Welsh Health Boards.

- There were 12 cases of Methicillin Sensitive Staphylococcus Aureus (MSSA) during April 2021. East 4 (equal to trajectory of 4), Central 5 (above trajectory of 3) and West 3 (above trajectory of 2). BCUHB is therefore 3 cases above trajectory overall. The number of cases in April 2021 is 50% more than during April 2020, when we saw 8 cases. When compared with other Health Boards, BCUHB has the lowest rate per 100,000 population.

- There were 42 E. coli cases during April 2021, which is above the trajectory of 39. East 15 (below trajectory of 16), Central 16 (above trajectory of 12) and West 11 (equal to trajectory). This is approximately 45% more than during April 2020, when there were 29 cases. Third position across Wales.

- There were 8 cases of Klebsiella during April 2021, which is above the trajectory of 7 cases. East 3 (equal to trajectory), Central 3 (above trajectory of 2) and West 2 (equal to trajectory of 2). This is 100% more than during April 2020 when there were 4 cases. Third position across Wales.

- We saw seven Pseudomonas Bloodstream Infections (BSI) in April 2021, which is above the trajectory of 2 cases. East 3 (above trajectory of 0), Central 3 (above trajectory of 1) West 1 (equal to trajectory). This is approximately 133% higher than April 2020, when there were 3 cases. Fifth position across Wales.

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Benchmark Chart - C. difficile rate per 100,000 of the population - Apr 21

Benchmark Chart - MRSA bacteraemia rate per 100,000 of the population - Apr 21

Benchmark Chart - MSSA bacteraemia rate per 100,000 of the population - Apr 21

Benchmark Chart - E. coli bacteraemia rate per 100,000 of the population - Apr 21

Benchmark Chart - Klebsiella bacteraemia rate per 100,000 of the population - Apr 21

Benchmark Chart - P. aeruginosa bacteraemia rate per 100,000 of the population - Apr 21

Source: PHW

- In comparison with other Welsh Health Boards we are not an outlier for 5 of the 6 organisms, where our position is either 1st or 3rd when looking at April '21 data. We are an outlier with Pseudomonas aeruginosa bacteraemia – 5th position.

Weekly number of inpatient confirmed cases in all hospital wards, by health board of admission
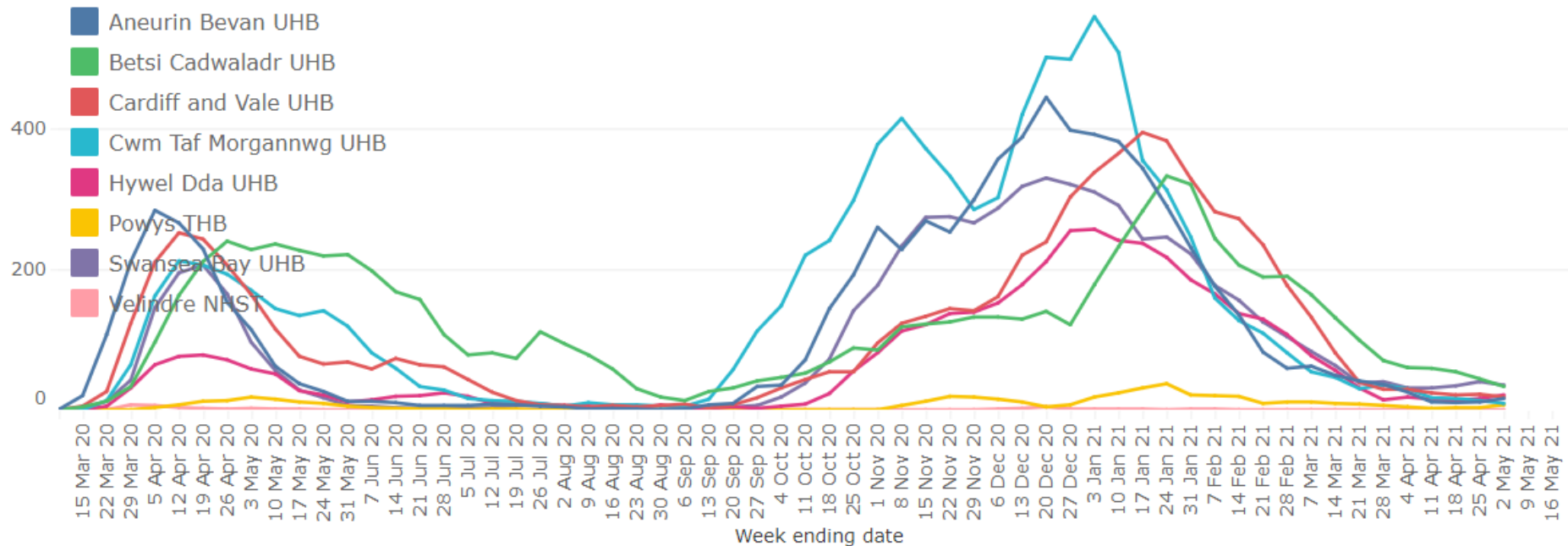
Although Hospital onset has now dropped to extremely low levels, we should acknowledge the increasing Community transmission. Some of the Health Boards Local Authority areas are seeing significant rates of transmission which increases the risk of Hospital transmission.

Source: PHW

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-11			Risk Rating	Impact	Likelihood	Score	Appetite	
Infection Prevention and Control								
There is a risk that Health Board may not be able to deliver appropriate care to patients and they may suffer harm due to healthcare associated infection. This may be caused by a failure to put in place systems, processes and practices that would prevent avoidable infection. The impact of this may increase morbidity and mortality, increase admissions and longer length of stay, increase treatment costs, reputational damage and loss of public confidence.			Inherent Risk	5	5	25	Low	
			Current Risk	5	4	20	1 - 6	
			Target Risk	5	3	15		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps (actions to achieve target risk score)	Date
New leadership in place with revised governance arrangements supporting Infection Prevention.	2	Business case approved and recruitment commenced to increase IPC team/resource. Risk register monitored and escalated via IPSG and Patient Safety & Quality Group. Safe, clean care harm free programme commenced.	2	1) Analysis to be undertaken to ensure that there is the right leadership in place across Directorates/Divisions/Teams who understand infection prevention and the appropriate escalation arrangments in place across the Health Board. 2) Finalise recruitment to increase IPC Team resource. 3) To develop the leadership to influence culture and behaviours to ensure that infection prevention becomes habit. This is an integral part of the safe, clean care harm free programme. 4) IT solution and information leadership required to ensure that the right data is captured which can then be tranformed into intelligence, so that people delivering care can see that they are delivering safe practice (real time system). 5) Safe clean care programme support required to support and manage and assure delivery.	31 December 2021 30 September 2021 31 December 2021 31 December 2021 31 July 2021
Infection Prevention Sub Group in place providing regular oversight and gaining assurance that the key controls are in place and effective, reporting into Quality, Safety and Experience Committee (QSE).	2	Monitoring of performance and risk in place by Public Health Wales and Welsh Government.	3	1) Identify decamp facilities on all clinical sites to ensure an effective deep cleaning programme (Hydrogen Peroxide Vapour {HPV}) 2) To build or purchase more isolation facilities to ensure all infected patients can be isolated within two hours.	31 October 2021
Major Outbreak policy (IPO5) currently in place for managing Covid 19 infections.	2	Work, policy and risk register review programmes in place. Microbiology and Antimicrobial stewardship activity overseen by Infection Prevention Sub Group (IPSG), Audit Committee/ Patient Safety & Quality Group and Quality and Safety Executive.	2	1) Strengthening of effective reporting arrangements through outbreak control groups and IPSG. 2) Ensuring that the most effective control measures are being monitored at a local level and assurance reporting to QSE Committee.	30 September 2021 30 August 2021

Review comments since last report: Additional actions identified including to ensure that the most effective control measure are being monitored at a local level and assurance reporting to QSE Committee, and safe clean care programme support required to support and manage and assure delivery. Actions reviewed in terms of which would have the most material impact on the risk. It is considered that the action to build or purchase more isolation facilities would have the most material impact on this risk.

Executive Lead:	Board / Committee:	Review Date: 8 June 2021
Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-16				Risk Rating	Impact		Likelihood		Score		Appetite	
Pandemic Exposure												
There is risk that patients, staff or visitors are exposed to COVID-19 due to inadequate/inappropriate resources, lack of compliance with prevention/protection measures across all settings, lack of understanding, skills, ownership of responsibilities, lack of systems and/or capacity and/or capability to identify, analyse, adapt, address immediate themes arising from intelligence both internal and external in a dynamic way. This could impact or effect avoidable harm caused to our patients, staff, visitors, increase in demand/length of stay/risk to other patients, reduction in availability of staff to support the delivery of safe care and services. This could led to prosecution for breach of statutory/legal duty and reputational damage to trust and confidence.				Inherent Risk	5		5		25		Low 1 - 6	
				Current Risk	5	↔	4	↔	20	↔		
				Target Risk	5		3		15			

Key Controls	Assurance level*	Key mitigations	Assurance level*	Gaps (actions to achieve target risk score)	Date
PPE monitoring and management in place with regular reporting to the Patient Safety and Quality Group and reporting through to Quality, Safety and Experience Committee.	1	PPE steering group (PPESG) and reporting into Infection Prevention Sub Group, Patient Safety & Quality Group with governance structure in place. In addition the formation of the Safe Clean Care Harm Free Group which now reports to Quality,Safety and Experience Committee.	2	Continuous supply is not secure, training availability limited due to staffing resource in PPE and IPC teams. BCUHB to approve second admission screen.	30 September 2021
Fit testing in place to prevent avoidable infection. This is monitored via IPSG and OH&SG.	1	Fit testing programme, Accreditation training and business case in place to increase assurance monitored by PPESG.	2	To ensure fit testing becomes business as usual and is kept under continuous review by the Health & Safety Group	30 September 2021
Review of all buildings has taken place against new regulations/guidance in relation to what the clinical environment should look like with regard to infection prevention, with a schedule of improvements identified.	1	Ventilation and Environmental groups reporting into Infection Prevention Sub Group and Patient Safety & Quality Group with governance structure in place. Implementation of segregation and screening to clinical areas.	1	1) Review and risk assess the improvement plans in order to address the environmental considerations necessary to meet new guidance in relation to the built environment. Some buildings are a risk due to infrastructure (dialysis and community hospitals). Improvement plans in place via Planning and Estates, approved by Board and currently with Welsh Government awaiting approval. 2) To build or purchase more isolation facilities to ensure all infected patients can be isolated within two hours.	30 September 2021 31 December 2021

Review comments since last report: Actions reviewed and updated:- Improvement plans in place via Planning and Estates, approved by Board and currently with Welsh Government awaiting approval; and ensuring fit testing becomes business as usual and is kept under continuous review by the Health & Safety Group. Actions reviewed in terms of which would have the most material impact on the risk. It is considered that the purchase/building of more isolation facilities will have the most material impact on this risk.

Executive Lead: Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	Board / Committee: Quality, Safety and Experience Committee	Review Date: 8 June 2021

Issues not discussed on the Board Assurance Framework:

- 'Start smart then focus' audits still demonstrate low compliance by Medical teams to undertake the audit (managed through SASG)
- Managing the polarity between patients needing to be admitted (Emergency) increasing elective capacity and the pace of improvement work required to keep patients and staff safe is a operational tension requiring focussed efforts
- Covid19 Addendum – key standards for Environmental cleanliness - £2.7m revenue funding bid to WG is still awaiting response
- Specialist Microbiologist opinion re Corwen Clinic (Dental): to provide staff reassurance and inform risk assessment around provision of Aerosol Generated Procedures with appropriate mitigations and decreasing fallow time (pending redesign/remodelling of current ventilation system)
- NICE guidance around antimicrobial Triclosan sutures not being consistently used in Theatre environments
- Infection prevention controls still need strengthening across the Health Board to prevent further outbreaks SCC Harms reassessments to be completed by the end of June.
- Review of Project management support needed for Safe Clean Care transformation programme

Required:

- IT solution for - monitoring antibiotic use

I. tracking MRSA screening at front door and in hospital at 30 days

II. Tracking of MSSA screening in our renal patients

III. a PIR database to support data capture, good governance and learning

All of the above are part of the SCC transformation programme and pending Dragons Den approach

- Consistent compliance with Antimicrobial audits

- Review of community high prescribing and follow up action plan

Both of the above have been escalated to the Office of the Medical Director

- increased isolation capacity particularly in our community hospitals, YG and WM

- Sustainable decant plans to undertake routine HPV cleaning to reduce bio burden across the health Board

The above form part of the accountable area 'plan on a page' roadmap

- Consistent completion of catheter care bundles

- PIRs to be undertaken rapidly within 72 hours to ensure safety and learning is quickly embedded

- reinforcement of Catheter appropriateness and management to develop regular monitoring around numbers and care bundle compliance

The above have been escalated to the Office of the Nurse Director with improvements in 72hr PIR compliance being noted

- operational support for Bed Spacing workstream in Safe Place

This has now been resolved with a risk based approach being pursued

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	New cases	Cumulative	Last 7 days				Prior 7 days	
			Cases	Incidence	Change		Cases	Incidence
Wales	+614	207,520	1,675	53.1	↑	24.0	917	29.1
Betsi Cadwaladr UHB	+274	36,877	684	97.8	↑	41.9	391	55.9
Isle of Anglesey	+17	2,408	37	52.8	↑	32.8	14	20.0
Gwynedd	+40	3,631	94	75.5	↑	63.5	15	12.0
Conwy	+36	4,248	106	90.4	↓	0.9	107	91.3
Denbighshire	+38	4,614	100	104.5	↑	27.2	74	77.3
Flintshire	+70	10,125	223	142.9	↑	68.6	116	74.3
Wrexham	+73	11,851	124	91.2	↑	43.4	65	47.8

Source: Public Health Wales

*Per 100,000 population. Incidence for the most recent 7 days may underestimate the true incidence due to samples still being processed and not yet authorised.

**Change in the actual number of cases per 100,000 compared to the previous 7 day period.

Last 7 days: Samples collected 17/06/2021 - 23/06/2021, with a lag of 4 days.

Prior 7 days: Samples collected 10/06/2021 - 16/06/2021

As of today 29/06/21 there ae currently 14 confirmed inpatient cases within the Health Board

Plan on a Page

NORTH WALES COMMINITY DENTAL SEVICES (NWCDS) INFECTION PREVENTION PLAN 2021-22

Aims:
- To provide the full range of dental care, safely, within North Wales Community Dental Service (NWCDS) surgeries and other working environments, such as care homes, domiciliary settings, offices, theatres.
- To support community and healthcare oral health improvement initiatives which prevent dental disease and concomitant infections such as sepsis, aspiration pneumonia.

Key Objectives / Assurance Framework

Environment and equipment

100% of work environments peer-risk assessed and peer-audited on an annual basis.
100% ICP risk assessments updated on a quarterly basis.
Annual update of NWCDS strategic planning document ("Building for Smiles").
100% compliance with environmental cleaning standards
100% compliance with enhanced cleaning standards
Quarterly review and update of all COVID SOPs, and risk assessments (non-AGP and AGP) at each site and in different work scenarios..
Bi-monthly review of COVID recovery plans, with comparison to prior activity figures by clinic.
100% compliance with PPE cleaning and maintenance regimes
100% annual review of Ventilation provision in all dental clinics by Estates and demonstrable progress to achieving site improvements to WHTM 03-01 standards.
100% compliance with water safety policies.
100% compliance with waste policies.
100% compliance with standards compressed air dental units
All clinics have Fallow time calculations reviewed at least quarterly.
Maintain Inventory of equipment, and update bi-annually.
Planned equipment and instrument replacement systems reviewed annually.
100% compliance with required validation, testing, maintenance and servicing processes.
100% compliance with safety alerts actions.
100% compliance with relevant Medical Devices Policies.
100% compliance with safe storage of instruments.
100% compliance and audit of safer sharps use,
100% compliance with protocols for single-use medical devices.

Behaviours

Ensure a robust risk assessment and audit process is maintained and peer-reviewed.
100% compliance with WHTM 01-05 and all relevant emerging national guidance.
100% compliance Policies, procedures, SOPs; for Universal and COVID-19 transmission-based status.
100% compliance with daily equipment and instrument visual inspection processes.
100% compliance Safe Clean Care, including hand hygiene
100% compliance with uniform and Level 1 and Level 2 PPE policies.
100% appropriate staff grades fit-tested and records maintained.
100% appropriate staff grades fitted to required respiratory protection and staff records maintained.
100% engagement with daily checklists, exception reports, audit systems, spot checks, clinical governance programmes.
100% compliance with Occupational Health pre-employment health checks and mandatory vaccination status.
Encourage staff immunizations against emerging infections.
100% feedback to alerts issued.
All staff encouraged to engage with Innovation and QI
Identify through the risk assessment process, scenarios which might impact on ICP at all clinics e.g. challenging patient behaviours and plan appropriate mitigations.
Encourage relevant Hospital staff to achieve 100% in monitoring MAH to prevent Ventilator Acquire Pneumonia
100% concerns and incidents reported are investigated and actioned appropriately within a month.
100% compliance with current antimicrobial prescribing guidance.

Education

100% of relevant staff to comply with all Continuing Professional Development in ICP and decontamination mandated by professional bodies and BCU:
Level 1 and 2 ICP
ANTT
COVID-19 training
Donning and doffing
Sepsis awareness.
Decontamination

100% compliance monthly update of staff training matrix.
% compliance must never fall below 70% overall.
Ongoing monitoring of staff performance linked to staff supervision, peer review and appraisals.
100% participation in daily huddle and de-brief session.
All staff to learn from incidents/ experience/events/ local quality initiatives through sharing monthly NWCDS management communications.
Staff to participate in Making Every Contact Count (MECC).
Educate health and social care staff and public via WG Oral health improvement programmes e.g. Gwên am Byth Older persons' programme, Mouth care for Adults in Hospital (MAH)., Lift The Lip and Designed to Smile targeted childrens' programmes, Learning Disabilities programmes.

Drivers

Required rollout of clinical services post-COVID
Continuous Improvement programme for premises
Need for Statutory compliances for equipment and premises
Maintaining mandatory staff training standards
Governance, Quality and Safety and Assurance frameworks
Antiimicrobial stewardship and contribution to holistic health

Controls

Sites risk assessed and mitigations in place
Governance and communications frameworks.
Approved allocation of protected time for improvement activities,
Quality and Safety Lead, Dedicated Clinical Governance Practitioner appointed; Senior Dental Nurses (IPC). Local Clinic champions clinical governance. Service champions MECC
Datix reports. Open culture to challenge behaviours across staff grades.

Nosocomial Action Plan

Version No: 28   Date updated: 01/06/2021

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.

Total No of Logged Actions	31	
Total Overdue	0	
Gantt Chart Start Date (Monday)	01/03/21	

Total Completed	24	
Total Not Yet Due / In Progress	7	

Total No of Actions	Ref. Activity No	Activity Description	Activity Description	Activity Lead	Start Date	Target Completion Date	Activity status -auto-populates	Update/Issues affecting delivery
3	1	Compliance with the WG 16 point plan / toolkit	1.2 Independent review of YG outbreak to have clear TOR approved by Board and reported back via QSE upon completion	GH	01/03/21	30/06/21	In Progress	5/5 Reviewer confirmed draft report anticipated 1st June 2021 29/4 TOR revised and confirmed via the office of the Board Secretary. External review commissioned via the HB process and reviewer confirmed. 24/4 external review completed and findings submitted DH & SB Previous update: External reviewer identified. TOR drafted for Executive and Board approval. TOR finalised with independent reviewer, review underway 2/4 Current review ceased. TOR to be amended following receipt of further comments from IMs & Chairman. New reviewer to be identified – request sent to WoD
5	1	Compliance with the WG 16 point plan / toolkit	1.4 Complete revision of remaining out of date policies and disseminate revised policies	AL/ SF	01/02/21	30/06/21	In Progress	29/4 confirmation that all remaining policy reviews to be complete by June 2021 28/4 AL - A review of the out of date policy, protocol, guidelines documents continues with further documents on the intranet for Consultation prior to going to IPSG in May. The remaining policies will go out for Consultation early June to be approved by IPSG in June. This is with the exception of the Water Safety which will be in July as it re to ensure it aligns with the Water Safety Plan. Previous update - Review complete, remaining policies under review. Chairs action taken where applicable for approval, some will require QSE approval 2/4 a number of updated policies are now on the intranet for consultation
10	1	Compliance with the WG 16 point plan / toolkit	1.8 Strengthen IP expertise and resource – considering Office of the Medical Director and Pharmacy colleagues	AG / SB	01/03/21	30/06/21	In Progress	5/5 peer review process with Area colleagues in pilot 29/4 IP Westleed change in personnel as of W/C 10/5 Additional support provided to YG by Deputy IP lead. Further external support requested via WoD 2/4 nil received via WoD YG Walk around and site presence continues to be supported by Deputy IP lead & SCDON minimum weekly.
14	2	Embedding of learning and practices to ensure sustainable zero tolerance to patient Harm as a result nosocomial transmission across all clinical areas	2.1 Develop capacity for targeted support of above work programmes with behavioural change / psychology/ PMO / Analytical expertise	DH/GA/DW	01/03/21	31/05/21	In Progress	5/5 further PMO support required – gap analysis underway as programme is evolving Analytic provision requires further review – Meeting TBA with GH and Dylan Williams. Proposal for 12 month programme resources to embed the programme to sustain the gains submitted to June QSE for approval to bid for capacity and capability funding. 28/04 Additional longer term support is needed at a senior PMO level to support the programme of work (2 off if possible). Previous update Additional PMO support required with the Site and Area teams, request for 3x Band 7 Project Managers and 3x Band 3-4 Project Admin Support, required for 6 months. In addition, Analytical support is still outstanding. 2/4 Analytical support – to be discussed at SRO meeting 7/4 as only limited support now available SI support confirmed PMO support confirmed for Workstream SROs. Safe Clean Care Harm Free to report into QSE
19	3	Absence of an Alert System	3.0 Development of Harm & IP dashboards	DW / RW / SB	01/03/21	30/06/21	In Progress	29/4 anticipated launch date of the harms dashboard is 21st May Enhanced IP dashboard – challenges re real-time data, currently options reviewed by informatics presentation at SCC steering group completed. User group testing to be undertaken Harm Dashboard created to support PSQG. Enhanced IP dashboard requirements to be confirmed by 6/4 to inform build time. 03/06 All Ip infromation being shown through IRIS so only one portal needs to be accessed for all IP information. Development of IP cockpit is part of the Safe Clean Care Harm Free Improvement Programme Informatics workstream being led by Dylan first meeting starting middle of June. Will close a action after first meeting as will report through to QSE.
24	4	Consistency of Communication	4.3 Review of communication process for Patients / NOK where nosocomial transmission has resulted in harm ensuring it is reflected in policy	MJ	01/04/21	30/06/21	In Progress	27/04 A weekly working group is in place and a report is being prepared for the Executive team aligned to the national framework and taking into account learning and collaboration from across all HBs via the HOPE Network. Previous update: Awaiting National framework release
25	4	Consistency of Communication	4.4 Review and strengthen operational escalation processes in line with IP triggers and escalation requirements	GM/MW	01/03/21	30/06/21	In Progress	03/06 MW reviewing bed spacing as part of SCC-HF. Clear escalation system being developed when needing to open extra bed capacity. Awaiting IP trigger confirmation 2/4 as per 3.1

	Main amendments to the guidance	What does this mean?	What does this mean for BCUHB?
1	Inclusion of the hierarchy of controls as these apply to COVID-19, with definitions and supporting materials for implementation. Also, where an unacceptable risk of transmission remains following the hierarchy of controls risk assessment, it may be necessary to consider the extended use of RPE for patient care in specific situations. The risk assessment should include evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area.	Are we prepared for a potential surge? This relates to identifying unacceptable risk with a key focus on high risk pathways only – so identifying these with the unacceptable risks focussed around all of the following •Ventilation •Over crowding •Prevalence of COVID-19 cases. The purpose of using the Hierarchy of controls methodology is to ensure that unacceptable risk does not occur. Therefore, where none of the above are achievable, these areas should not be considered for high risk pathways and should be removed from consideration.	HMTs to arrange forums to meet to include representation from H&S, IPC, OH, local clinicians, bed management teams, estates and facilities to: Define adequate ventilation For example: •6 area changes/hr •Opening of windows? how many windows – considering in this case patient groups (MHLD, elderly) Define overcrowding by considering what good looks like For example: •anything < 3.6 metres •Where patients may be sitting in chair whilst another is in bed should also be considered •The wandering patient •Additional space – staff breaks COVID-19 cases/prevalence - •Increasing incidence within local epidemiology •Explore previous outbreak hotspots. Much of this is being picked up through Safe Clean Care – Harm Free programme
2	Further advice on the use of valved respirators with examples of sterile procedures in the clinical setting.	This is not new guidance but provides clarification of when sterile procedure should be considered	

	Main amendments to the guidance	What does this mean?	What does this mean for BCUHB?
3	a) Further advice on minimising sessional or extended use of gowns where cohorts of confirmed COVID-19 patients are managed and there is a lack of single rooms/isolation rooms. a) Gloves are no longer required for some tasks whereby the staff is within 2 metres of the patient.	a) Where we experience reduced prevalence of COVID patient requiring AGPs with more patients being isolated, we should be able to reduce the sessional use of gowns due to reduce need to cohort b)This is limited to: • Giving oral medication • Distributing or collecting dietary trays • Writing in the patients charts	Be aware of the need to escalation into cohort areas should COVID cases requiring AGP increase – in which cases sessional use of gowns will be acceptable when going between patients, however should not be worn when moving around the unit or department Clear guidence is to be communicated and this monitored through the daily COVID/PPE audits and the IPC/PPE champions
4	Amendment to the AGP list to state 'upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs beyond the oro-pharynx'.	This is not new but additional has been included to clarify reference to open suction of the upper respiratory tract	
5	Individuals who are clinically extremely vulnerable from COVID-19 will require protective IPC measures depending on their medical condition and treatment whilst receiving healthcare for example, priority for single room isolation.	This strengthens the recommended pathway for this at risk patient group. The definition of extremely vulnerable patient remains the same as detailed within the green book on immunisation and previous guidance	The admission / clerking should identify any individual meeting the criteria for being clinical extremely vulnerable The IPT to update the single room matrix to prioritise these patients for single room

Cyfarfod a dyddiad: Meeting and date:	Quality Safety and Experience Committee 6th July 2021			
Cyhoeddus neu Breifat: Public or Private:	Public			
Teitl yr Adroddiad Report Title:	Covid-19 update			
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing & Midwifery			
Awdur yr Adroddiad Report Author:	Co-ordinated by Sally Baxter, Associate Director – Coronavirus Co-ordination Unit Programme reports produced by senior strategic leads			
Craffu blaenorol: Prior Scrutiny:	Executive Director of Public Health			
Atodiadau Appendices:	Appendix 1: staff vaccination tables Appendix 2: Nosocomial Action Plan			
Argymhelliad / Recommendation:				
The Committee is requested to note the position outlined in this report and provide comments on progress of the programmes and issues raised.				
Please tick as appropriate				
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	Ar gyfer Trafodaeth For Discussion	Ar gyfer sicrwydd For Assurance	x	Er gwybodaeth For Information
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable				N The report is brought for assurance. As the next stages of plans are developed – e.g. for the vaccination programme – the SED will be considered and future plans will take the duty into account.

Sefyllfa / Situation:

Since the report to the previous Committee meeting, the situation with regard to the Covid-19 pandemic has changed, with rapidly escalating levels of community transmission in parts of North Wales and the Delta variant becoming dominant. Easing of national restrictions has slowed in order to allow more time to study the impact of the current incidence trends and the effectiveness of the vaccination programme in reducing severe illness and hospital admissions. In this context the Health Board has continued to progress the major Covid programmes, to focus on the safety and quality of care provided and to work in partnership with other organisations on the response to the pandemic. This report provides an update on key programme areas of the Covid-19 response and issues of significance.

Cefndir / Background:

The programmes established to respond to the pandemic within the Health Board and with partners have been working to address the immediate impact and also to ensure readiness to respond to incidents, outbreaks and future trends. Across each programme, there have been changes as lessons are learned and the response amended. This report summarises some of the more significant issues in respect of:

- Vaccination
- Test, Trace and Protect
- Health and Safety
- the Ysbyty Gwynedd Outbreak Review
- the Nosocomial Action Plan
- matters requiring escalation from Executive Incident Management Team (EIMT)

It should be noted that there are mandated (and in respect of certain areas, statutory) reporting requirements in respect of all programmes.

Asesiad / Assessment & Analysis

Strategy Implications

The programmes work within and respond to national and BCUHB strategy in respect of the pandemic including the Welsh Government (WG) Coronavirus Control Plan (revised March 2021.) There are a range of more specific strategies in existence including, for example, the Testing Strategy, and the national Vaccination Strategy. In respect of Health and Safety, the Health Board is in the process of implementing the Occupational Health & Safety (OHS) 3-year Strategy.

Options considered

Each of the programmes has considered operational delivery options in respect of the model of operation as appropriate (such as vaccination delivery models.) As each programme is now well established, ongoing review of delivery is relevant to ensure ongoing response to revised national strategy and local circumstance.

There are limited alternative options in respect of compliance with legislation and guidance. Furthermore, failure to implement recommendations in respect of Health and Safety may result in criminal proceeding against the body corporate or individuals.

Financial implications

There are significant budgetary implications arising from the pandemic response, which are recorded and reported against Covid budgets. In respect of Health and Safety, a business case is being further developed and will be shared with the relevant Executive Directors. All programmes are incurring costs against Covid funding. Ongoing funding for Test, Trace & Protect (TTP) and vaccination programmes has been confirmed.

Risk analysis

The significant risks have been escalated to the Board Assurance Framework (BAF) and were previously agreed by the Quality, Safety & Experience (QSE) Committee. A separate report on the

BAF is on the agenda for the meeting. These include Infection Prevention Control (IPC), Health and Safety (H&S), Exposure to Covid-19 (IPC) and overall Covid programme 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. Failure to comply with Covid related regulations might also lead to fines and potential future compensation claims.

Impact Assessment

The newly established and defined programmes, including Vaccination and TTP, have undertaken Equality Impact Assessment and are continuing to review the action plans and mitigations on an ongoing basis. The Equity Steering Group of the Vaccination Programme has supported the operational delivery teams in targeting support to specific groups identified as being under-served by the programme, supported by the engagement team.

1. VACCINATION PROGRAMME

1.1 Delivery of the vaccination programme

The Vaccination Programme is now well established and progressing through delivery of first and second doses for all priority groups. All targets to date have been met:
- Vaccination of cohorts 1- 4 by 14th February
- Vaccination of cohorts 5 – 9 by 18th April
- Offer of a first dose vaccination to all adults over 18 in North Wales was achieved by 7th June

As at 28 June, over 870,000 vaccinations have been delivered across North Wales. Over 362,000 people have received both first and second doses.

Implementation of the programme has been required to be fluid in order to respond to changing scenarios in relation to priority cohorts, vaccine supply, and changing guidance from the Joint Committee Vaccination Immunisation (JCVI) in relation to the vaccines. In particular, changes to the recommended eligible groups for the Astra Zeneca vaccine have necessitated rapid changes in delivery. Since the previous report to the Committee, when the change in guidance on vaccines suitable for those aged under 29 had been implemented, the guidance was also amended for the 30 - 39 age group, with Astra Zeneca no longer recommended for use for this cohort.

Immediate next steps for the vaccination programme include:
- Retention of facilities at Deeside leisure centre to ensure successful completion of the initial vaccination cycle
- Secure new sites to ensure adequate local capacity including the OpTic Centre in St Asaph and Bangor Cathedral
- Expansion of the network of Local Vaccination Centres in the East
- Diversifying delivery methods to ensure all groups have access to the vaccine – leaving no-one behind
- Developing surge vaccination proposals to support areas of outbreaks and high risk areas and settings, including response to the impact of emerging Variants of Concern

- Planning for future requirements including the possibility of boosters and clarification of any likely immunisation arrangements for younger people detailed below

Ongoing issues of concern include:

- the change of recommended age groups for AZ, as referred to above, creating reluctance to take up the vaccine in the younger adult cohorts;
- vaccine supply concerns due to an increase of 60,000 in the 30-39 age group requiring Pfizer, as well as disruption caused by pressures on the global supply chain
- the increasing need to return to Business As Usual within the Health Board, with consequent impact on staff capacity and availability.

Further work will be undertaken pending confirmation of the Booster Programme by the JVCI, which will also link into the BCUHB flu vaccine programme for the purposes of planning and delivery.
The programme is currently working up future models for the booster programme, based on the most likely option identified by WG:

- Cohorts 1-9 and children 12 to 17 (2 doses)
- Cohort 10 in priority order from circa 6 months from 2nd dose.

This equates to circa 700,000 doses needing to be delivered. Outline plans are in development, to be shared with WG on the 18th June. Key assumptions still outstanding include vaccine type; length of programme; concurrent delivery with flu; start date; heterologous vaccine to initial; supply chain and potential primary care support. Confirmation is awaited on the detail.

1.2 Staff Vaccination Programme

Background

The background to the staff vaccination programme for staff in JCVI group 2 was included within the previous report to the Committee.

It was originally set out that all BCU staff would be vaccinated in Hospital Vaccination Centres (HVCs), with all other priority groups in the population directed to the Mass Vaccination Centres (MVCs). However, significant numbers of staff were invited to MVCs to ensure no wastage, particularly in the early weeks of the vaccination programme as systems were put in place. This resulted in staff in priority groups 3-4 also receiving invites to HVCs in the latter weeks of the programme, as well as external bodies in group 1-4 such as funeral directors.

HVCs reopened for 2nd doses on 16 February 2021 and closed week commencing 15th March 2021. Staff who received their 1st vaccine at an MVC received an invite to the same location for their 2nd dose.

Demographics

Updated demographic tables are included at Appendix 1. Key issues to note are as follows.

Table 1 indicates the numbers and percentage vaccinated with at least one dose for priority groups 1 – 4. This includes substantive and bank staff directly employed by BCU - a total of 16,677 staff have

been vaccinated with an uptake of 89.6%. This is significantly higher than uptake for the very successful flu vaccination programme in winter 2020.

Table 2 - excludes bank staff and indicated the numbers and percentage vaccinated with at least 1 dose for priority groups 1 – 4 by staff group and locality:
>East 89.7%
>Centre 92.7%
>West 94.7%

Table 3 - demonstrates the numbers and percentages vaccinated by Division in priority groups 1 – 4.
Table 4 - provides a breakdown of all staff who have received 2 doses in the Health Board by Division.
Table 5 - provides a breakdown of black, Asian and minority ethnic groups.
Table 6 - provides a breakdown by pay bands, showing demographic of vaccines.
Table 7 - provides a breakdown by age bands
Table 8 - provides a breakdown by gender

Ongoing vaccinations

All HVCs have now closed, and the residual vaccination activity required for staff falls into 3 categories
- Employees awaiting 1st / 2nd dose
- New employees in priority groups 1 – 4
- Employees who have not taken up offer of vaccination

- **Employees awaiting 1st / 2nd dose**

All staff in priority groups 1 – 4 who had not received / had an appointment for 1st / 2nd dose were asked to e-mail the staff Covid queries inbox by Thursday 18th March 2021. Lists were compiled and forwarded to the central vaccination team for invite to MVCs.

- **New employees in priority groups 1 – 4**

The draft process is detailed below:

Covid Vaccination Pathway For Occupational Workers Who Have not had The Covid Jab to Date – Draft 19.03.2021				
BCU Staff & Bank Staff				Non BCU staff
Dose 1	Dose 2 Astra	Dose 2 Pfizer	Large intakes	All scenarios

• New starter not had vaccination previously
• Work in Health Board but not had to date
   • DNA
   • Previous decliner
   • Had illness
   • Previous contraindication
	• New starter and had 1st jab elsewhere
	• Due dose 2 and out of schedule – recommence full course
		• New starter and had 1st jab elsewhere	e.g. students(400 in September) Large recruitment drive of 100 plus	For all doses & scenarios

Assess whether had Jab and date of previous jab Offer vaccinations within scheduled time scale				

At Occupational Health & Wellbeing Site	Go MVC	Go MVC	Go MVC

Additional considerations:

- Access to supplies of AstraZeneca (AZ) vaccine
- Occupational Health staff trained to operate the Welsh Immunisation System
- Occupational Health staff trained to support delivery of AZ vaccine
- Require a multiple of 10 people booked on each site at any one time to administer AZ vial
- Require vaccines with long expiry dates
- Standard Operating Procedure (SOP) for delivery across the 3 regional sites
- Identified areas for observation post vaccination
- Pending details of numbers of new starters

Staff who have not taken up the offer of the vaccine

Lists of staff who did not take up the offer of the vaccine following their 1st dose invites to HVCs (around the end of January), were forwarded to managers to enable them to have conversations re the benefits of vaccination. This will inevitably resulted in additional staff requesting a jab, but these have to be forwarded to MVCs. An additional exercise will now be undertaken with managers, but it should be noted that this is likely to generate additional concerns who have still not been able to have the 1st jab.

2. TEST, TRACE AND PROTECT

The Test, Trace and Protect programme (TTP) has continued to deliver essential support in the control of Covid, working in partnership with the six Local Authorities. Since the previous report, the First Minister has announced that TTP would remain a vital service in response to Covid at least until 31st March 2022. This has led to the challenge of securing resources across the region to support the delivery of the service, in terms of workforce as well as funding.

2.1 Testing

Demand for testing is starting to increase again across the region, as anticipated, as Covid restrictions have been eased.
- Demand on Community Testing Units (CTUs) has decreased over the 5 week reporting period to 1/6/21 and is now starting to increase again as testing is provided for all planned care procedures.
- Mobile Testing Units (MTUs) continue to operate across the region and support clusters and outbreaks, particularly related to Variant of Concern responses.
- LFD (Lateral Flow Device) Collect is now available in all counties across North Wales with three Leisure Centres offering LFD Collect in Anglesey.
- Local Testing Sites (LTS) are located in Rhyl, Wrexham, Bangor and Connah's Quay and are now providing a LFD Collect in the am and PCR (polymerase chain reaction) testing service pm.
- Regional Testing Sites (RTS) are located in Llandudno and Deeside and are also now providing PCR testing service in the am and LFD Collect pm.

The rollout of LFD Staff testing continues with LFD tests distributed to 14,044 (up to 26.05.21) NHS staff and students. Replenished stock is also being issued for those staff who are coming to the end of their first batch of kits. Shared Services are managing the replenishment of kits.

A Rapid Response Plan and SOPs has been agreed with Local Authorities to develop a regional response.

The Minister for Health and Social Services launched the Framework for Testing Patients on 10th March, across all health settings. In relation to testing vulnerable, high risk patients, plans for cancer patients have been agreed, all patients prior to receiving treatment in the central area will be tested. This commenced on May 24th 2021 in Central and will be introduced to patients in the West and then the East in a phased approach. Capacity planning is a priority and on-going with the three sites for pre-ops.

Community Testing Unit (CTU) capacity will be directed to supporting testing for planned care. This will mean keyworkers are directed to MTU, RTS and LTS facilities for testing.

Point of Care Testing:

- Lumira: IT tests are ongoing and a generic process has been prepared ready for approval.
- ID Now: Validation is now complete and maternity ready to go live and will be used for patient testing and could be made available for partner testing.
- Roche LIAT: Validation is ongoing and delivery of new LIATs is expected this week.
- The use of Point of Care Testing (POCT) is being considered for visitors but considerable discussion is required on the feasibility of this.
- Visitor testing: discussions are ongoing to establish solutions in response to updating of the Visiting Policy which is being led by the Nursing Directorate.

2.2 Tracing

- Total number of positive cases remained low in North Wales through May. Now, the growing trend in terms of the increase in contacts week on week, and the spread of the Delta variant, is seeing positive cases and associated contacts increase rapidly
- There are reported Variants of Concern (VoC) in the region. Tracers have been trained to deal with VoC and managing the identified cases effectively to ease the burden on Health Protection and Environmental Health Officers (EHOs).
- As previously noted the national modelling was published and provided a Realistic Worst Case (RWC) and Most Likely Scenario (MLS) in February to the end of June 2021. Further regional and VoC modelling is awaited and urgently required.
- Returning travellers is a growing pressure as numbers soar. At present there are over 3,855 travellers isolating in Wales and 669 in North Wales who continue to be managed by the Arriving Traveller Team (ATT). North Wales teams are supporting the national response.
- North Wales has agreed to the testing in the context of wider symptoms which are not caused by a known conditions such may be hay fever, including any or all of:
  - myalgia (muscle ache or pain);
  - excessive tiredness;

- persistent headache;
- runny nose or blocked nose;
- persistent sneezing;
- sore throat and/or hoarseness, shortness of breath or wheezing;
- any new or change in symptoms following a previous negative test.
Formal communication has been issued.

- Funding for 2021/22 has been agreed to 31/3/22.
- Performance as a whole has improved with an average of 74% of Contacts successfully contacted within 24 hours of the positive Index Case notified in the Customer Records Management (CRM) System (aim is to achieve 80%).

2.3 Protect

- Very high profile in Welsh Government as North Wales trail blazes with a number of Covid support hubs across the region.

The Covid Support Hubs continue to progress

- Holyhead: has been running for 4 weeks. Over 400 LFDs issued, and a number of individuals signposted to other services.
- Bangor: operational from 7 June
- Denbigh: operational from 14 June
- Plas Madoc: some services have commenced form 7 June, others to follow over the next 2 weeks
- Flintshire: location being addressed. Hopeful of an end-of-June start date

3. HEALTH AND SAFETY UPDATE: RIDDOR REPORTING

A full report on health and safety matters related to the Covid-19 pandemic was included in the update to the Committee in May. The annual health and safety report is submitted as a separate agenda item for this meeting. The report covers the full year period and data in this report gives an update on the past 2 months.

3.1 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reporting

In the first two months of 21/22, the following RIDDORs have been reported:

Area	COVID-19 RIDDORs	Non-COVID-19 RIDDORs	Total April & May 2021	Comparison total April & May 2020
East	0	7	7	8
Central	0	6	6	10
West	10	5	15	5

Total	10	18	28	23

As previously reported, increases seen in RIDDOR reporting during 2020/21 were predominantly due to the numbers reported as Occupational Diseases following the requirement to report a person at work who has been diagnosed as having COVID-19 attributed to an occupational exposure to coronavirus.

The 10 reported staff COVID-19 RIDDOR's in West were from Moelwyn Ward, Tryfan Ward and Conwy Ward. The lessons learned reporting references the following:

- Areas for improvement were social distancing of health care professionals in the ward environment, donning and doffing training and mask awareness, i.e. wearing correctly.
- Staff changing room availability and general de-cluttering of the ward.
- Ensure all audits are completed daily and updated.
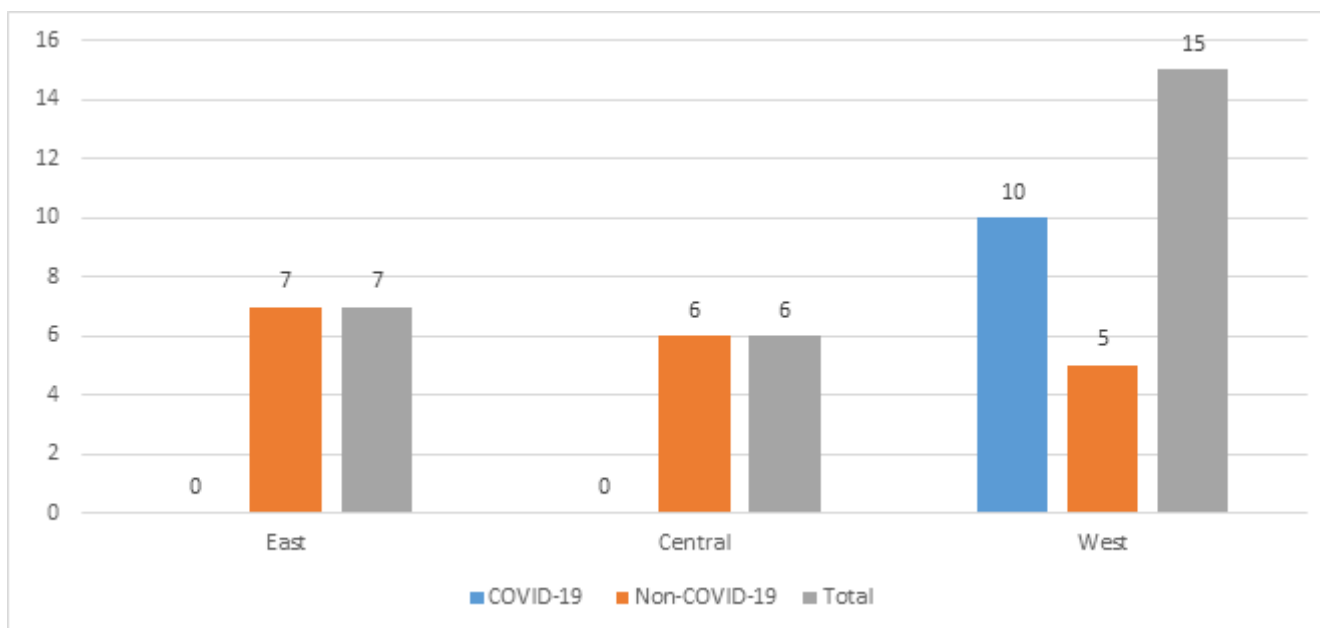
In April / May, the team undertook 60 social distancing visits and 34 Corporate Health & Safety (H&S) reviews. The team are working closely with Divisional leads and the Infection Prevention Control (IPC) team and lessons learned are feeding in to the Nosocomial Action Plan as well.

4. YSBYTY GWYNEDD OUTBREAK REVIEW

The external review of the Ysbyty Gwynedd Outbreak is being finalised and will be presented to the Board when available. The last outbreak-associated case was recorded on the 26th April 2021. The outbreak involved a total of 11 wards across Ysbyty Gwynedd, 1 ward in Ysbyty Alltwen and 1 ward in Ysbyty Eryri. In line with the Health Board's Outbreak Control Policy IPC05, the strategic Outbreak

Control Team continued to oversee management of the outbreak, seek assurance regards control measures and respond to intelligence for a further 28 days to ensure transmission episodes had been interrupted, with updates provided to both Executive and Independent Members as regards progress.

The position as at closure of the outbreak is set out below.

4.1 Outbreak closure position – numerical

Cumulative position from 28th January 2021

Patients confirmed as positive		Total Patients	Outbreak	Deaths
HCAI cases	Definite	87	77	16
	Probable	66	51	15
		153	128	31
Non-HCAI cases	Indeterminate	56	37	17
Sub Total Outbreak		209	165	47
	Community Onset	77		20
Total Cases	**(as per Line List)**	286	165	68

4.2 Outbreak closure position - graphical

Positive patients (n=286) YG and West Outbreak, 28th January 2021 onwards. *Patient data PowerBI, midnight 21st May 21*
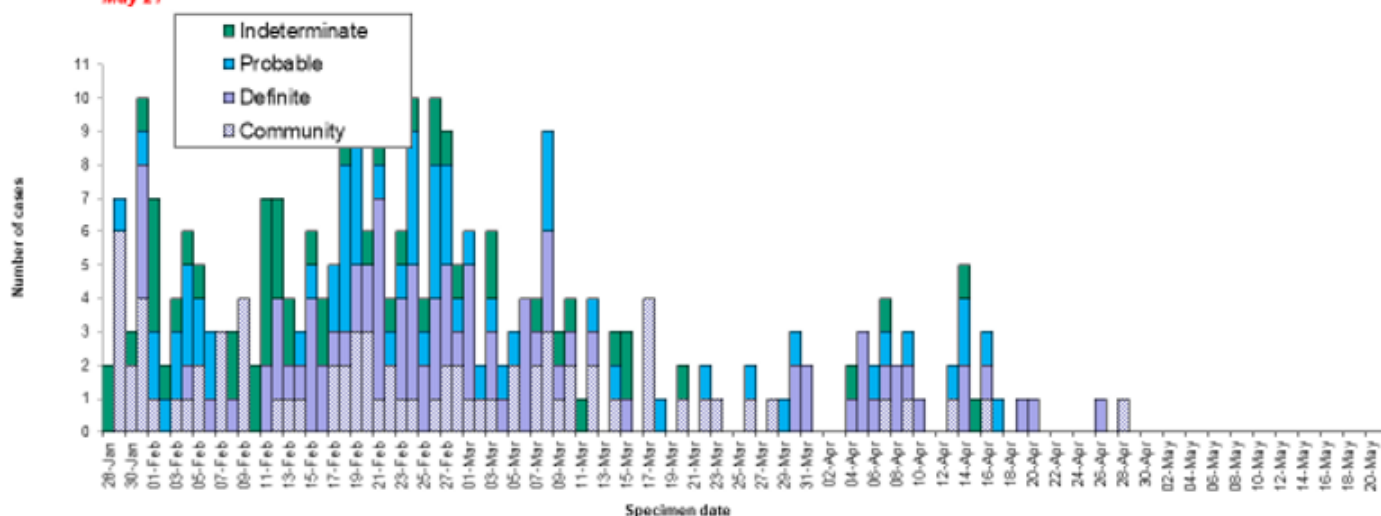
4.3 Outbreak closure position – staff numbers

West Staff Data (all workers including Substantive, Bank and Agency): full SitRep dated 21 May

- Number of workers reported as testing positive for West outbreak since 17/05 = 0
- Number of workers reported as testing positive for West locality since 17/05 = 0 (includes outbreak areas)
- Cumulative figures for West outbreak wards = 61 since 28th January: 61 BCU employees (figure includes 4 student nurses), 0 Agency workers
- Total number of staff tests undertaken across West area = 4,437 (outbreak wards 802)
- Staff in West in isolation = 2, 0 commencing 17/05

4.4 All Wales comparative HCAI data
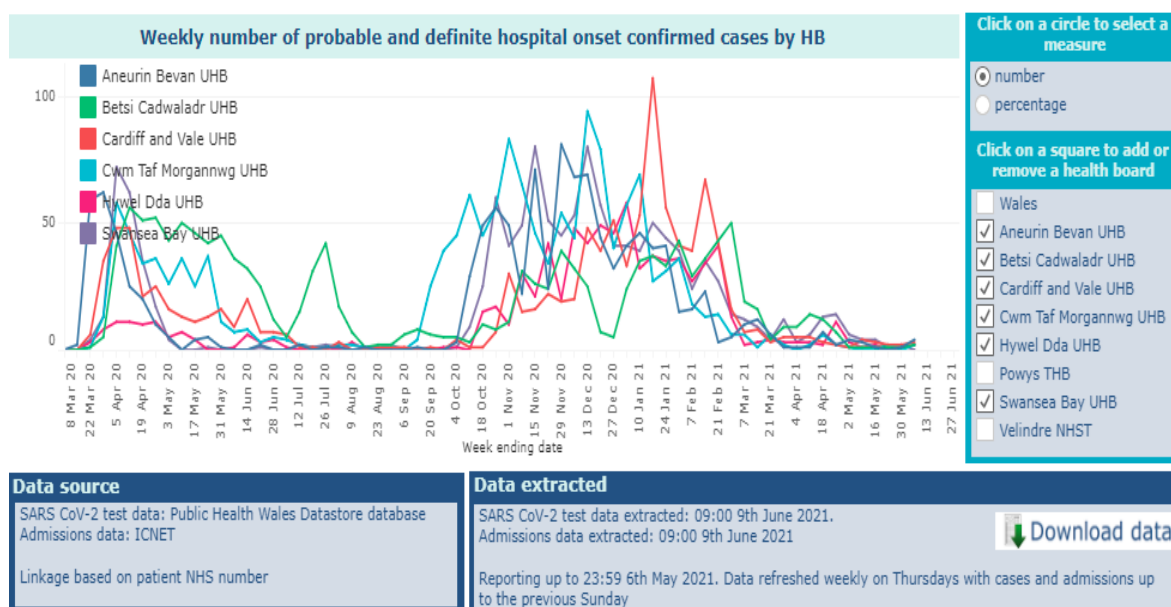
The all Wales data shows the pattern and impact of hospital onset confirmed cases. All Health Boards have experienced similar and significant peaks, with the timing differing, and in the second wave period BCUHB peaks occurring slightly later. This is consistent with the timing of peak case incidence in North Wales, albeit that the causes are multifactorial. It can be noted that Health Boards of similar size have experienced higher peaks in the second wave period.

4.5 Analysis

Presentations were provided by the current Hospital Management Team members to both Quality Safety Experience Committee and Executive Management Group to reflect on learning and provide some insight into the situation highlighting some key points:

- Understanding of changes between 1st wave to 2nd wave
- Complacency – experienced first surge with no adverse outcomes
- Human Factors – both Public, Stakeholders and BCUHB staff
- Implementation of actions from previous learning
- Estate issues

In summary:

- Leadership and Behaviour
- Operational/Practice
- Technical
- Infrastructure

Epidemiological evidence confirmed predominance of the B.1.1.7 variant of concern (the Alpha variant, previously known as Kent variant) associated with higher rates of transmission than previous variants and considerable concern around levels of community transmission. Public Health Wales (PHW) colleagues also confirmed when one type is dominant amongst samples from both the community and within hospital, transmission routes are difficult to identify. Repeated introductions may have occurred of the same type on different wards, rather than between ward transmissions

Control measures in place:

- admission screening
- 5 day repeat screening
- Discharge screening
- Staff movement monitoring
- Non Clinical transfers (capacity impact)
- Wandering patient checklist
- Discharge information
- Senior Leadership Peer review programme
- Site Access Monitoring
- Enhanced cleaning
- Infection prevention measures compliance
- Lateral flow device testing for staff

A further assessment has been undertaken in parallel under the guise of the safe clean care programme; this is informing ongoing work and reported via the Infection Prevention Steering Group.

An external Health Board review is concluding with a draft report anticipated imminently.

5. NOSOCOMIAL ACTION PLAN

The Nosocomial Action Plan which gives a full update against actions agreed including building on lessons learned is included at Appendix 2.

Given the increasing incidence rates within the community currently, the lessons learned from the outbreak management and the actions ongoing within the Nosocomial Action Plan are critical to support the effective prevention and management of potential HCAIs across healthcare settings. recognising the increased transmissibility of the Delta variant, this is vital to ensure that staff, patients and the community are protected from risk of infection in our services.

Updated visiting guidance has been issued by Welsh Government, which includes principles for organisations to consider regarding hospital visiting, including consideration of the use of testing as an additional protective measure. This is being developed as referenced in the section above on Testing.

As is to be expected, there has been a slight upturn in the number of staff reporting positive test results, although the increase is currently small (fewer than 10 in the week to 20/06/21). There has also been an increase in numbers of staff self-isolating following contact with an index case. The figures are being monitored on a weekly basis. There is a risk to sustainability of some elements of services should a number of staff be required to self-isolate, leading to loss of capacity. Staff are required to escalate any such identified risks immediately.

Whilst the Delta variant was identified as an emerging variant of concern and the "contain" approach was in place, an advisory self-isolation period of 14 days was notified to all contacts of index cases by the Tracing service on the advice of Public Health Wales. As the Delta variant has become the dominant variant, previous risk management processes now apply, and contacts will not be asked to voluntarily isolate beyond the statutory 10-day period. However, advice is that staff with direct patient contact roles should not undertake duties, which involve contact with vulnerable people during the additional 4 days following self-isolation, should avoid social contact and should adhere strictly to all Covid-safe precautions.

6. EXECUTIVE INCIDENT MANAGEMENT TEAM

As reported to Board, the Executive Incident Management Team (EIMT) has reduced in frequency to fortnightly, with all programmes required to submit a highlight report and review and update programme risks. Surveillance data is monitored on a minimum weekly basis and any significant change reported through Gold commander to the Executive Team.

In the previous reporting period the Care Home Cell, which was established under the Strategic Co-ordinating Group, has been stood down with the agreement of the Health & Social Care Recovery Group. There are daily and weekly multi-agency meetings which continue to monitor the situation. With the recent increase in community transmission, a small number of residential and nursing homes have reported positive test results. This is being carefully monitored. The extent of onward

infection within the homes affected appears to be significantly reduced compared to previous phases of the pandemic, but it is early to draw any firm conclusions.

EIMT has recently received and approved recommendations in relation to maternity hospital visiting guidelines, in addition to actions relating to the ongoing delivery of the vaccination programme and the changes to the commissioned use of the Ysbytai Enfys. Updated SOPs for the vaccination programme are also approved by clinical members of EIMT and recorded. The current position with regard to the Delta variant was discussed at the Board Workshop on 24 June 2021

7. RECOMMENDATION

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

Appendix 1
Staff vaccination programme – demographic tables

Table 1 – staff vaccinated with at least one dose by staff group

Staff Group	Priority Group 2 Frontline workers**			Priority Group 3 Non DPC staff 75 years and above			Priority Group 4 Non DPC staff 70 years and above Clinically Extremely vulnerable			Total Priority 2 - 4		
	Invited and vaccinated	Invited and Not Vaccinated	% Vaccinated	Invited and vaccinated	Invited and Not Vaccinated	% Vaccinated	Invited and vaccinated	Invited and Not Vaccinated	% Vaccinated	Vaccinated	Not Vaccinated	% Vaccinated
Add Prof Scientific and Technic	770	66	92.11%							770	66	92.11%
Additional Clinical Services	3797	335	91.89%							3797	335	91.89%
Administrative and Clerical	299	10	96.76%	2		100.00%	151	4	97.42%	452	14	97.00%
Allied Health Professionals	1028	78	92.95%							1028	78	92.95%
Estates and Ancillary	911	45	95.29%	3		100.00%	54	2	96.43%	968	47	95.37%
Healthcare Scientists	259	22	92.17%							259	22	92.17%
Medical and Dental	1199	165	87.90%							1199	165	87.90%
Nursing and Midwifery Registered	5478	425	92.80%							5478	425	92.80%
Students	48	15	76.19%							48	15	76.19%
BCU Bank	2646	767	77.53%	7	1	87.50%	25	5	83.33%	2678	773	77.60%
BCU Bank (Active)	2007	464	81.22%	3	1	75.00%	19	2	90.48%	2029	467	81.29%
BCU Bank (Inactive)*	639	303	67.83%	4		100.00%	6	3	66.67%	649	306	67.96%
BCU Total	16435	1928	89.50%	12	1	92.31%	230	11	95.44%	16677	1940	89.58%
BCU Total exc Inactive Bank	15796	1625	90.67%	8	1	88.89%	224	8	96.55%	16028	1634	90.75%

*Bank assignments not worked March 21 to June 21

Table 2 – staff vaccinated with at least one dose by staff group and locality

Region	Staff Group	Priority Group 2 Frontline (DPC) workers			Priority Group 3 non DPC staff 15 years and above			Priority Group 4 non DPC staff 16 years and above Clinically Extremely vulnerable			Total Priority 2 - 4		
		Invited and vaccinate	Invited and Not Vaccinat	% Vaccinated	Invited and vaccinate	Invited and Not Vaccinat	% Vaccinated	Invited and vaccinate	Invited and Not Vaccinat	% Vaccinated	Vaccinated	Not Vaccinated	% Vaccinated
East	Add Prof Scientific and Technic	242	32	88.32%							242	32	88.32%
	Additional Clinical Services	1293	174	88.14%							1293	174	88.14%
	Administrative and Clerical	103	3	97.17%	1		100.00%	46	2	95.83%	150	5	96.77%
	Allied Health Professionals	350	29	92.35%							350	29	92.35%
	Estates and Ancillary	309	7	97.78%	1			13	2	86.67%	323	9	97.29%
	Healthcare Scientists	76	6	92.68%							76	6	92.68%
	Medical and Dental	360	68	84.11%							360	68	84.11%
	Nursing and Midwifery Registered	1777	200	89.88%							1777	200	89.88%
	Students	10	3	76.92%							10	3	76.92%
East Total		4520	522	89.65%	2		100.00%	59	4	93.65%	4581	526	89.70%
Centre	Add Prof Scientific and Technic	251	20	92.62%							251	20	92.62%
	Additional Clinical Services	1278	108	92.21%							1278	108	92.21%
	Administrative and Clerical	143	5	96.62%	1		100.00%	55	1	98.21%	199	6	97.07%
	Allied Health Professionals	397	33	92.33%							397	33	92.33%
	Estates and Ancillary	319	19	94.38%	1		100.00%	14		100.00%	334	19	94.62%
	Healthcare Scientists	110	8	93.22%							110	8	93.22%
	Medical and Dental	465	62	88.24%							465	62	88.24%
	Nursing and Midwifery Registered	1928	136	93.41%							1928	136	93.41%
	Students	23	1	95.83%							23	1	95.83%
Centre Total		4914	392	92.61%	2		100.00%	69	1	98.10%	4985	393	92.69%
West	Add Prof Scientific and Technic	277	14	95.19%							277	14	95.19%
	Additional Clinical Services	1226	53	95.86%							1226	53	95.86%
	Administrative and Clerical	53	2	96.36%				50	1	98.04%	103	3	97.17%
	Allied Health Professionals	281	16	94.61%							281	16	94.61%
	Estates and Ancillary	283	19	93.71%	1		100.00%	27		100.00%	311	19	94.24%
	Healthcare Scientists	73	8	90.12%							73	8	90.12%
	Medical and Dental	374	35	91.44%							374	35	91.44%
	Nursing and Midwifery Registered	1773	89	95.22%							1773	89	95.22%
	Students	15	11	57.69%							15	11	57.69%
West Total		4355	247	94.63%	1		100.00%	77	1	98.72%	4433	248	94.70%
Grand Total***		13789	1161	92.23%	5		100.00%	205	6	97.16%	13999	1167	92.31%
*** Figures exclude Bank and as such different totals													

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Table 3 - Demonstrates the numbers and percentages vaccinated by Division in priority groups 1 – 4

Staff Group	Priority Group 2 Frontline workers**			Priority Group 3 Non DPC staff 75 years and above			Priority Group 4 Non DPC staff 70 years and above Clinically Extremely vulnerable			Total Priority 2 - 4		
	Invited and vaccinated	Invited and Not Vaccinated	% Vaccinated	Invited and vaccinated	Invited and Not Vaccinated	% Vaccinated	Invited and vaccinated	Invited and Not Vaccinated	% Vaccinated	Vaccinated	Not Vaccinated	% Vaccinated
Area Centre	1889	147	92.78%				16	1	94.12%	1905	148	92.79%
Area East	1945	196	90.85%	2		100.00%	23	1	95.83%	1970	197	90.91%
Area West	1324	70	94.98%				14		100.00%	1338	70	95.03%
MHLD	1561	138	91.88%				13		100.00%	1574	138	91.94%
NWMCS	1034	61	94.43%	1		100.00%	12		100.00%	1047	61	94.49%
Womens	639	56	91.94%				3		100.00%	642	56	91.98%
YGC	1470	161	90.13%				10		100.00%	1480	161	90.19%
YG	1375	81	94.44%				16	1	94.12%	1391	82	94.43%
YMW	1273	174	87.98%				7		100.00%	1280	174	88.03%
Estates and Facilities	895	45	95.21%	2		100.00%	44		100.00%	941	45	95.44%
Corporate	384	32	92.31%				47	3	94.00%	431	35	92.49%
BCU Bank	2646	767	77.53%	7	1	87.50%	25	5	83.33%	2678	773	77.60%
BCU Total	**16435**	**1928**	**89.50%**	**12**	**1**	**92.31%**	**230**	**11**	**95.44%**	**16677**	**1940**	**89.58%**

Table 4 Breakdown of staff who have received 2 doses in the Health Board by Division

All Staff								
Type	Division	Vaccinated 1 Dose	Vaccinated 1 Dose %	Vaccinated 2 Doses	Vaccinated 2 Doses %	Not Vaccinated	Not Vaccinated %	Grand Total
BCU	Area Centre	180	7.5%	2061	85.9%	159	6.6%	2400
	Area East	159	6.3%	2148	85.2%	215	8.5%	2522
	Area West	130	8.0%	1407	87.0%	81	5.0%	1618
	MHLD	172	8.7%	1647	83.8%	147	7.5%	1966
	NWMCS	105	8.1%	1129	86.8%	66	5.1%	1300
	Womens	74	10.0%	605	81.6%	62	8.4%	741
	YGC	186	9.8%	1541	80.9%	177	9.3%	1904
	YG	193	11.5%	1391	82.9%	93	5.5%	1677
	YMW	137	8.3%	1337	80.8%	181	10.9%	1655
	Estates and Facilities	148	9.6%	1323	85.9%	70	4.5%	1541
	Corp	311	18.7%	1237	74.5%	112	6.7%	1660
BCU - Bank		596	15.6%	2374	62.1%	850	22.3%	3820
Grand Total		2391	10.5%	18200	79.8%	2213	9.7%	22804

Priority Groups 1 to 4								
Type	Division	Vaccinated 1 Dose	Vaccinated 1 Dose %	Vaccinated 2 Doses	Vaccinated 2 Doses %	Not Vaccinated	Not Vaccinated %	Grand Total
BCU	Area Centre	147	7.2%	1758	85.6%	148	7.2%	2053
	Area East	121	5.6%	1849	85.3%	197	9.1%	2167
	Area West	111	7.9%	1227	87.1%	70	5.0%	1408
	MHLD	134	7.8%	1440	84.1%	138	8.1%	1712
	NWMCS	76	6.9%	971	87.6%	61	5.5%	1108
	Womens	62	8.9%	580	83.1%	56	8.0%	698
	YGC	161	9.8%	1319	80.4%	161	9.8%	1641
	YG	167	11.3%	1224	83.1%	82	5.6%	1473
	YMW	112	7.7%	1168	80.3%	174	12.0%	1454
	Estates and Facilities	80	8.1%	861	87.3%	45	4.6%	986
	Corp	27	5.8%	404	86.7%	35	7.5%	466
BCU - Bank		501	14.5%	2177	63.1%	773	22.4%	3451
Grand Total		1699	9.1%	14978	80.5%	1940	10.4%	18617

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Table 5 - Black, Asian and Minority Ethnic Groups

Type	DPC List (priority group 2)	Vaccinated	Not Vaccinated	Grand Total	
BCU	Yes	875	116	991	
	No	68	<10	78	
BCU - Bank		169	97	266	
Grand Total		1112	223	1335	
By Staff Group					

Type	DPC List (priority group 2)	Staff Group	Vaccinated	Not Vaccinated	Grand Total
BCU	yes	Add Prof Scientific and Technic	23	<10	33
		Additional Clinical Services	106	17	123
		Administrative and Clerical	<10		10
		Allied Health Professionals	31	<10	41
		Estates and Ancillary	11		11
		Healthcare Scientists	20	<10	30
		Medical and Dental	452	63	515
		Nursing and Midwifery Registered	230	23	253
		Students	<10		10
	No	Administrative and Clerical	43	<10	53
		Estates and Ancillary	25		25
BCU - Bank			169	97	266
Grand Total			1130	240	1370

Values less than 10 in these tables have been shown as <10 to respect confidentiality

Black, Asian and Minority Ethnic Groups all staff vaccinations

Pay Band	Vaccinated	Vaccinated %	Not Vaccinated	Not Vaccinated %	Grand Total
Permanent/Fixed Term	943	88%	123	12%	1066
Bank/Locum/Honorary	169	64%	97	36%	266
	1112	83.5%	220	16.5%	1332

Values less than 10 in these tables have been shown as <10 to respect confidentiality

Black, Asian and Minority Ethnic Groups priority groups 2-4 vaccinations

Pay Band	Vaccinated	Vaccinated %	Not Vaccinated	Not Vaccinated %	Grand Total
Permanent/Fixed Term	884	88%	116	12%	1000
Bank/Locum/Honorary	166	63%	96	37%	262
	1050	83.2%	212	16.8%	1262

Values less than 10 in these tables have been shown as <10 to respect confidentiality

Table 6a - Groups Vaccinated by Pay Band

Table 6a - Groups Vaccinated by Pay Band

Pay Band	Vaccinated	Vaccinated %	Not Vaccinated	Not Vaccinated %	Grand Total
Band 2	5529	89%	663	11%	6192
Band 3	2904	93%	220	7%	3124
Band 4	1330	90%	145	10%	1475
Band 5	3578	90%	403	10%	3981
Band 6	2991	93%	228	7%	3219
Band 7	1644	95%	86	5%	1730
Band 8 to 9	921	93%	70	7%	991
M&D/Non AfC/Ad Hoc Grades	1694	81%	398	19%	2092
Grand Total	**20591**	**90.3%**	**2213**	**9.7%**	**22804**

includes Bank

Table 6b - Priority Groups 2- 4 Vaccinated by Pay Band

Pay Band	Vaccinated	Vaccinated %	Not Vaccinated	Not Vaccinated %	Grand Total
Band 2	4423	88%	586	12%	5009
Band 3	1914	93%	151	7%	2065
Band 4	648	85%	115	15%	763
Band 5	3155	89%	382	11%	3537
Band 6	2757	93%	209	7%	2966
Band 7	1456	95%	72	5%	1528
Band 8 to 9	694	93%	49	7%	743
M&D/Non AfC/Ad Hoc Grades	1630	81%	376	19%	2006
Grand Total	**16677**	**89.6%**	**1940**	**10.4%**	**18617**

Table 7a - Groups Vaccinated by Age Band

Table 7a - Groups Vaccinated by Age Band

Age Band	Vaccinated	Vaccinated %	Not Vaccinated	Not Vaccinated %	Grand Total
<=20 Years	185	86%	29	14%	214
21-25	1273	84%	243	16%	1516
26-30	1927	82%	435	18%	2362
31-35	2154	83%	439	17%	2593
36-40	2204	88%	310	12%	2514
41-45	2226	92%	202	8%	2428
46-50	2659	94%	168	6%	2827
51-55	3054	96%	132	4%	3186
56-60	2814	95%	160	5%	2974
61-65	1510	96%	64	4%	1574
66-70	412	96%	15	4%	427
>=71 Years	173	92%	16	8%	189
Grand Total	**20591**	**90.3%**	**2213**	**9.7%**	**22804**

Table 7b - Priority Groups 2-4 Vaccinated by Age Band

Age Band	Vaccinated	Vaccinated %	Not Vaccinated	Not Vaccinated %	Grand Total
<=20 Years	154	89%	19	11%	173
21-25	1107	84%	217	16%	1324
26-30	1667	81%	403	19%	2070
31-35	1832	82%	403	18%	2235
36-40	1786	87%	262	13%	2048
41-45	1826	91%	178	9%	2004
46-50	2080	93%	145	7%	2225
51-55	2353	96%	105	4%	2458
56-60	2187	94%	134	6%	2321
61-65	1178	96%	46	4%	1224
66-70	334	97%	12	3%	346
>=71 Years	173	92%	16	8%	189
Grand Total	**16677**	**89.6%**	**1940**	**10.4%**	**18617**

Table 8a - Groups Vaccinated by Gender

Gender	Vaccinated	Vaccinated %	Not Vaccinated	Not Vaccinated %	Grand Total
Female	16693	91%	1720	9%	18413
Male	3898	89%	493	11%	4391
Grand Total	**20591**	**90.3%**	**2213**	**9.7%**	**22804**

Table 8b - Priority Groups 2-4 Vaccinated by Gender

Gender	Vaccinated	Vaccinated %	Not Vaccinated	Not Vaccinated %	Grand Total
Female	13623	90%	1511	10%	15134
Male	3054	88%	429	12%	3483
Grand Total	**16677**	**89.6%**	**1940**	**10.4%**	**18617**

Nosocomial Action Plan

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.

Version No: 28
Date updated: 15/06/2021

Total No of Logged Actions	31
Total Overdue	0
Total Completed	24
Total Not Yet Due / In Progress	7

Gantt Chart Start Date (Monday)	01/03/21

Total No of Actions	Ref. Activity No.	Activity Description	Activity Description	Activity Lead	Start Date	Target Completion Date	Revised Activity Completion Date	Activity Completed Date	Activity status -auto-populates	Update/Issues affecting delivery	Assurance (how do we know the activity has been delivered and embedded?)
3	1	Compliance with the WG 16 point plan / toolkit	1.2 Independent review of YG outbreak to have clear TOR approved by Board and reported back via QSE upon completion	GH	01/03/21	30/06/21			In Progress	5/5 Reviewer confirmed draft report anticipated 1st June 2021 29/4 TOR revised and confirmed via the office of the Board Secretary. External review commissioned via the HB process and reviewer confirmed. 24/4 external review completed and findings submitted DH & SB Previous update: External reviewer identified. TOR drafted for Executive and Board approval. TOR finalised with independent reviewer, review underway 2/4 Current review ceased. TOR to be amended following receipt of further comments from IMs & Chairman. New reviewer to be identified – request sent to WoD	
5	1	Compliance with the WG 16 point plan / toolkit	1.4 Complete revision of remaining out of date policies **and disseminate revised policies**	AL / SF	01/02/21	30/06/21			In Progress	29/4 confirmation that all remaining policy reviews to be complete by June 2021 28/4 AL - A review of the out of date policy, protocol, guidelines documents continues with further documents on the intranet for Consultation prior to going to IPSG in May. The remaining policies will go out for Consultation early June to be approved by IPSG in June. This is with the exception of the Water Safety which will be in July as it re to ensure it aligns with the Water Safety Plan. Previous update - Review complete, remaining policies under review. Chairs action taken where applicable for approval, some will require QSE approval 2/4 a number of updated policies are now on the intranet for consultation	
10	1	Compliance with the WG 16 point plan / toolkit	1.8 Strengthen IP expertise and resource – considering Office of the Medical Director and Pharmacy colleagues	AG / SB	01/03/21	30/06/21			In Progress	5/5 peer review process with Area colleagues in pilot 29/4 IP West lead change in personnel as of W/C 10/5 Additional support provided to YG by Deputy IP lead. Further external support requested via WoD 2/4 nil received via WoD YG Walk around and site presence continues to be supported by Deputy IP lead & SCDON minimum weekly.	
14	2	Embedding of learning and practices to ensure sustainable zero tolerance to patient Harm as a result nosocomial transmission **across all clinical areas**	2.1 Develop capacity for targeted support of above work programmes with behavioural change / psychology/ PMO / Analytical expertise	DH/GA/DW	01/03/21	31/05/21	30/06/21		In Progress	5/5 further PMO support required – gap analysis underway as programme is evolving Analytic provision requires further review – Meeting TBA with GH and Dylan Williams. Proposal for12 month programme resourses to embed the programme to sustain the gains submitted to June QSE for approval to bid for capacity and capability funding. 28/04 Additional longer term support is needed at a senior PMO level to support the programme of work (2 off if possible) Previous update Additional PMO support required with the Site and Area teams, request for 3x Band 7 Project Managers and 3x Band 3-4 Project Admin Support, required for 6 months. In addition, Analytical support is still outstanding. 2/4 Analytical support – to be discussed at SRO meeting 7/4 as only limited support now available SI support confirmed PMO support confirmed for Workstream SROs. Safe Clean Care Harm Free to report into QSE moving forward.	
19	3	Absence of an Alert System	3.0 Development of Harm & IP dashboards	DW / RW / SB	01/03/21	30/06/21			In Progress	29/ 4 anticipated launch date of the harms dashboard is 21st May Enhanced IP dashboard – challenges re real-time data, currently options reviewed by informatics presentation at SCC steering group completed. User group testing to be undertaken Harm Dashboard created to support PSQG. Enhanced IP dashboard requirements to be confirmed by 6/4 to inform build time. 03/06 All Ip infromation being shown through IRIS so only one portal needs to be accessed for all IP information. Development of IP cockpit is part of the Safe Clean Care Harm Free Improvement Programme Informatics workstream being led by Dylan first meeting starting middle of June. Will close action after first meeting as will report through to QSE.	

24	4	Consistency of Communication	4.3 Review of communication process for Patients / NOK where nosocomial transmission has resulted in harm ensuring it is reflected in policy	MJ	01/04/21	30/06/21			In Progress	11/60 - National framework received and BCU plans in place, dependent upon business case being approved that is being submitted to the Exec Team w/c 14 June 2021 27/04 A weekly working group is in place and a report is being prepared for the Executive team aligned to the national framework and taking into account learning and collaboration from across al HBs via the HOPE Network.	
25	4	Consistency of Communication	4.4 Review and strengthen operational escalation processes in line with IP triggers and escalation requirements	GM/MW	01/03/21	30/06/21			In Progress	03/06 MW reviewing bed spacing as part of SCC-HF. Clear escalation system being developed when needing to open extra bed capacity.Awaiting IP trigger confirmation 2/4 as per 3.1	

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 6th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Serious Incident Report - April and May 2021 (including separate Never Event Thematic Report)
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris Executive Director of Nursing and Midwifery/Deputy Chief Executive
Awdur yr Adroddiad **Report Author:**	Matthew Joyes, Acting Associate Director of Quality Assurance Dr Kath Clarke, Head of Patient Safety Sarah Musgrave, Lead Manager (Incidents and Learning)
Craffu blaenorol: **Prior Scrutiny:**	Review by: - Debra Hickman, Nurse Director - Matthew Joyes, Acting Associate Director of Quality Assurance - Presentation at the Corporate Patient Safety and Quality Group and Corporate Patient and Carer Experience Group
Atodiadau **Appendices:**	1. Serious Incident Report - April and May 2021 2. Never Event Thematic Report

Argymhelliad / Recommendation:

The Committee is asked to note this report and the significant increase in the number of falls with harm that have occurred over the last 18 months and the planned improvement work.

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

Sefyllfa / Situation:

This 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 several 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.

In addition, at the request of the Committee Chair and Executive Lead, a thematic report on Never Events is included.

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.
Asesu a Dadansoddi / 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.

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable. |

APPENDIX 1

Serious Incident Report
April and May 2021

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 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.

1.3 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.

1.4   In October 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 regularly met with the NHS Wales Delivery Unit and will continue its strong working relationship with them.

1.5 A revised NHS Wales National Incident Reporting Policy was received in June 2021.

1.6   This report provides the Quality, Safety and Experience Committee with information and analysis on Serious Incidents and Never Events occurring in April and May 2021 although 14 months of trend data is included to allow for period on period comparison in the last year.

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. | **REPORTABLE SERIOUS INCIDENTS** |

2.1 As of 4th January 2021, in response to increased pressure to services as the number of patients admitted with and staff testing positive for Covid-19 increased, the Welsh Government reintroduced their reduced list of reportable Serious Incidents.

2.2 As part of the new National Incident Reporting Policy mentioned above, a revised reporting requirement is in place from 14th June 2021. This covers both Serious Incidents (now to be called nationally reportable) and sensitive issue/no surprises notifications (now to be called Early Warning). This new national requirement will be detailed in the next full Patient Safety Report.

2.3 During the time period under review, 14 Serious Incidents were reported nationally to the Delivery Unit and 4 sensitive issue notifications were submitted to Welsh Government.
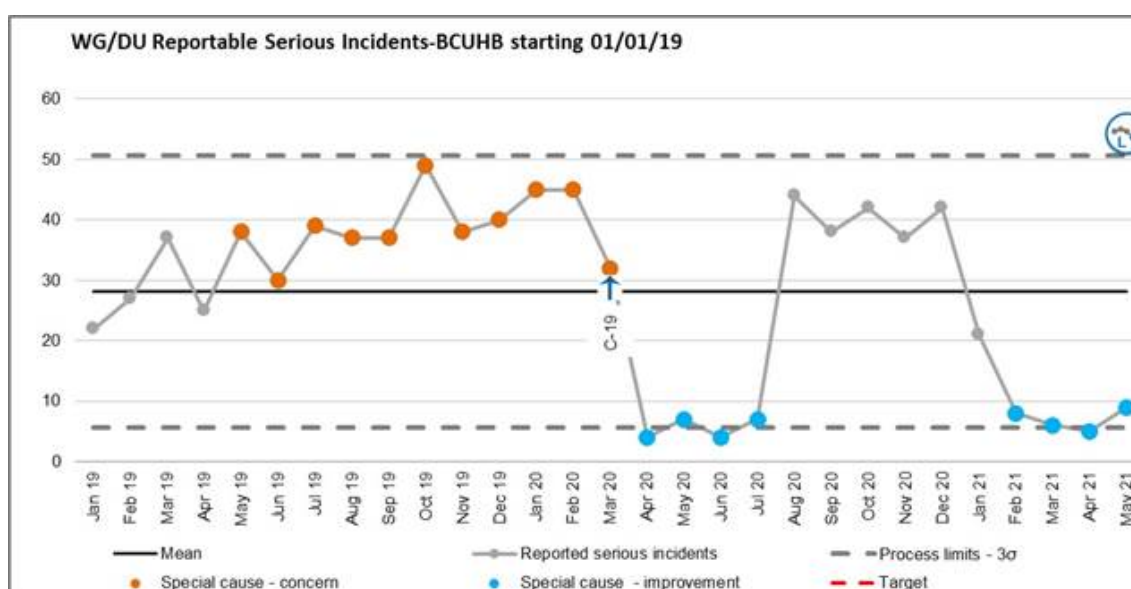
2.4 At the time of writing, 43 Serious Incidents remain open of which 31 are overdue (72%). Over the last three months these figures have remained fairly consistent. The number of incidents reported has remained low due to a suspension of some of the criteria for reporting. Only 14 incidents were reported in April and May 2021. It could be argued that there has been a missed opportunity to clear the overdue incidents whilst numbers reported were drastically reduced. Scrutiny is in place along with support to ensure services reduce the number of overdue incidents. The predominance of overdue incidents relate to Central Acute (8), MHLD (5), West Acute (7) and East Acute (5). A small number of incidents are overdue by twelve months (2, one is being investigated through the Prudic process and the other sits with Radiology (which is a complex multi service, multi-patient investigation), a small number (2) are overdue by 6-12 months and (11) are overdue by 3-6 months.

Overall closure rate within timeframe for the year is now 25% which is a reduced level of compliance compared with 66% in January 2021.

3.	SPECIFIC SERIOUS INCIDENTS

3.1 The following Serious Incidents were reported during the reporting period are being specifically highlighted for the attention of the Committee (this includes those which meet the national criteria and local criteria):

Mental Health and Learning Disability Division

- Death by suicide of a patient open to Community Mental Health Team (CMHT) (n=2).
- Unexpected deaths of patients open to community services including substance misuse services (cause unknown) in April and May 2021 (n= 21). Same period in 2020 (n=12) and in 2019 (n=9).

Of these unexpected deaths, 10 occurred in the East, 8 in Central and 3 in West. A total of 7 patients were found dead at home. 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.

- In patient suicide (n=1). Patient found having completed suicide using a dressing gown cord as a ligature. As well as a Make it Safe Plus being undertaken, a Rapid Learning Panel was also convened within 24 hours to ensure support was in place for family, staff and immediate learning captured (see Section 5.2 below). The Corporate Patient Safety Team have commissioned an Investigating Officer outside of the Health Board to investigate this incident as per the new incident process. Additionally, enquiries by North Wales Police and the Health and Safety Executive are underway as per normal process.

Secondary Care Division

- Falls resulting in severe harm (n=21), of which one patient died. Wrexham Maelor Hospital (WMH) (n=9), Ysbyty Glan Clwyd (YGC) (n=5) and Ysbyty Gwynedd (YG) (n=7). To compare the same period, the numbers are 2020 (n=8) and 2019 (n=7). The increase in numbers could be accounted for by an improvement in validation of incidents as a result of the introduction of Corporate-led Daily Incident Review Meeting. It could also be an impact of the Covid-19 pandemic where staff pressures and fatigue, or an increase in a cohort of frail patients with mobility issues or associated rehabilitation of patients post COVID.
- National reporting of Grade 3, 4 and unstageable Hospital Acquired Pressure Ulcers (HAPUs) will re-commence on the 14th June. As part of the new incident process, the Corporate Patient Safety Team now commission an investigation report to be submitted to the Incident Learning Panel for all Grade 3, 4 and unstageable HAPUs and this is only stood down if the Make it Safe Plus/All Wales review Tool demonstrated the incident was unavoidable. Prior to this, in line with the old internal process, scrutiny was undertaken on a devolved local basis.

- A patient on Intensive Treatment Unit (ITU) having had tracheostomy fitted previous day was turned by staff for personal care. The tracheostomy became displaced and was unable to ventilate the patient. Staff proceeded to re-intubate but were unsuccessful. CPR was commenced. Staff proceeded to front of neck access which proved difficult and eventually gained access through the original tracheostomy window and began ventilation however the decision was made in best interests to withdraw treatment. A Rapid Learning Panel was arranged within 24hours. Early learning from this incident includes:

  - Ear Nose & Throat (ENT) should be bleeped to attend lost airway emergency;
  - Team leader should be nominated for airway emergencies;
  - Multidisciplinary Team (MDT) between ENT and ITU clinicians prior to surgical tracheostomy being performed.

Area Divisions

- Two falls resulting in harm.

3.2   Falls with harm since the start of the COVID-19 pandemic have followed an upwards trend over time across the Health Board which is demonstrated by the graph shown below. The reasons for this increase may include increased use of cubicles, staff sickness, use of agency staff, or an increase in acuity of patients. Analysis of falls per 100,000 occupied beds days indicated the Health Board has a higher than expected rate of falls.

Fall's with Harm
Major / Catastrophic
Jan 2020 - May 2021

The Health and Safety Executive issued the Health Board with an improvement notice in relation to falls management in June 2021. This specifically related to falls risk assessments and falls training. The notice followed investigation into two falls incidents which occurred in 2020.

The Health Board Inpatient Falls Group has been reconvened under the leadership of Debra Hickman, Secondary Care Nurse Director. A new improvement plan has been developed and significant improvement work is planned. This includes a review of the

falls collaborative work, improving access to falls information and training for staff, implementation of a bespoke rapid review tool (Make it Safe Plus) in Datix, and an "immersion event" using COM B methodology across the Health Board to support the co-design development of further actions.

4.	NEVER EVENTS

4.1 During the reporting period, three Never Events were reported:

- Wrong site surgery – chest drain inserted wrong side (YGC).
- Wrong site surgery – nerve block administered on wrong side (WMH).
- Overdose of methotrexate – patient prescribed methotrexate within 2 days of previous dose (YGC).

4.2 The Never Event investigations remain underway. Rapid Learning Panels were held for all incidents. Early findings from the investigations are as follows:

Overdose of Methotrexate

- Prescriptions for Methotrexate should clearly state date of week to be taken.
- Pharmacists should supply one dose of methotrexate at a time to reduce the risk of errors.
- Patients own Methotrexate brought into hospital will be re-used by a pharmacist and either returned home or placed in POD locker.

Wrong side chest drain

- The environment the procedure was undertaken in was cramped limiting all key people from being accessible.
- Importance of using Local Safety Standards for Invasive Procedures (LocSSIP) for invasive procedures.
- Importance of maintaining situational awareness.

Wrong site nerve block

- Failure to use a LocSSIP.

4.3 Surgical safety has been identified as a concern, particularly in relation to LocSSIPs as reported previously. A new LocSSIP portal was launched in June 2021. Audits of compliance are underway during quarter one of 2021/22. Discussions are underway to develop a "surgical safety taskforce" to drive forward a wider range of quality improvements. This group will particularly focus on the application of human factors in a clinical context as this is likely to be a key safety solution.

4.4 In total, three Never Events have been reported so far in 2021/22 (compared to five in 2020/21 and six in 2019/20).

4.5 A report was presented to the Patient Safety and Quality Group outlining the findings of work to assess the external review of a Never Event in urology against the action plan put in place, to identify any further actions needed. The independent opinion and

review of the internal investigation overall did not raise any additional issues other than a review of staffing and, more significantly, the issue of surgical culture not being sufficiently addressed in the action plan. Staffing had been identified within the internal investigation as an issue but focused on the availability of vascular support rather than staffing within the Urology Department. Staffing of the Urology Department has been addressed through a North Wales Urology Review. In terms of surgical culture, the original action plan proposed "human factors training." It is clear more significant work is needed. The Acting Associate Director of Quality Assurance is meeting the new Hospital Management Team to progress a new action plan in this regard. Much of the other observations from the independent expert focused on the performance of the operating consultant. This does not form part of the scope for an incident investigation and was reviewed under appropriate Upholding Professional Standards Wales (UPSW) process. Assurance has been received from the Acting Deputy Executive Medical Director and Acting Executive Medical Director that the process was completed properly.

5   INQUESTS

5.1   A Regulation 28, Prevention of Future Deaths Notice was received relating to an inquest occurring in mental health services. A patient sadly died by suicide, and the Coroner identified concerns that the team did not make proactive attempts to contact the patient in the afternoon and evening following the patient expressing risks earlier in the day. In response, the Mental Health and Learning Disability Division have carefully considered the findings, and worked in partnership with Wrexham County Borough Council (who were co-named in the Notice) and have implemented a daily, end of day safety review huddle to ensure all risks are being managed or escalated to out of hours teams. The process will be reviewed and audited to monitor its implementation and impact.

6   CONCLUSION AND RECOMMENDATIONS

6.1   This report provides the Quality, Safety and Experience Committee with information and analysis on Serious Incidents and Never Events occurring in the last two months although 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.

6.2   The QSE Committee is asked to note the report.

6.3   The QSE Committee is asked to note the significant increase in the number of falls with harm that have occurred over the last 18 months and the planned improvement work.

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APPENDIX 2

Thematic Review
Never Events

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

Never Events Thematic Review

Dr Kath Clarke, Head of Patient Safety

May 2021

Introduction

Never Events are defined as *Serious Incidents that are wholly preventable because guidance or safety recommendations are available at national level and should have been implemented by all health care providers* (NHS Wales and Welsh Government, 2018). In total, there are 16 types of Never Events listed, all of which, should they occur, require reporting to the Delivery Unit (DU) and investigated comprehensively within the Health Board.

Each never event has clear definitions to ensure consistent application and confirmation of such Never Events. The Patient Safety Team (part of the Patient Safety and Experience Department) will review any potential never event and ensure that the definition is met, prior to the notification of the incident to the DU.

A thematic review of all Never Events was requested by the Executive Director of Nursing and Midwifery Services with reference to action plans and mitigating actions taken.

Search criteria

A Datix search was undertaken using the following search criteria:

- Date range: 1st January 2018 up to and including 22nd May 2021 (41 month period)
- Adverse event: all Never Events

In addition, a cross check was made of all Never Events reported to the Welsh Government or Delivery Unit for that same time period.

Results

In total 24 Never Events were reported during this time period.

Year	Number of Never Events	WMH	YGC	YG	LLGH (Llandudno General Hospital)
2018	10	1	2	6	1
2019	5	2	3	0	0
2020	6	3	3	0	0
2021 (5 months)	3	1	2	0	0
Totals	24	7	10	6	1

Never event categories

The following categories of Never Events (n=5) had been reported over this period:

Category	Number per category	WMH	YGC	YG	LLGH
Administration of medication by wrong route	1	0	0	1	0
Misplace naso or oro-gastric tubes	1			1	
Overdose of methotrexate for non-cancer treatment	3	0	2	0	1
Retained foreign object post procedure	6	2	2	2	0
Wrong site surgery	13	5	6	2	0
	24	7	10	6	1

Severity of Never Events reported

Severity grading within datix	Numbers reported
Negligible	11
Minor	3
Moderate	3
Major	7

Thematic review findings

The first two categories to be reviewed have been isolated incidents within BCUHB, however, the detail is provided for completeness.

Administration of medication by the wrong route (oral medication by any parenteral route)

In this incident (INC150862), reported as negligible harm by YG in 2018, a patient was given oral Ranitidine intravenously, and IV Hydrocortisone was administered orally. The nurse had drawn up both medications and placed in the same tray. Neither drug was labelled nor an oral (purple) syringe had been used for the Ranitidine.

Issues identified:

- Incorrect syringe use for oral medication
- Syringes not labelled
- Nurse did not follow Aseptic Non Touch Technique (ANTT) procedure – syringes were carried to patient in same tray
- There was no second checker as per BCUHB Medicines Management policy.

Actions taken:

- An alert was circulated following the incident to reinforce the NPSA patient safety alert from 2007 (NPSA, 2007).
- Staff involved were stopped from medication administration until additional training had been undertaken.

Misplaced naso- or oro-gastric tubes

This incident reported as a never event does not fit the never event definition for misplaced naso- or oro-gastric tubes which is *misplacement of a naso- or oro-gastric tube in the pleura or respiratory tract that is not detected before starting a feed, flush or medication administration*, however, this incident would have met the criteria for the never event of undetected oesophageal intubation. The definition of which is ventilation of a patient following oesophageal intubation instead of the intended tracheal intubation, which is not identified because capnography is not used or capnography readings indicating the need for tracheal intubation are not acted on. Please note the closure form for this incident has been reviewed as the investigation report has not been uploaded to Datix.

This incident (INC153282), reported as negligible harm by YG in 2018 details a child with a history of Dravet Syndrome who required intubation for ongoing management of seizures and reduced oxygen saturation levels. The first on-call anaesthetist initiated a pediatric intubation unsupported by anesthetic colleagues and without recognising that the situation required additional medical support. When it became apparent the endotracheal tube was sited in the oesophagus the patient was successfully re-intubated and her oxygen saturations recovered.

Issues identified:

- Failure to use capnography when undertaking the initial intubation
- Failure to follow protocol for deteriorating respiratory situation
- On call staff unable to access (electronic swipe access) the paediatric ward
- Child Intubated without sedation without a clear clinical justification

Actions taken
- Ensure compliance for the routine use of capnography for all intubated patients.
- Review formal anaesthetic induction programme for Doctors and provide assurance that awareness of all high risk areas are included.
- Arrange for all Anaesthetic staff including ODPs to have swipe access to the Children's wards.
- Clinical Lead for Anaesthetics to highlight case to colleagues and advise that the child was intubated twice without sedation without a clear clinical justification
- Clinical Service Manager for Paediatrics to review the timing of the child's transfer to the resuscitation area with Dewi staff and to highlight that, where it is anticipated intubation will be required, the child should be transferred to the resuscitation area of the ward in anticipation of the arrival of the anaesthetic team.

All actions were completed by November 2018 although no evidence has been uploaded to Datix. The Case was discussed at the Anaesthetics and Critical Care Mortality and Morbidity (ACC M&M) meeting week of 12 November 2018.

Overdose of methotrexate for non-cancer treatment

In total, three Never Events have been recorded, since January 2018, as being an "overdose of methotrexate for non-cancer treatment" (INC159220; INC248248; INC261688). The definition provided for a methotrexate never event is *a patient is given a dose of methotrexate, by any route, for non-cancer treatment that is more than the intended weekly dose; such an overdose was given in a care setting with an electronic prescribing system.*

As the Health Board does not have an electronic prescribing system the three Never Events recorded within the Health Board do not actually fit the definition. It is noted, however, that in October 2014, the Delivery Unit (DU) was asked to carry out assurance reviews of each never event reported by Health Boards to Welsh Government. At that time, the Health Board was instructed by the DU to treat an overdose of methotrexate, despite NOT having an electronic prescribing system, as a never event. This assurance process of Never Events ceased in April 2018 but the Health Board has continued to report any overdose of methotrexate as a never event. This has since been discussed with the Delivery Unit in June 2021, and going forward only incidents that truly fit the definition of a never event will be reported as such.

Following an overdose of methotrexate in April 2016 the *Policy for the Prescribing, Supply and Administration of Methotrexate for Hospital Inpatients* (MM31) was developed within BCUHB and went live in March 2018. This policy also included a quick reference guide to aid practitioners in the prescribing and safe administration of methotrexate.

A theme running throughout all three incidents is a failure to follow the Methotrexate Policy.

Table 1: Brief description of methotrexate incidents and failings identified

INC number	Description	Failings identified	Actions taken
INC159220 Harm: negligible Site: Llandudno General Hospital	Patient prescribed 12.5mg methotrexate weekly. Given appropriately on 28 May 2018. Prescription chart re-written (transcribed) by Advanced Nurse Practitioner (ANP) on 30 May 2018 Given again on 30 May 2018 Given again on 4 June 2018	Transcription of medication by ANP was not completed correctly with crosses in the days medication was not to be administered. Weekly reviews only were being undertaken by ward pharmacists at that time due to limited staffing resources and cover for part-time pharmacy staff.	ANPs have been retrained on the transcribing policy Pharmacy and medicines management senior staff have reviewed the pharmacy staffing complement in Llandudno General Hospital (LLGH), and additional staff capacity has been committed to long-term. The increased staffing has enabled increased pharmacy presence on the wards, reducing the time from a medication chart being transcribed to being clinically checked. All pharmacy staff have been required to read the methotrexate policy, their understanding has been confirmed.
		Methotrexate wrongly dispensed: 24 x 2.5mg tablets dispensed instead of a single dose of 5 x 2.5mg.	A new methotrexate only once weekly administration chart is being piloted in LLGH

INC number	Description	Failings identified	Actions taken
			Methotrexate prescribing and administration has now been added into the back to basics training for registered nurses Staff in Llandudno Hospital have attended back to basics training sessions (3 sessions were put on for staff in September 2018) and more sessions scheduled for the new year Ongoing monitoring of staff on the wards who have made drug errors and medication competencies are being completed Methotrexate posters are on all wards Methotrexate policy has been sent out to all community hospital wards
INC248248 (taken from draft report, incident still under investigation) Harm: major	Patient was discharged from Ward 9, YGC, with a discharge advice letter that confirmed the dose of methotrexate as 10mg weekly (4x 2.5mg tablets to be taken on a Saturday). A copy of the advice label from the take home medication box detailed the correct dose and frequency of administration. A quantity of 8 doses (8 weeks supply) was	Methotrexate was initially prescribed for the patient as an in-patient by a locum gastroenterology consultant (other gastroenterology consultants, rheumatology consultants and dermatology consultants do not initiate methotrexate for in-patients).	These are recommendations from the draft report action plan not currently available That the Methotrexate policy is reviewed to consider in-patient prescribing by medicines management and prescribing colleagues and ensure the supply fits in with the shared care arrangements.

INC number	Description	Failings identified	Actions taken
Site: YGC ward 9/ Central Area	requested and initially 32 tablets were dispensed from YGC Pharmacy (8 weeks) supply. Gastroenterology secretary contacted gastroenterology pharmacist (AM) on 24th December 2020 requesting a further supply for patient who had ran out of methotrexate medication. AM prescribed additional Methotrexate intending to deliver personally to the patient's home in order to check patient's compliance.	The conversation between the patient and prescriber was not documented to clarify the patient's understanding on initiation of treatment. The written instruction on the discharge advice letter was unclear regarding the quantity of medication supplied	Hospital pharmacy team to provide written information to every patient commencing on Methotrexate on discharge from hospital. Review what written information should be provided to patients on initiation of Methotrexate as part of the Methotrexate policy review. Patients are supplied with 8 weeks supply of medication when Methotrexate is initiated to allow time for GP practices to receive the shared care agreement.
	GP had also prescribed further doses for patient, dispensed by local pharmacy on 24th December 2020 and labelled as 10mg to be taken 4 times per day The YGC Gastroenterology pharmacist (AM) visited the patient, at home, to deliver an additional supply of Methotrexate on 25th December 2020 and to try and identify any reason for why the patient may have run out of medication. The pharmacist noted that the patient had taken the 8 doses of Methotrexate in less than 2 weeks; 8 doses should last 8 weeks. In addition, on	The Methotrexate monitoring booklet (with drug information and monitoring details) was not supplied with the discharge prescription as per NPSA recommendations from 2006. Methotrexate should not be prescribed in primary care until a shared care agreement is received.	It is safer for the GP practice not to prescribe Methotrexate and for the patient to run out of methotrexate while awaiting a shared care agreement.

INC number	Description	Failings identified	Actions taken
	questioning, JW confirmed to the pharmacist that she had been taking the medication daily for 8 days. When the pharmacist asked to view any medication the patient had in the house, the pharmacist saw the box of medication dispensed by the community pharmacy the previous day which looked like some doses of Methotrexate had been taken. The pharmacist was unsure if the patient had actually taken the community pharmacy supply or not (possibly had taken one extra dosage, equalling 9 weeks supply in 9 days) but by that point he had established that the patient had taken an overdose and advised about the need for a hospital admission Patient was admitted to hospital for signs of methotrexate toxicity, e.g. purpura, ulcers in the mouth, diarrhoea	The label instructions for taking methotrexate were unclear as typed by the community pharmacy. Lloyds Pharmacies internal processes states 'ask for the Methotrexate book and if not available contact the prescriber'. This was not followed. The checking process in the community pharmacy failed to identify that the Methotrexate label had incorrect and unclear instructions on it.	
INC261688 (taken from Make it Safe Plus, investigation still underway)	Patient was admitted to YGC from Residential Home. . She was already on methotrexate due to rheumatoid arthritis. She was prescribed methotrexate once a week (correct but day of the week not specified) with the first dose being given on admission on 6 May 2021. The patient had	There is no evidence that the day of administration had been checked. The Medicine Administration Record (MAR) record from the residential home was sent in with the patient and signed	(from Make it Safe Plus) Methotrexate policy and alert circulated to Hon, Matrons, Ward Managers, Clinical Directors, Governance Leads across the HB. Cross reference to previous learning from 2018 is similar theme although the days were crossed

INC number	Description	Failings identified	Actions taken
Harm: negligible Site: ED, YGC	received a dose on 4 May in the Residential home prior to admission. This means she had two doses in two days. There is no evidence that the day of administration had been checked. The MAR record from the residential home was sent in with the patient and signed for on Tuesday, although not very clear. The patient's own medication was used which was labelled correctly with once a week on a Tuesday.	for on Tuesday, although not very clear. The patient's own medication was used which was labelled correctly with once a week on a Tuesday. Previous day of administration needs to be identified before prescribing. Methotrexate should not be given by the nurse until the prescription has been clinically checked and endorsed by a pharmacist (as per policy).	off on this occasion the previous day of administration appears to not have been checked or been misread. Comprehensive review to be undertaken.

Analysis

If the application of the definition had been applied strictly none of these incidents would have been reported as a Never Event as the Health Board does not have electronic prescribing (INC159220; INC261688) and in the case of INC248248 the incident did not occur within a health care setting but in the patient's home. A thematic analysis for these three incidents is somewhat problematic currently as two of the incidents are still under investigation (with no completed available action plans available).

Despite this, it can be seen that if the *Policy for the Prescribing, Supply and Administration of Methotrexate for Hospital Inpatients* (MM31) had been followed these incidents would have been avoided:

Policy	INC15922 Transcribing error on ward	INC248248 Patient error	INC261688 Pt given a second dose following admission
1. The decision to treat with weekly oral or subcutaneous methotrexate is made by specialists experienced in its use, i.e. rheumatologists, dermatologists and gastroenterologists.	√	X Prescribed whilst patient an inpatient	√
2. The prescriber should ensure that the dose of methotrexate (in milligrams) is prescribed clearly and correctly.	√	√	√
3. The route of administration should be clearly stated for each prescription; oral (PO), subcutaneous (SC), or intramuscular (IM). This policy applies to all 3 routes of administration.	√	√	√
4. Prescriptions should clearly state "ONCE a WEEK" …	√	√	√
4 cont. …and preferably specify the day of the week. This should not be abbreviated.	x	x	x
6. Ward pharmacists should be informed of any methotrexate prescription, and the prescription must be clinically checked by a pharmacist before administration. The pharmacist will supply one dose of	x	x	x

Policy	INC15922 Transcribing error on ward	INC248248 Patient error	INC261688 Pt given a second dose following admission
methotrexate at a time to reduce the chance of administration errors.			
7. Most patients taking regular weekly methotrexate will know their dose regimen. When administering methotrexate, the patient should be asked to confirm they are expecting the actual dose to be given and that the day of the week is correct. The dose must be withheld if there is any other doubt concerning whether the dose should be given.	unknown	Not applicable (patient taking own in community)	unknown
8. Remind patients to be alert for signs of adverse effects and they should be encouraged to contact their prescribing department and given details of how to do so (e.g Methotrexate alert cards, Appendix E) if they have any concerns. Patients should be reminded to ensure that they inform community pharmacists that they are taking methotrexate when purchasing medications over the counter (OTC).	√	x	Unknown

The role of the ward pharmacist in verifying prescription charts and appropriate dispensing of the weekly dose of methotrexate on a weekly basis supports the safe administration of methotrexate for non-cancer treatment within hospital settings.

It is noted that electronic prescribing and administration systems are an evidence-based method to reduce patient harm from medicines (NHS Wales and Welsh Government, 2018) and that all NHS organisations should introduce them as soon as possible, as the systemic protective barriers for this particular never event is deemed not to be strong enough within care settings where electronic barriers do not exist. If BCUHB had electronic prescribing, it is likely that two out of these three incidents would have been prevented.

Retained foreign object post procedure

In total, six incidents have been reported since January 2018 detailing the retention of a foreign object in a patient after a surgical/invasive procedure. A foreign object is defined as any item that is subject to a formal counting/checking process at the start of the procedure and before its completion (such as swabs, instruments and guidewires). This includes interventional radiology, cardiology, interventions related o vaginal birth, and interventions performed outside the surgical environment (for example central line placement in ward areas). These six incidents can be subdivided into two categories: retained swab; retained guidewire following peripherally inserted central catheter (PICC) or midline insertion. Each acute hospital (YGC, YG and WMH) have reported two incidents each.

Within a surgical setting all swabs used within that procedure are subject to a count. All swabs (instruments/cotton wools, packs etc) are counted in and counted out to ensure that nothing is unintentionally left within the patient. Should a count be incorrect (and this should happen prior to skin closure) then the procedure for discrepancy in counts would be followed.

Missing swab (INC150920) YG theatres and (INC164003) WMH Gynae outpatient department

Following a swab being identified as missing following closure of the patient the procedure for discrepancy was followed. The swab identified on x ray and the patient underwent a second procedure to remove the swab. The investigation identified that the consultant had left the theatre to write his operation notes and communication between the surgeon and theatre support staff was poor.

Actions taken included:

- Sourcing additional computer terminals for each theatre
- Having a formal debrief (to include surgeon and anaesthetist) when an adverse event has occurred in theatre

All theatres now have access to computers and formal debriefs are in place across BCUHB.

The second missing swab incident occurred during a colposcopy procedure in Gynae outpatient department where a cotton wool ball was left in situ. The investigation identified that the practice of counting cotton wool balls was per bag (of five balls) rather than counting each individual ball. This practice was changed and embedded across all sites across BCUHB where colposcopy is undertaken. This practice is embedded and sustained although it is now rare that cotton wool balls are

used, instead smaller gauze swabs are in use, however, each swab is individually counted. .

Retained guidewire following PICC or midline insertion (INC174655; 205114; 208945; 235852)

In total, over the period under review, four incidents have been reported where a guidewire has unintentionally been left in a patient during PICC or midline insertion. The table below provides a synopsis of the incident details, failings identified and actions taken in chronological order of occurrence. It can be seen, however, that in 2018 there was no LocSSIP for midline insertion only for PICC line insertion, therefore the action from this investigation was to amend the PICC LocSSIP to become a PICC and Midline insertion LocSSIP. This was uploaded to Datix in March 2019. Themes identified from these four incidents:

- LocSSIP not being embedded with critical care environments
- Failure to use a LocSSIP or to follow the LocSSIP accurately
- Familiarity with equipment

Actions taken:

Various actions have taken place across the Health Board in relation to the insertion of mid and PICC lines.

Within Cancers Services, a nurse led service holds a register of inserters within the Division to ensure competency assessments and training are current.

In YGC as a result of the Never Events PICC lines are no longer inserted in critical care or anaesthetist, instead a specific form of mid-line (called a power wand) is used which is inherently safer. LocSSIPs are being used consistently within critical care which is evidenced through a regular local two monthly audit of all patients who have had invasive procedures in addition LocSSIPs are also separately audited in response to a request from CEG, using an electronic proforma.

In WMH PICC lines are occasionally placed on critical care by anaesthetists, however, more commonly this procedure is undertaken on the IV suite by a vascular access nurse. Unfortunately when the nurse is away there is no one no one recently skilled left to put them in. This is being raised as an agenda item at the next anaesthetic clinical governance meeting. In addition, LocSSIPs are in place and audited.

In YG, PICC lines are not often put in on ITU with midlines being used more frequently. As with Wrexham PICCs tend to be inserted by the oncology nurses, and there are a small number of consultant anaesthetists who may insert, and radiology do the difficult ones. There is an ongoing business case / discussion (linked to OPAT) to get a sustainable vascular access team up and running for oncology patients. Ultrasound used for all PICCs and midlines. Checklist/LocSSIP is used – but audit not fully established (yet).

The development of a LocSSIPs' Library SharePoint commenced in line was a patient safety notice (PSN034 – supporting the introduction of the National safety Standards for Invasive Procedures). This work has been undertaken with the support of the Patient Safety Team and in conjunction Ysbyty Gwynedd HMT. To date, a total of 147 LocSSIPs have been uploaded to the library as well as useful guides and tips on searching. The library will be launched on Monday 14th June 2021 and will available for all staff to view and utilise LocSSIPs within their clinical area.

The aim of the LocSSIPS' Library is to:

- Provide the standard against which LocSSIPs are developed wherever invasive procedures are performed.
- Ensure the auditing, monitoring and governance of LocSSIPs as a continuous cycle of improvement.
- Maintain a safe culture to promote team work, minimise avoidable complications, and prevent patient safety Never Events.

The LocSSIPs' Library can be found on the BCUHB intranet home-page or via the following link:
https://nhswales365.sharepoint.com/sites/BCU_SIPPS?e=1%3A6e395a17501b4e9fa598fc6aa49e9409

Table 2: Brief description of retained guidewire incidents and failings identified

INC number	Description	Failing identified	Actions taken
174655 Nov 2018 YG	The insertion of midline was required as access via a peripheral cannula was not possible. An initial attempt to insert the line was made by a Senior nurse without success who appropriately then requested the assistance from a doctor. The Doctor inserted the midline into the right mid forearm under ultrasound guidance (as per protocol). The line was not used for any treatment until the 1st December when a nurse attempted to flush the line as part of the maintenance bundle and reported that the line appeared to be blocked. As a result the line was then removed identifying that the guide wire was still in place and had not been removed following insertion.	No procedural check list (LocSIPPs)	LocSSIPs to be introduced for insertion of midlines Second person to be present during insertion to acknowledge guidewire removal and sign "sticker" to be placed in medical records Clinical Alert to be issued BCUHB- wide to raise awareness of risk of retained guidewire
205114 Oct 2019 YGC	Patient had a PiCC line inserted on the intensive care unit on the 10.10.19 under aseptic technique, however the locking and suturing clamp was not attached to the line. The line was sutured in place over the introducing cannula and an x-ray was taken to confirm position. On the 12.10.19 it was reported that the line was not flushing. The	Failure by anaesthetist to use LocSSIP for PICC line insertion. General lack of awareness of PiCC line LocSSIP applying to ITU	LocSSIp for PiCC line insertion re-introduced into ITU. The checklist is now situated with the PiCC line kit and this has been audited to check that this is in place. Anaesthetists discouraged from inserting PiCC lines unless there is NO alternative. Issue raised, discussed and agreed at Anaesthetic Medical

INC number	Description	Failing identified	Actions taken
	PiCC line was removed. When the line was pulled back, no catheter came out but the guidewire did. It was at this point that it was realised that the PiCC line had not been placed correctly.		Advisory Committee on 12/11/19. In addition a register of PiCC line insertions is now being kept and only consultants allow to insert when there is no alternative.
208945 Nov 2019 WMH	A peripherally inserted central catheter (PICC) was inserted in theatre by a locum anaesthetic doctor on Saturday 16th November 2019. The PICC position was checked post procedure (chest x-ray), and reviewed by a consultant surgeon and verified for use. On Monday 18th November 2019, it was noted that fluid was leaking from the end of the PICC. On examination of the catheter, it was noted that the PICC did not have the correct end connection and still had the guidewire in place.	The LocSSIPS was unsigned and incorrect i.e. it stated that the guidewire had been removed The PICC guidewire was left in and the fixings and connections were incorrectly applied The locum anaesthetic doctor did not highlight that he was unfamiliar with the equipment	Clinicians are not to put in PICCs until a competency assessment has been formally completed and signed off by a designated Health Professional Development and introduction across BCUHB • Improved LocSSIPS for PICC insertion • PICC referral pathway • PICC insertion risk assessment
235852 Aug 2020 YGC	On 26th August 2020, following a consultation from ITU EPIC Fellow, it was found that the patient had difficult venous access and only one vein was visible on the ultrasound. A decision was made to place a midline rather than a cannula as intermediate-term	Poor design of midline device - Midline product of poor design, which contains a second guidewire.	Stock of Vygon Lifecath Midline [1296.442] to be removed in Critical Care and procurement of this line stopped Device reported to MHRA, for the manufacturers further investigation

INC number	Description	Failing identified	Actions taken
	antibiotics were needed and the cannula would have compromised the only vein available. The midline (midline kit utilised was the Vygon Lifecath Midline [1296.442]) was sited at approximately 07:00 hours on 26th August 2020 by the Consultant Anaesthetist and no issues were noted at the time of insertion. Later during that day, the retained Seldinger guidewire was seen as an incidental finding on the subsequent CT scan of the lower abdomen and chest x-ray. The guidewire was safely removed by the Interventional Radiology Team on 27th August 2020 and no long term harm has been caused to the patient	Location and availability of LocSIPPS procedures within the CCU All operators should know the equipment they are using and if not completely familiar with the set they are using, should not proceed. Ensure LocSIPP process is embedded in the culture and practice in the CCU	Midline checklist communicated in the ICU communication brief & placed in ICU drawers

Wrong site surgery

Wrong site surgery is defined as an invasive procedure on the wrong patient or at the wrong site and includes interventions that are considered to be surgical but may be done outside of a surgical environment (local anaesthetic blocks for pain management; biopsy; drain insertion).

Detail	total	WMH	YGC	YG
Wrong organ removed	1		1	
Procedures undertaken on wrong patient	1	1		
Biopsy from wrong site	1		1	
Venous line inserted into artery	1			1
Injection into wrong site	2	2		
Chest drain inserted into wrong side	2	1	1	
Local anaesthetic block into wrong side	5	1	3	1
	13	5	6	2

Reviewing all Never Events that were reported under this category the most common wrong site surgery is the placement of a local anaesthetic block into the wrong site (n=5) and results in minor harm to the patient.

Wrong organ removed (INC210834)

The never event that caused major harm to the patient was the removal of a patient's gall bladder instead of a kidney. During surgery, the patient bled which caused additional complications and two other consultant surgeons were called in to assist. Following surgery the patient spent a short time on ITU before being discharged back to the ward and then home. Approximately two weeks following surgery the patient became acutely unwell and required treatment at a specialist unit where she required a partial hepatectomy and portal vein reconstruction. This never event was investigated both internally and externally and is currently subject to a clinical negligence claim. Issues identified from both investigations included:

- Culture within theatres resulting in

    o poor communication between Consultants and theatre team whilst in theatre.
    o no concerns relating to events in theatre (despite being raised) were communicated to other services such as pathology or handover of patient to ITU staff
    o no measures were taken, despite concerns raised in theatre, to clarify further peri or postoperatively.
    o disagreements and concerns expressed by the Consultants who attended intraoperatively that were never resolved.

The earlier paper outlines further work planned in regards to this.

Procedures undertaken on wrong patient (INC202545)

This never event took place in September 2019. The incorrect patient identification label had been placed onto the referral form resulting in patient having both upper GI endoscopy and colonoscopy. Although the patient came to no long term harm she did have two unnecessary procedures. The actions arising from this incident focused on the lack of a second checker when a referral is being written after an appointment and it was determined that referrals, where possible, should be written in clinic before the patient has left so that the second checker becomes the patient. Where this is not possible, all referrals should be checked against the patient's medical records

Wrong site surgery, biopsy on wrong side, injection into wrong site, chest drain inserted into wrong side; local anaesthetic block into wrong side

Thematically, the five incidents that reported a local anaesthetic block being administered into the wrong site reported a failure to "Stop Before you Block". This pause prior to administering the block is led by the practitioner undertaking the block and is a brief period of time in which the site of the block is checked for accuracy.

Actions taken:
- In Sept 2018 the "stop before you block" prompt was added to the World Health Organisation (WHO) checklist (YGC).
- In Sept 2018 a clinical alert reminding of the need to "stop before you block" was circulated to clinicians in YG, following a wrong site block.
- In Sept 2019 the WHO safer procedure checklist identified to staff in theatre (YGC) that the block was on the wrong side, but the WHO checklist hadn't been followed accurately and no "Stop before you block" was undertaken, therefore visual prompts were added to the ultrasound machine and block trolley.
- In May 2020 further reminders were sent to all clinicians who undertake the procedure, via email and a local WhatsApp group, to "Stop before you Block."
- In May 2021, a further wrong site block occurred in theaters in Wrexham and although this is an ongoing investigation it has been identified that a "stop before you block" did not happen and would have prevented the error.

In both chest drain incidents (INC223521 and 261764) a LocSSIP wasn't used. For the first incident (ITU, WMH) the action was taken that the LocSSIP should be kept in the chest drain drawer. This action did not prevent the second incident of happening in May 2021 (ward 1, YGC) where no LocSSIP was used at all.

For the incidents (INC221683 and 230025) which recorded an injection being given into the wrong site (wrong eye/wrong finger) and a CVC being placed in an artery it was

determined that there were no LocSSIPs available to be used. Actions from these have resulted in LocSSIPs being created.

It is important to note that for the majority of these incidents there was either a LocSSIP available, or the procedure was subject to the WHO safer procedure checklist. In effect the safeguards are in place as required through various national safety requirements (Safer Practice Notices (2005 and 2007); Patient Safety Alert (2009) WHO surgical safety checklist; National safety standards for invasive procedures (2015) and Patient Safety Alert supporting the introduction of the national safety standards for invasive procedures (2015)) but are not being used and therefore the safety net is being removed through non-adherence.

Conclusion

Excluding the methotrexate incidents, which are not technically a never event as we do not have the protective barrier of an electronic prescribing system, for all other Never Events described we do have the appropriate protective barriers in place:

- Capnography
- LocSSIPs
- Stop before you block
- WHO safer procedure checklist
- Purple oral syringes

The challenge that has emerged from this review is to ensure that these additional safeguards become embedded in practice in order to ensure the safety of our patients.

To support this thematic review, a Never Events Learning Event is planned for August 2021 to bring together teams involved in recent Never Events to support reflection, cross-service sharing and the identification of further improvement opportunities.

As outlined in the earlier paper, work is underway to form a "surgical safety task force" which is clinically led and operationally supported by the Patient Safety Team. This group will focus on taking forward consistent, sustainable improvements across the organization underpinned by a strong human factors approach. It is proposed that a further update on this work is made to the Committee at a future meeting. This work will be a key strand of the new Quality Strategy in development.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience (QSE) Committee 6th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Vascular Task and Finish Group update
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Professor Arpan Guha, Acting Executive Medical Director
Awdur yr Adroddiad **Report Author:**	Patrick Johnson, Interim Acute Care Director
Craffu blaenorol: **Prior Scrutiny:**	Vascular Task and Finish Group [improvement plan] Acting Executive Medical Director Chief Executive
Atodiadau **Appendices:**	Appendix 1 -Vascular Task and Finish Group Action Plan Tracker Appendix 2 – Vascular Activity

Argymhelliad / Recommendation:
The Committee is asked to receive the update from the Vascular Task and Finish Group.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Sefyllfa / Situation:
This report provides an update to the Quality, Safety and Experience Committee on the work undertaken to date by the Vascular Task and Finish Group following the Royal College of Surgeons' [RCS] review of the vascular service. The Task and Finish group last met on 7th June 2021.

Cefndir / Background:
As part of assessing the potential for improving the vascular services following centralisation of arterial services in North Wales in 2019, the Health Board commissioned an external and independent review of the vascular service from the Royal College of Surgeons of England (RCS) which has been now been partially completed. The first part of the report, based on stakeholder interviews and examination of documents, was provided to the Health Board in March 2021. The second part of this review, based on the analysis of 50 case notes, will commence on the 19th of July and is anticipated to conclude in 8-10 weeks.

Asesiad / Assessment & Analysis

Strategy Implications

This report reports on the progress of the refreshed improvement plan following the RCS report and has been approved by the Board.

Updates to the Quality, Safety and Experience Committee

An extraordinary meeting of the Task & Finish Group was held on 7th June 2021 at which the first part of the RCS report was the sole item on the agenda. There was a good range of representation from multidisciplinary team members as well as patient and Community Health Council (CHC) presence. The original action plan is being tracked by the Group with regular updates provided to QSE and Welsh Government.

The first part of the RCS report was provided to the Executive Medical Director in March 2021. The case note review will now take place on 19th July 2021 and the RCS have advised that the second part of the report will be received by the Health Board between eight and ten weeks after the case note review takes place – this will be mid to late September 2021.

The report detailed nine urgent recommendations that may impact on patient safety and two for service improvement.

The report has highlighted that several of the actions require a response across the BCUHB system [e.g. the diabetic foot pathway, which is a pathway largely driven by diabetes care and not a vascular only pathway] involving operational improvement plans across several clinical areas across primary, community and secondary care. As this work is more complex than previously appreciated, some of the completion dates will require amendments.

RCS urgent recommendations to address potential patient safety risks
- Agreed pathway for timely and effective treatment at the hub site
- Vascular bed capacity and associated nursing resources should be adequate to allow timely transfer from spoke to hub site
- More effective use of the hybrid theatre
- Vascular consultant presence to enable patient review within 24hrs at spoke sites
- Finalise pathway for management of patients post major arterial vascular surgery to ensure timely rehabilitation and repatriation
- Develop non-arterial diabetic foot pathway
- Finalise other pathways currently in draft
- Confirm pathway for non-complex/low risk vascular interventions at spoke sites
- Improve effectiveness of clinical governance process

Recommendations for service improvement
- Clarify phase 2 of centralisation plans (services accessible at spoke sites)

- Improve communication and team working across hub and spoke sites

Patrick Johnson at Ysbyty Glan Clwyd is supporting the Acting Executive Medical Director as a member of the Task and Finish Group to deliver the vascular action plan.

Following the receipt of this feedback the structure and function of the Task and Finish Group, including the terms of reference, have been reviewed to address the internal and external concerns raised. The revised terms of reference which have been reviewed at the Task and Finish Group in May are expected to be finalised at the Task and Finish Group meeting on 28th June 2021.

The key proposed change is that the Task and Finish Group is now designated as a steering group with subsidiary Task and Finish Groups to address specific topics such as the diabetic foot pathway.

Vascular Task and Finish Group

North Wales Vascular Task and Finish Group Action Plan

Each of the recommendations that are summarised above are included in the Task and Finish Group Action Plan Tracker (Appendix 1).

The Action Plan Tracker has been updated as of 22nd June 2021 and will be reviewed at the next meeting of the Task and Finish Group on 28th June 2021.

Progress is reported against each of the recommendations on the Action Plan Tracker and where progress is not in line with the original plan the explanations / recovery measures are detailed.

Develop non-arterial diabetic foot pathway.

The progress is described in the action tacker.

There are documented and working pathways in both primary and secondary care which comply with NICE guidelines. Diabetic foot screening takes place in primary care. There are robust referral pathways for any diabetic patient with foot problems or those screened as medium or high risk to be seen by the foot protection team in line with guidelines. The patients receive care closer to home in a community clinic, in keeping with the Heath Board's diabetic delivery plan.

A secondary care pathway is agreed at each acute hospital by the team involved in delivering the pathway.

Pathways and alignment of vascular inpatient bed base

The progress is described in the action tracker.

A review of the capacity and demand for inpatient beds across the service was completed at the commencement of the Task and Finish Group. It has been agreed at the Task and Finish Group that this will be reviewed again once all the pathways have been agreed.

All pathways have been agreed with the exception of the Intravenous Drug User Pathway ay YG, and it is anticipated that YG will adopt the same pathway as has been adopted at YM and YGC in early July.

A snapshot audit shows a potential of up to 10 patients per day at Ysbyty Glan Clwyd could be treated at their local hospitals and the final bed numbers and theatre sessions will be agreed in July 2021.

More effective use of the hybrid theatre

A number of actions have been identified that will be taken to improve theatre utilisation. Standard operating procedures have been agreed and operational implementation awaited. This is indicated on the action tracker.

These have been identified as a result of discussions with the Surgical Clinical Director at YGC along with the theatre manager and the Vascular Clinical Lead. These actions include
- Agreements have been reached on the standard operating protocol, which will be implemented in from July.
- Changes to the day the weekly Multidisciplinary Team (MDT) and theatre scheduling meeting take place to reduce the current high risk of disruption and cancellations at the beginning of the week. This will have a knock on effect as to how other clinical sessions are provided in the week.

Vascular consultant presence to enable patient review within 24hrs at spoke sites

The RCS report has prompted a further detailed examination of how the medical workforce is deployed across the network to ensure that the agreed hub and spokes model is strengthened. With c. A revised rota has improved the situation, with presence across all sites on all five days of the week. Access to a Consultant of the week and an on call consultant is always ensured.

The Clinical Lead is now completing a detailed review of all job plans to address physical presence at all three hospitals but also to address the re-localisation of some of the patient pathways. This review will be completed in July 2021.

There is a round of substantive Consultant appointments being planned once the exact requirement is defined.

Communications plan

To support the North Wales vascular service and highlight the progress being made, a communications plan is in development and will be completed by Friday 9th July. The key elements of this are to build confidence in the service by showcasing innovation and staff achievements, highlight positive patient experiences, outline progress against the improvement plan that has been approved by the Board and clearly communicate next steps.

The dedicated vascular services page on our website will be developed to include a patient stories section, a 'meet the team' component and pictures and video content to demonstrate the high quality facilities and equipment available. This work is underway and will be completed by the end of July.

A regular supply of press releases will be delivered which will also be shared on our website and on our social media channels. Opportunities will also be taken to include positive key messages in any reactive media statements we issue on the service.

Opsiynau a ystyriwyd / Options considered

Next steps
- The exceptions to planned progress are being addressed.
- Recruitment to the Vascular Network Manager role is vital. Further interviews are planned for w/c 5th July 2021. Additional support for the implementation of the Royal College of Surgeons report has also been made available.

Goblygiadau Ariannol / Financial Implications

It is evident from the above narrative that the operational changes needed for improvement may require financial outlay, which will be quantified by the service as part of the implementation plan.

Dadansoddiad Risk / Risk Analysis

There is a need to review the risk register for the service within the remit of the Task and Finish Group terms of reference. This will be done at the next meeting on 28th June 2021.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

There are no legal implications associated with this report. The Task and Finish Group reports by exception and the action plan is tracked through QSE.

Asesiad Effaith / Impact Assessment

Impact assessments will be completed as part of the development and approval of clinical pathways as required by the Clinical Advisory Group.

CONTENTS

Vascular Task and Finish Group Action Plan and

Recommendations following the Royal College of Surgeons Invited Service Report Report - Part One

Immediate Royal College of Surgeons actions (embedded documents are available to Committee members via ibabs)

Recommendations for service improvement

Additional recommendations

Vascular Task and Finish Group Action Plan

Version 0.5

Royal College of Surgeons (March 2021 report) recommendations to address patient safety risks

Ref	Recommendation	Detail	Action by	Owner	Start Date as per report date (for tasks only) DD/MM/YYYY	End Date for milestones (as per PID) and tasks DD/MM/YYYY	Task Status - *this will autopopulate once the start/end dates are inserted*	If overdue, task status	Progress update - include reasons in here for revised start or end date, and impact this will have on the overall deliver of the milestone	Assurance
1.0	Agreed pathway for timely and effective treatment at the hub site	There must be an agreed pathway which is clear to all staff to ensure the timely and effective treatment at the hub site for patients requiring specific arterial surgery and complex endovascular interventions. This should include but not limited to: (i) Appropriate and timely MDT review at both the hub and spoke sites. At the spoke sites, this should, wherever possible, be undertaken by the consultant vascular surgeon assigned to the spoke site, when available (see 4 below). When the on-site consultant vascular surgeon is unavailable, the on call arrangement will be used. (ii) Diagnostic and assessment services should be available in a timely manner at both the hub and spoke sites. This should include non-invasive imaging (CT and MRI) and, if available, cardiorespiratory work up. (iii) A repatriation protocol, including timescales, for admission to hub from a spoke site should be introduced. Treatment plans for transfer must include a robust mechanism to ensure that the medical and any non-vascular clinical needs of patients are communicated to the appropriate specialist teams at the hub site. Renal patients with dialysis needs, is highlighted specifically including that renal function assessment needs are met prior to undergoing vascular surgery.	Clinical Director - Vascular	Secondary Care Medical Director	01/04/2021	31/05/2021	Completed		The vascular recovery plan was drafted based on national guidance and approved by the Clinical Advisory Group and Executives on 25/09/20. This provides timelines for the assessment and management of patients with vascular conditions. This recovery plan has been updated during May 2021 and circulated to all three Hospital Medical Directors for dissemination. Communication to all senior management teams at all three hospitals will be ongoing during Q2 2021/22 to ensure that it is fully understood and embedded. A North Wales MDT is held every Friday pm involving all available vascular consultants, interventional radiology and anaesthesia which covers patients from all three areas. In addition a meeting has been established in June 2021 at YGC involving vascular and microbiology to discuss the ongoing care of inpatients. Diagnostic services are available at all three hospitals. The Clinical Lead for Radiology has confirmed that this is the case though there are some capacity constraints which will require investment to address. Assessment and management of renal patients with dialysis needs has been discussed in a meeting with renal and vascular leads and a draft route into the hub dialysis ward proposed. Further meeting held on 21/05/21 with Acute Care Director, Head of Nursing for Medicine, CD for Medicine and Vascular Network Manager at which requirements were agreed.	\\cymru.nhs bcu\wmh\ho Pa214822\
2.0	Vascular bed capacity and associated nursing resources should be adequate to allow timely transfer from spoke to hub site	Admission should be to a vascular ward and where this is not possible and vascular patients are admitted under a different specialty, robust arrangements must be in place to ensure appropriate review by the vascular multi-disciplinary team (MDT) and continuity of care.	Site Hospital Directors/ Site Nurse Directors	Chief Operating Officer	01/04/2021	30/06/2021	In progress but not on track/overdue/late starting		Prior to the centralisation of major arterial vascular surgery, the lower limb service at Ysbyty Gwynedd admitted patients from across North Wales, managing the care for patients with diabetic foot disease and difficult to manage lower limb tissue loss and limb ischaemia. Post centralisation, these patients would continue to be managed at Ysbyty Gwynedd (although lower limb surgical arterial procedures would be performed at the hub). Maintaining this model of care in Ysbyty Gwynedd, an analysis of the caseload by patient episode indicated a bed requirement of 15 beds. However, this was based on 2015/16 coded data and did not take into account the increase in demand from East and Central. There were also plans to implement a community hub and spoke model with community beds to allow a reduction in the number of these beds. The Health Board's plans to retain beds in Ysbyty Gwynedd for the lower limb salvage service had to be severely curtailed due to the resignation of senior clinicians and resultant staff shortages. This has provided the opportunity to review and determine the most appropriate pathways for vascular related patients across North Wales in line with national guidance. The NICE guidance for the management of patients with diabetic foot problems recommends that each hospital should have a care pathway for people with diabetic foot problems managed by a multi-disciplinary foot care service. There is now work underway through the Diabetic Foot Task and Finish Group to agree the pathways for the assessment and management of patients including patient requiring admission. A full audit of beds used since centralisation is underway and once the pathways and the audit are completed a recommendation will be made on the number of beds required at each of the three hospitals will be made. **Delivered under the remit of the Vascular Task and Finish Group:** A new calculation of the beds required at each of the three hopsitals will be undertaken when all pathways have been determined and an audit of actual bed usage since April 2019 is completed.	
3.0	More effective use of the hybrid theatre	The potential capacity of the hybrid theatre at the hub could be more effectively utilised by (but not limited to): (i) Ensuring that only cases requiring hybrid theatre facilities (as opposed to regular theatre) are undertaken there. (ii) Commencing lists on time and introducing a "golden patient" initiative for each theatre list (with beds ring-fenced for these patients). (iii) Avoiding any vacant sessions by ensuring that consultant surgeon cover is in place. (iv) Introducing three session lists to allow more flexibility and less 'overloading' of lists. (v) Addressing other factors which have contributed to cancellation of cases. These include: Considering alternative appropriate options to ITU beds where there is not availability, such as post-anaesthesia care unit (PACU) and high dependency unit (HDU). (vi) Anaesthetist involvement in the Friday theatre meetings to help avoid cancellation of cases 'on the day' due to anaesthetic concerns.	Theatre Manager/ Critical care lead YGC	Chief Operating Officer	01/04/2021	28/05/2021	Completed		• ToR for local Task and Finish group involving the CD for surgery, vascular and operational leads. The duties of the Task and Finish Group: - • Agree allocation of operating lists in accordance with schedule in a timely manner working towards 6 week review. • Ensure that processes conform with what is outlined in the Operating Department Standard Operating Procedure 3 – Operating List Management • Agreement of process for cancellation and subsequent relocation of operating lists. • Agree and promote robust method of communication with regard to the above to reduce communication errors. • Analysis of cancelled sessions, monitoring trends and agreeing action points • Ensuring that only cases requiring hybrid theatre facilities (as opposed to regular theatre) are undertaken there. • Commencing lists on time and introducing a "golden patient" initiative for each theatre list (with beds ring-fenced for these patients). • Addressing other factors, which have contributed to cancellation of cases. These include considering alternative appropriate options to ITU beds where there is not availability, such as post-anaesthesia care unit (PACU) and high dependency unit (HDU). • Anaesthetist present in the Friday theatre meetings to help avoid cancellation of cases 'on the day' due to anaesthetic concerns." • Theatre utilisation to be reported to site Q&S	C:\Users\ Pa214822\Des TOR Hybr C:\Users\ Pa214822\Des ODSOP
4.0	Vascular consultant presence to enable patient review within 24hrs at spoke sites	Regarding the vascular surgical presence at the spoke sites: (i) This should ensure consultant review of patients within twenty four hours. (ii) The on-site consultant vascular surgeons should be accessible to all relevant specialties, including but not limited to: Diabetology, Orthopaedics and Endocrinology. (iii) The availability of and means of accessing the consultant vascular surgeons at the spoke sites needs to be made clear to all staff who require their input for review of patients.	Vascular Network Manager	Clinical Director - Vascular	01/04/2021	30/06/2021	In progress but not on track/overdue/late starting	First analysis shows presence at WMH and YG not certain due to annual leave/sickness. Though as an example the rota for the next two weeks has presence every weekday.	• (i). Gap analysis undertaken and proposal for any resource to be presented to the Secondary Care Medical Director. • (ii). Local meetings with diabetology, endocrinology, podiatry and orthopaedics have taken place on all sites as part of the development of a diabetic foot pathway and this includes the means to access vascular support (further detail in recommendation 6 update). • (iii). The vascular rota is circulated across sites, specialties and teams. The rota also includes the allocation of surgeons and the site, together with the contact details.	

5.0	Finalise pathway for management of patients post major arterial vascular surgery to ensure timely rehabilitation and repatriation	The draft pathway for the management of patients post major arterial vascular surgery29 needs to be agreed and finalised. It should ensure that communication from the hub to spoke sites and community services regarding discharge and follow up is improved and standardised. This should include but is not limited to: (i) Rehabilitation needs are assessed by the relevant clinical teams prior to discharge and appropriate rehabilitation services accessed locally, wherever possible. (ii) All relevant clinical services at both hub and spoke sites are aware of the pathway and that robust mechanisms are established to ensure that discharge plans (including rehabilitation) are communicated to the relevant teams.	Vascular Network Manager	YGC Medical Director	22/05/2020	27/01/2021	Completed		**Delivered under the remit of the Vascular Task and Finish Group:** Approved at CAG on 27/01/21. Implemented. Focus now on communication of the process across sites and teams. • (i) The process details the referral pathway and includes the access to assessment by the clinical specialty locally as required to ensure rehabilitation needs are appropriately assessed. • (ii). This pathway has now been discussed with the acute care directors and includes transfer within 24 hours of acceptance and the patient being medically fit and the escalation process.	
6.0	Develop a non-arterial diabetic foot pathway	The milestone identified in the Vascular Task and Finish Group to develop the non-arterial diabetic foot pathway should be progressed urgently with the involvement of representatives from all relevant clinical teams. This should include but is not limited to: (i) Assessment protocols by a member of the diabetic team (identified consultant, podiatrist or clinical nurse specialist). (ii) Identifying a diabetic foot lead within the consultant vascular surgeon team, ideally for the entire network to support consolidation of pathways and protocols. (iii) A robust MDT approach across the vascular network with input from relevant clinical specialities, including (but not limited to): Anaesthetics, Podiatry, Diabetology, Microbiology, orthopaedic surgery, prosthetic limb and specialist vascular nursing. This should include: ☑ Establishing a foot MDT for each spoke site. ☑ The re-introduction of MDT clinic sessions. Podiatry and Diabetology should be central with input from other relevant clinical specialities, including (but not limited to): Microbiology, orthopaedic surgery, prosthetic limb and specialist vascular nursing. (iv) Patients at spoke sites diagnosed with diabetic foot sepsis with no arterial compromise, should be treated at the spoke site where possible. If it is not possible, a protocol should be in place for urgent transfer to the hub. (v) Clear admission arrangements at spoke sites, including the specialty the patient is admitted under, which allows for input from vascular surgery. Admission responsibilities need to be included in job planning for the admitting consultant(s). (vi) Robust mechanisms should be established to ensure that discharge plans are communicated to the relevant teams. In particular, communication with CNS/ANP, vascular outreach nursing and podiatry should be addressed. **See also additional recommendation number 15**	Senior Diabetic Clinician	Secondary Care Medical Director	01/04/2021	30/06/2021(+E9:G10)	In progress but not on track/overdue/late starting	The only outstanding part of the pathway to agree is under which clinical team any patients requiring an inpatient spell. At the time of writing this isn't agreed but should be before the date of the meeting. The further work required will also need to focus on securing theatre capacity.	The secondary care diabetic foot pathway has been agreed with all three hospitals. (The one page version attached). Each hospital/areas has then produced a gap analysis highlighting the resources that are required to have a sustainable service. The gaps are mainly human resources but there also some physical space that need to be addressed. A weekly meeting is held between Centre and East / West so that relevant information about their patients that are being discharged to include: 1 Date and location of vascular follow up 2 Antibiotic plan for the patient 3 Offloading plan 4 Date podiatry review required For consistency, this information is also required for central patient being discharged	C:\Users\Pa214822\Desktop\OUTPATIENT MDET C:\Users\Pa214822\Desktop\Central Outpatient C:\Users\Pa214822\Desktop\West Outpatient C:\Users\Pa214822\Desktop\East Outpatient C:\Users\Pa214822\Desktop\Diabetic Foot C:\Users\Pa214822\Desktop\ToR Diabetic Foot
7.0	Finalise other pathways currently in draft	The review team noted that in addition to the two clinical pathways referred to in recommendations 5 and 6, the Vascular task and Finish Group have identified actions in respect of a further three pathways. It is recommended that these are agreed, finalised and implemented and that relevant clinical services at both hub and spoke sites are made aware of the pathways.	Clinical Lead for General Surgery	Secondary Care Medical Director	01/04/2021	30/06/2021	In progress but not on track/overdue/late starting	Final sign of pathway required by Vascular Clinical Lead or deputy in his absence.	• IVDU pathway outstanding. Secondary Care Medical Director is determining best practice and will facilitate a meeting with all stakeholders with the intention that the pathway is appropriately led by General Surgery. • Acute Care Director (YGC) met with the Hospital Medical Director (YG) on 25/05/21 to understand the local issues. **Delivered under the remit of the Vascular Task and Finish Group:** • The day case vascular angioplasty pathway was approved by Clinical Advisory Group and the executives in January 2021 and has been implemented. • The pathway for the management of patients post vascular intervention at Glan Clwyd Hospital was approved by the Clinical Advisory Group in January 2021 and has been implemented. • The pathway for non-surgical arterial condition for 'palliative' patients, in conjunction with palliative care team was incorporated into the agreed pathway for the management of patients post vascular intervention at Glan Clwyd Hospital and was approved by the Clinical Advisory Group in January 2021 and has been implemented.	C:\Users\Pa214822\Des Managing IV
8.0	Confirm pathway for non-complex/low risk vascular interventions at spoke sites	Pathway/pathways is/are needed to enable non-complex/low risk peripheral vascular interventions to be undertaken (in line with VSGBI guidelines), mainly as day cases at the spoke sites. This should involve discussions between the hub and spoke Medical Directors and will need to include, but is not limited to: (i) Agreement regarding interventions undertaken at the spoke sites in line with VSGBI. (ii) Details for inpatient responsibility for patients requiring admission following general anaesthesia, which includes input from vascular surgery. The potential inpatient responsibilities could include (but are not limited to): general surgery, general medical, diabetes or orthopaedics. (iii) A mechanism in place for timely transfer to the hub site should the need for complex vascular intervention arise.	Clinical Leads for East and West - Vascular	Clinical Director - Vascular	01/04/2021	30/06/2021	In progress but not on track/overdue/late starting	It is necessary to secure the required theatre sessions and access to beds before this can be progressed further. At Wrexham a full day elective orthopaedic list has been made available so that patients requiring urgent surgery can be prioritised away from the daily trauma lists.	The vascular recovery plan was drafted based on national guidance and approved by the Clinical Advisory Group and Executives on 25/09/20. This provides timelines for the assessment and management of patients with vascular conditions. This recovery plan has been updated during May 2021 and circulated to all three Hospital Medical Directors for dissemination. Communication to all senior management teams at all three hospitals will be ongoing during Q2 2021/22 to ensure that it is fully understood and embedded. It is agreed which vascualr procedures can be carried out at WMH and YG as well as any orthopaedic interventions. Changes haven't yet been implemented as discussions are ongoing regarding theatre availability and where necessary, inpatient beds. Expectation is that from Q3 that changes will be fully implemented. The main reason for caution now is that there is severe pressure on all three hospitals for elective capacity and inpatient beds as a result of high non-elective demand, primarily medical.	

		Improvements are required in respect of the effectiveness of the clinical governance	Vascular Clinical	Secondary Care					

No.		Recommendation	Description	Lead	Owner	Start Date	Target Date	Status	Comments	
9.0	S:\Concerr Concerns pro BCUHB incide	Improve effectiveness of clinical governance process	Improvements are required in respect of the effectiveness of the clinical governance processes. This includes, but is not limited to: (i) Steps taken to ensure that there is confidence in the independence of the sign off on Datix reports as part of clinical governance and feedback. (ii) Consideration given to appointing an external chair (for an agreed defined period) for clinical governance meetings to (remotely) oversee the process. This could be considered in conjunction with expert support/input for vascular MDT meetings [see recommendation 12 (i)]. (iii) A mechanism in place to ensure that agreed changes to clinical practice arising from shared learning are clearly identified and effected. (iv) Addressing any concerns regarding the submission of Datix reports as a method of complaining about colleagues. In addition, all staff should be made aware of the Health Board policy/guidelines in respect of Datix submissions and the other appropriate process(es) in place for raising concerns. Alignment with these policies/guidelines/process(es) should be managed by the Medical Director. (v) Clarifying the requirements for undertaking root cause analyses (RCAs) for all major amputations, and that processes are in place to ensure any requirements are met.	Vascular Clinical Governance Lead	Secondary Care Medical Director	01/04/2021	28/05/2021	Completed	• This feedback was provided to the vascular team for their reflection and ideas for improvement following the publication of the report on 13/05/21. • Meeting held on 20/05/21 with the vascular governance lead, vascular network manager, CD for vascular and acute care director for YGC to discuss actions for improvement. • Support will be provided from a specialty with a well established governance process. • Proposals for improvement to be presented to the site Q&S. • (i). The vascular service complies with the approved Health Board concerns and incident process. • (ii). Appointment of the Secondary Care Medical Director as Chair of the vascular clinical governance meetings to oversee the process. • (iii). The service now ensures that actions from goverance meeting including sharing of learning are now documented and tracked in an action log, which includes all RCAs, e.g. for major amputations. • (iv). Clinical Director presented to the Vascular Clinical Governance meeting on 22/04/21 on civility and partnership working. An Anaesthetic consultant will also attend Vascular Clinical Governance meetings as well as General Surgery consultant on an as required basis.	

Royal College of Surgeons (March 2021 report) recommendations for service improvement

Ref	Recommendation	Detail	Action by	Owner	Start Date as per report date (for tasks only) DD/MM/YYYY	End Date for milestones (as per PID) and tasks DD/MM/YYYY	Task Status - this will autopopulate once the start/end dates are inserted	If overdue, task status	Progress update - include reasons in here for revised start or end date, and impact this will have on the overall deliver of the milestone
10.0	Clarify phase 2 of centralisation plans (services accessible at spoke sites)	Given the focus on the establishment of the provision of arterial and complex vascular surgery service at the hub site as the primary phase of centralisation, a clear action plan should be put in place (as phase 2 of centralisation) to enable the return of spoke services within accepted guidelines.	Acute Care Director	Chief Operating Officer	01/04/2021	30/09/2021	In progress and on track		There has been a comprehensive review of all pathways undertaken and subsequent implemnation and communication which will result in a clear understanding of what services are to be provided in spoke sites. This will affect patients who are currenty transferred to YGC that should be treated closer to home.
11.0	Improve communication and team working across hub and spoke sites	Support should be provided to improve and facilitate communication and team working across hub and spoke sites to reflect a network approach, which supports spoke services. This could include agreed non-patient facing job plan time timetabled at the spoke sites, which could also help maximise the availability of vascular clinical expertise there.	Vascular Network Manager Clinical Director - Vascular	Secondary Care Medical Director	01/04/2021	30/06/2021	In progress but not on track/overdue /late starting		• Review of consultant presence and any resource gaps to be identified and proposal to be presented to the Secondary Care Medical Director has not fully completed by the deadline but will be completed in July 2021. • SPA on-site presence is currently within existing job plans and cpmplied with.
12.0	Improving clinical leadership	The potential for improving clinical leadership should be explored. This should include but is not limited to: (i) Formalising a complex case MDT and governance process (with Liverpool suggested as the nearest major centre) by establishing a model for the vascular network to enable joint supra-regional MDT and case sharing. (ii) Establishing a clinical lead for each spoke site to enable and support: Local MDT working; Improved communication between the vascular surgery service and an appropriate member of the spoke management team that the vascular team can meet with regularly to consider local issues and service development.	Clinical Director - Vascular	Secondary Care Medical Director	01/04/2021	31/08/2021	In progress and on track		(i) Vascular CD / governance lead to contact the Liverpool Lead to initiate discussions for formalising a complex case MDT and governance process by the end of August 2021 (ii) CD for vascular has established a clinical lead for each spoke site
13.0	Improving effectiveness of mortality and morbidity discussions and shared learning	Review of a number of issues relating to M&M meetings to improve their effectiveness in enabling comprehensive MDT discussion and shared learning, is recommended. These should include but are not limited to: (i) The timing of meetings to enable anaesthetists to attend. (ii) A system to ensure that discussion items that are not able to be discussed at a meeting are carried forward to the next. (iii) A robust system to record and share all agreed actions.	Vascular Clinical Governance Lead	Secondary Care Medical Director	01/04/2021	01/07/2021	In progress and on track		(i) The timing of meetings to enable anaesthetists to attend has been initially discussed with the Directorate General Manager and the governance lead for anaesthetics - attendance to be timetabled in line wtih current dates. This has already been established with general surgery. Vascular Network Manager met with the clinical goverance lead for anaesthetics and agreed joint sessions throughout the year. (ii) The service is drafting a cycle of business for clinical governance that will be presented to the clinical effectiveness group and quallity and safety for approval in the June 2021 meetings (iii) Actions are now tracked in a separate rolling action log implemented in April 2021.
14.0	Progression of clinical audits within the department	The six audits identified by the vascular task and finish group to be undertaken utilising National Vascular Registry (NVR) data should be progressed as part of assessment, evaluation and shared learning.	Vascular Clinical Audit Lead	Secondary Care Medical Director	01/04/2021	31/08/2021	In progress and on track		The identified clinical audits are now timetabled for discussion at vascular clinical governance meetings and two audits were presented at the last two governance meeting in March and April 2021. The next governance meeting is 15/06/21. The improvement plans will be shared with the TFG and QSE.

15.0	Further actions to progress the non-arterial diabetic foot pathway	Following (and to support) recommendation 6, the following requires consideration: (i) The need for an additional consultant diabetes physician to the YG spoke site (including non-consultant grade support) to ensure capacity to meet the workload requirements. This would enable ward beds to be hosted by a consultant diabetes physician and to play a key role in vascular care. (ii) The provision of a diabetic foot clinic by consultant vascular surgery in partnership with podiatry at all three sites. (iii) A network wide appointment in podiatric surgery, or an orthopaedic surgeon with special interest in vascular, to support the foot salvage service on all three sites with the in-house teams. (iv) A lead vascular surgery clinician for foot salvage across three sites to support the spoke teams and standardise care and pathways.	Senior Diabetic Clinician	Secondary Care Medical Director Area Medical Director	01/04/2021	28/01/2022	In progress and on track		• The Diabetic Foot Pathway Task and Finish Group is a subsidiary of the Vascular Task and Finish Group. • See recommendation 6 update.
16.0	Improved communication across nursing teams	Regular vascular nursing staff meetings should be established to support this and enable effective discussion and communication. These time slots will need to be protected in order to enable attendance by all vascular nursing staff.	Head of Nursing - all sites	Secondary Care Nurse Director	01/04/2021	30/06/2021	Completed		There are now established weekly vascular nurse and podiatry meetings on a Monday (Centre and East) and Thursday (Centre and West) to enable improved communication across sites. Work is ongoing to coordinate a single meeting.
17.0	Deanery and non-training grade surgeons at the spoke sites	Additional Deanery and non-training grade vascular surgeons are needed to allow both for support for learning opportunities at the spoke sites and to take the reliance on general surgery trainees out of the on call process.	Educational Lead for Vascular	Secondary Care Medical Director	01/04/2021	04/08/2021	In progress and on track		Discussions with the West general surgical team to look at getting a general surgical trainee to rotate into vascular. The East have appointed a middle grade and SHO level non-training grade doctors, both of these doctors have now commenced in the service. Two additional speaciliast trainees have been allocated by HEIW to the service, acknowledging North Wales as a vascular training hub.
18.0	Developing working relationships between vascular surgery and interventional radiology at spoke sites	The Health Board should maintain and develop the working relationships between vascular surgery and interventional radiology (IR) at spoke sites to ensure timely intervention in line with the VSGBI quality improvement framework for lower limb ischaemia.	Clinical Leads for East and West - Vascular IR Lead for Vascular	Secondary Care Medical Director Clinical Director for Radiology	01/04/2021	30/06/2021	Completed		There is a weekly MDT pan BCU which is attended by the Interventional Radiologists and Vascular Consultants. Weekly local MDTs with IR and Vascular input are also undertaken. Vascular Network Manager met with the Vascular IR lead radiologist on 13/05/21 to understand areas for further improvement. which is developing well.
19.0	Developing nurse outreach services	The service expansion plan for the vascular nursing outreach team at YG spoke site, which was reported to have been prepared prior to centralisation of the vascular service, should be re-visited.	Vascular Network Manager	Secondary Care Nurse Director	01/04/2021	30/06/2021	In progress but not on track/overdue /late starting		Will be considered as part of overall nursing resource plan for pan BCU rather than in isolation.

Royal College of Surgeons (March 2021 report) recommendations for the healthcare organisation to consider as part of its future development of the service:

Ref	Recommendation	Detail	Action by	Owner	Start Date as per report date (for tasks only) DD/MM/YYYY	End Date for milestones (as per PID) and tasks DD/MM/YYYY	Task Status - *this will autopopulate once the start/end dates are inserted*	If overdue, task status	Progress update - include reasons in here for revised start or end date, and impact this will have on the overall deliver of the milestone
20.0	Vascular on-call for vascular surgical trainees	Including vascular surgical trainees in the vascular on-call to enable exposure to more complex procedures.	Clinical Director - Vascular	Secondary Care Medical Director	01/04/2021	30/06/2021	In progress and on track		There is currently one HEIW general surgical trainee on rotation in vascular. From August 2021 there will be an additional HEIW vascular trainee. These trainees are on the general surgical on-call. The possibility of involvement in the vascular on-call will be explored and a proposal made to the Secondary Care Medical Director by the end of June 2021.
21.0	Tenure of clinical leadership / management roles	Having agreed guidelines for the length of tenure of clinical leadership/management roles to facilitate rotation of the roles, and thereby, support the potential for new ideas and leadership styles.	Secondary Care Medical Director	Executive Medical Director	01/04/2021	30/06/2021	Completed		Discussions have taken place regarding rotating leadership roles and creating asdtional roles, such as resaerch leadership to strnthen the service. A balance will be struck between stability and managing change accordingly.
22.0	Recruitment and retention of clinicians	The development of an action plan designed to maintain stability and attract further clinicians, given the relatively rapid turnover of vascular surgeons within the service.	Secondary Care Medical Director	Executive Medical Director	01/04/2021	28/01/2022	Completed		The action plan includes highlighting the potential for increased academic activity within the vascular service and the potential of contribution to the emerging medical and health sciences school in North Wales. Agreement has been reached with Bangor university to support this activity for current and potential applicants to the service.

Vascular Task and Finish Group Review Action Plan

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 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	Addresses RCS recommendations	Assurance
1.0	**Alignment of vascular bed base**	Milestone 1 - Alignment of vascular bed base												
1.1		Review of the capacity and demand for inpatient beds across the service.	YGC Site Hospital Director/ YGC Nurse Director	Chief Operating Officer	22 May 2020	16/06/2020		01/01/2021 Amended to 30/09/21 in line with Diabetic Foot pathway deadline		In progress but not on track/overdue/late starting		Agreed by T&F group to re-assess the requirement for inpatient beds as part of the finalisation of clinical pathways. The pathways will determine the bed requirement and alignment. A new calculation of the beds required at each of the three hopsitals will be undertaken when all pathways have been determined and an audit of actual bed usage since April 2019 is completed. All pathways need to be finalised before a definitive calculation can be made. A review of the patients under vascular care at YGC has shown that there are around 8 patients who could have had their care at WMH or YG. In addition there are diabetic foot patients who will under orthopaedic care at all three hospitals.	Safety: 1, 2, 5, 8 Service: 1, 2	Audit of bed occupancy and capacity and demand has been done on three separate dates and it shows that there are between 8 and 10 patients who could have been treated locally.
1.3		Continued delivery of the lower limb service across all sites with local access to consultant and MDT review.	Vascular Network Manager	Secondary Care Medical Director	22 May 2020	16/06/2020		01/01/2021		Completed		Agreed by T&F group to review as part of the development of clinical pathways. The pathways will determine the bed requirement and alignment. The service continues locally with consultant reviews, clinics and daycase procedures. Changes to this provision will be determined by any changes resulting from the development of the diabetic foot pathway.		
2.0	**Pathways of care**	Milestone 2 - Pathways of care												
2.1		Develop the non-arterial diabetic foot pathway consistent with National Diabetic Foot Pathway and NICE guidelines	Senior Diabetic Clinician	Secondary Care Medical Director	22 May 2020	30/04/2021		30/06/21 with timeframes detailed in pathways of care tab		Completed		June 2021: • One secondary care diabetic foot pathway agrred for all three hospitals.Appropraite orthopaedic input has now been identified at all three hospitals. Gap analysis completed for each location. In the East there is a requirement for an additional seesion from diabetes. The centre.	Safety: 1,4,5,6,7,8,9	National Diabetic Foot Audit

2.2		Review and refine angioplasty pathway	Vascular Network Manager	Clinical Director for Radiology	22 May 2020	09/10/2020		30 November 2020		Completed		**Update February 2021:** Approved at CAG on 20/01/21.	Safety: 1,4,5,6,7,8,9	Audit of day-case angioplasty procedures in line with national standards. To be presented to Vascular Clinical Governance 15/06/21
2.3		Review and refine pathways for patients that use drugs intravenously presenting with groin abscesses	Clinical Lead for General Surgery	Secondary Care Medical Director	22 May 2020	02/11/2020		30/11/2020 Amended to 31/07/21 as further discussions between clinicians and site medical director at YG is required.		In progress but not on track/overdue/late starting		**Update June 2021:** Secondary Care Medical Director has agrred with WMH and YGC that current pathway led by general surgery is appropriate. Meeting still to occur at YG.	Safety: 1,4,5,6,7,8,9	Audit of compliance to the pathway to be undertaken once pathway agreed
2.4		Review and refine pathway for patients post major arterial surgery requiring rehabilitation	Vascular Network Manager	YGC Medical Director	22 May 2020	02/11/2020		30 November 2020		Completed		**Update February 2021:** Approved at CAG on 27/01/21.	Safety: 1,4,5,6,7,8,9	Audit of compliance to the pathway to be undertaken
2.5		Refine and review pathway for non-surgical arterial condition for 'palliative' patients, in conjunction with palliative care team	Vascular Network Manager	YGC Medical Director	22 May 2020	23/10/2020				Completed		**Update February 2021:** Approved at CAG on 27/01/21.	Safety: 1,4,5,6,7,8,9	Audit of compliance to the pathway to be undertaken
3.0	**Communication and Engagement**	Milestone 3 - Communication and Engagement											
3.1		Communication Plan to be drafted with input from staff, CHC, service user representatives for presentation at the Vascular Task and Finish Group	Communications Officer	Assistant Director Of Communications And Engagement,	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 and approved on 13/08/20 Vascular T&F Group meeting	Service: 1, 2 Safety: Indirectly supports all recommendations	
3.2		Ensure any service change includes service user and carer involvement, and utilise patient feedback to inform improvement	Head Of Patient & Carer Experience	Head Of Patient & Carer Experience	22 May 2020	Ongoing		01/09/2020 Revised as the initial deadline was the first T&F group meeting date	01/09/2020	Completed		Plan detail in the Communication & Engagement section	Service: 1, 2 Safety: Indirectly supports all recommendations	Patient evaluation of ward patient information undertaken December 2020 - completed
3.3		Review opportunities for staff to speak and feel able to raise concerns, including Safe Haven arrangements	Executive Medical Director	Executive Medical Director	22/05/2020	15/10/2020		01/11/2020 Revised as the initial deadline was the first T&F group meeting date		Completed		Update from AG that review of process for freedom to speak up is underway to create a BCUHB policy. To be brought to the group once finalised.	Service: 1, 2 Safety: Indirectly supports all recommendations	
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	Head Of Patient & Carer Experience	Head Of Patient & Carer Experience	22/05/2020	16/06/2020			16/06/2020	Completed on time		Sent out by CO 23/06/20	Service: 1, 2 Safety: Indirectly supports all recommendations	Ongoing patient experience feedback with support of the corporate team
3.5		Review of patient information and accessibility (including travel) with the support of the patient experience team	Head Of Patient & Carer Experience	Head Of Patient & Carer Experience	22/05/2020	16/06/2020			16/06/2020	Completed on time			Service: 1, 2 Safety: Indirectly supports all recommendations	
4.0	**Quality and Safety**	Milestone 4 - Quality and Safety											

4.1		Baseline Safety culture survey to be undertaken to inform areas for improvement	Head Of Patient & Carer Experience	Associate Director Of Quality Assurance And Assistant Director Of Patient Safety And Experience	22/05/2020	17/07/2020		30/10/2020 This was extended due to the logistics of undertaking the survey across the Health Board. 15/04/21 Closing period for survey extended due to poor response in the first round. Results being presented 15/04/21		Completed		Update February 2021: Interim organisational report drafted. Segmentation not granular enough to identify vascular services. Chair has commissioned a targeted sample to those who work in vascular services. To be sent out 08/02/21 for 3 weeks. Update March 2021: Survey had been out for 3 weeks. Feedback that there have not been sufficient responses to analyse (n=10). Analyst advised keeping it open for another week. As at 09/03/21 there were n=28 responses. Awaiting analysis of this. Update April 2021: Report circulated to Task and Finish Group and presented to the group by Peter Morris, Patietn, Safety and Experiecnce Business Analyst on 15/04/21.	Safety: 2,3,4,5,6,7,9 Service: 2	Repeat survey at a time determined by the T&F group
4.2		Benchmarking of service incident reporting to improve safety via an open incident reporting culture and improve learning	Head Of Patient & Carer Experience	Associate Director Of Quality Assurance And Assistant Director Of Patient Safety And Experience	22/05/2020	17/07/2020		20/08/2020 Deadline extended as team unable to provide the anaylsis for original date.	13/08/2020	Completed		Action plan updated for 17/09/20 meeting and plan detail in the Communication and Engagement section	Safety: 2,3,4,5,6,7,9 Service: 3	Discussion and sharing of learning at Clinical Governance
4.3		Explore the potential to work with a high reporting service to share good practice	Head Of Patient & Carer Experience	Associate Director Of Quality Assurance And Assistant Director Of Patient Safety And Experience	22/05/2020	01/09/2020		01/09/2020	15/10/2020	Completed		Action plan updated for 17/09/20 meeting and plan detail in the Communication and Engagement section	Safety: 2,3,4,5,6,7,9 Service: 4	
4.5		Develop key workforce indicators to provide assurance on the safety of the workforce, including escalation measures	Vascular Network Manager	Vascular Network Manager	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.	Safety: 2,3,4,5,6,7,9 Service: 5	Workforce indicators to be reviewed in Q&S
4.6		Training Needs Analysis to be undertaken to support the emerging clinical pathways and future workforce model	Service Clinical Leads	Service Clinical Leads	22/05/2020	13/08/2020		27/11/2020 - complete for all pathways except the non-arterial diabetic foot pathway. Extended to 30/06/21		In progress and on track		Work ongoing with pathways prior to this being actioned. As delay on IVDU conclusion and finalisation of diabteic foot pathway is close to the June month end this action won't be completed on time but can be done in July 2021. June 2021: Learning needs to be identified post IVDU pathway meeting with Secondary Care Medical Director. Learning needs associated with the diabetic foot pathway will be developed as part of the gap analysis by the Diabetic Foot Pathway TFG.	Safety: 2,3,4,5,6,7,9 Service: 6	
4.7		Issues of significance report from Vascular Task and Finish group to Quality, Safety and Experience Committee	Secondary Care Medical Director Vascular Network Manager	Executive Medical Director	22/05/2020	Ongoing		01/09/2020	01/09/2020	Completed on time		Regular reports to QSE and Welsh Government on progresss.	Safety: 2,3,4,5,6,7,9 Service: 7	
5.0	Clinical Effectiveness	Milestone 5 - Clinical Effectiveness												

5.1		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	Clinical Director - Vascular	Secondary Care Medical Director	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. September 2020: Detailed update on the audits currently underway within the service and the opportunities to benchmark provided	Safety: 9	Compliance with Tier I-III audits
5.2		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	Head Of Patient & Carer Experience	Secondary Care Medical Director	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. Dashboard in use by the service.	Safety: 9	
5.3		Review of PROM/PREM measures to improve patient experience alongside existing patient experience data	Vascular Network Manager	Secondary Care Medical Director	22/05/2020	16/06/2020			16/06/2020	Completed			Safety: 9	
5.4		Evaluate and report to Quality, Safety and Experience Committee compliance with agreed service implementation plans	Vascular Network Manager	Secondary Care Medical Director	22/05/2020	Ongoing		01/03/2021		Completed		Regular reports to QSE and Welsh Government on progresss.	Safety: 9	
5.5		Monitor vascular waiting times	Vascular Network Manager	Chief Operating Officer	22/05/2020	Ongoing		17/09/2020		Completed			Safety: 9	Monitoring via the vascular dashboard
5.6		Reporting template and submission to be drafted by the Secondary Care leadership team and to be ratified	Vascular Network Manager	Secondary Care Medical Director	22/05/2020	16/06/2020			16/06/2020	Completed on time		Kate Clark to re-circulate reporting template. Action closed.	Safety: 9	

Appendix 2 - Vascular Activity Across District General Hospitals

Ysbyty Gwynedd (YG)			
Date	**pre 2015 (3 site model)**	**2015-2019 (2 site model)**	**Current (YGC vascular hub, WMH and YG as vascular spoke sites)**
Procedures	all major and minor vascular procedures	all major and minor vascular procedures	• Dialysis access formation (Fistulas and PD catheters) • Minor vascular procedures including minor amputations, foot debridement • IR procedures including angioplasty / stents • Varicose vein procedures (open, ednovenous)
Outpatients	Vascular outpatient clinics	Vascular outpatient clinics	Vascular outpatient clinics
Referrals/reviews	• Inpatient and AE referrals • Inpatient reviews	• Inpatient and AE referrals • Inpatient reviews	• Inpatient and AE referrals • Inpatient reviews • Urgent patients are referred to the vascular consultant on call in YGC
Inpatient care	vascular inpatient beds	vascular inpatient beds	No vascular inpatient beds

Wrexham Maelor Hospital (WMH)			
Date	**pre 2015 (3 site model)**	**2015-2019 (2 site model)**	**Current (YGC vascular hub, WMH and YG as vascular spoke sites)**
Procedures	all major and minor vascular procedures	all major and minor vascular procedures	• Dialysis access formation (Fistulas and PD catheters) • Minor vascular procedures including minor amputations, foot debridement • IR procedures including angioplasty / stents • Varicose vein procedures (open, ednovenous)
Outpatients	Vascular outpatient clinics	Vascular outpatient clinics	Vascular outpatient clinics
Referrals/reviews	• Inpatient and AE referrals • Inpatient reviews	• Inpatient and AE referrals • Inpatient reviews	• Inpatient and AE referrals • Inpatient reviews • Urgent patients are referred to the vascular consultant on call in YGC
Inpatient care	vascular inpatient beds	vascular inpatient beds	No vascular inpatient beds

Ysbyty Glan Clwyd (YGC)			
Date	**pre 2015 (3 site model)**	**2015-2019 (2 site model)**	**Current (YGC vascular hub, WMH and YG as vascular spoke sites)**
Procedures	all major and minor vascular procedures	all major and minor vascular procedures	all major and minor procedures
Outpatients	Vascular outpatient clinics	Vascular outpatient clinics	Vascular outpatient clinics
Referrals/reviews	• Inpatient and AE referrals • Inpatient reviews	• Inpatient and AE referrals • Inpatient reviews	• Inpatient and AE referrals • Inpatient reviews
Inpatient care	vascular inpatient beds	no vascular inpatient bed	Vascular inpatient beds as vascular hub

Cyfarfod a dyddiad: Meeting and date:	Quality Safety and Experience Committee 6th July 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Health and Safety 2020/21 Annual and Quarter 4 Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Green, Executive Director of Workforce and Organisational Development
Awdur yr Adroddiad Report Author:	Pete Bohan, Associate Director of Occupational Health, Safety & Security Sue Morgan, Head of Health and Safety
Craffu blaenorol: Prior Scrutiny:	Strategic Occupational Health and Safety Group 25th May 2021
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Committee is asked to note the position outlined in the Annual and Quarter 4 Report support the recommendations identified within the findings:
1. Implement year 2 of the Occupational Health & Safety (OHS) Strategy.
2. Ensure adequate staffing is available to provide an appropriate H&S security function to BCUHB.
3. Ensure adequate staff and premises to provide Manual Handling training
4. Establish a permanent fit test program
5. Develop further policies and safe systems of work to provide evidence of practice.
6. Establish monitoring systems from the Divisions and Hospital Management Teams to measure performance including clear key performance indicators.
7. Train senior leaders and develop further competence in the workforce at all levels
8. Learn lessons from incidents and develop further the risk profile

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

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:

The Annual and Quarter 4 report provides an update on the work undertaken by the Corporate Health and Safety (H&S) Team during the period between the 1st of April 2020 and 31st of March 2021 with an overview of Q4 1st of January to the 31st of March 2021. 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 is fully compliant with legislation.

Asesiad / Assessment & Analysis

Strategy Implications
BCUHB are in the process of implementing the OHS 3-year Strategy. The priority being wherever practicable to eliminate or minimise 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. It will also reduce financial waste and improve the quality of care and quality outcomes given to clinical services and non-clinical support services. We are now in the second year of the plan which has been delayed due to Covid 19 work over the past 12 months. We collect 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 all elements of 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. Failure to implement recommendations may result in criminal proceeding against the body corporate or individuals.

Financial implications
There are significant budgetary implications, which are currently not funded. A business case is being further developed and will be shared with the relevant Executive Directors. The major financial implications include staffing for Security and Health and Safety, Training packages include the Institute of Occupational Health (IOSH) Director/Leading Safely and Managing Safely programmes and fit testing staffing. Estates related software includes MiCad for schematic drawings of the estate and SHE for managing contractors, Sypol for Control of Substances Hazardous to Health, water safety findings and asbestos management plan with the implementation of risk assessment findings for fire and compartmentation particularly in Bangor Hospital and health surveillance systems for staff.

Risk analysis
The significant risks have been escalated to the Board Assurance Framework and were previously agreed by QSE. These include Leadership of OHS, Security Management. The specific Estates related risks including Contractor Management and Control, Asbestos, Legionella and Fire Safety are now on Tier 1 Estates will directly manage these with OHS support.

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 required priorities reallocating. Those areas that sit with Estates including fire safety, asbestos, control of contractors, working at height, electricity and water management will remain under review by the Estates team. Authorisation was given to recruit a temporary H&S Advisor specifically to support this work with the Estates Team with a dedicated 15 hours per week. In Q4 a detailed review of Water Safety was undertaken and a comprehensive report has been provided to the Estates Team with recommendations and an action plan. Work has now commenced on a detailed review of Electrical Safety with a draft report for Estates in the West completed. Further work to be undertaken for Central and East areas.

To support the additional work required for the gap analysis, a list of H&S policies, procedures and guidance documents have been collated. The team are working through updating these, with all of the guidance documents now completed.

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. With changes in restrictions of movement since this date the H&S team primarily focused on supporting the Hospital Management Teams and department managers with site visits to support with the 'social distancing and staying safe' program and later with undertaking risk assessments for staff returning from shielding. In Q4 a further 127 social distancing and staying safe visits were undertaken bringing the total for the 2020/21 year to 431. The Key Performance Indicator implemented in January 2021 is for one of the team to attend within 2 weeks of the request being made. All visits in Q4 were within this timescale.

The team also reintroduced on a small scale the formal Corporate Health and Safety reviews in Q3 as part of the BCUHB auditing process. In Q4 48 H&S reviews were undertaken giving an overall total of 85 Corporate Health and Safety reviews undertaken in 2020/21.

3.   Corporate Health and Safety Team COVID-19 specific guidance

Along with the site social distancing visits, the team have provided guidance documents since the beginning of the pandemic for all staff with advice on staying safe and keeping well. To date there have been 20 short guidance documents produced which have been regularly updated in line with Welsh Government guidance changes. These guidance documents included advice for staff working from home and particularly the use of laptops, mobile phones and tablets and guidance for additional controls for staff at increased health risk from COVID-19 as examples. The guidance documents are stored on the Corporate H&S team webpage and are linked into the team's Frequently Asked Questions (FAQs) document. This document was first produced on the 27th of March 2020 and to date there have been a total of 14 versions updated onto the webpage.

4.   Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

4.1   Q4 RIDDOR incidents reported to the Health and Safety Executive
In Q4 the following RIDDORs have been reported:

Area	COVID-19 RIDDORs	Non-COVID-19 RIDDORs	Total Q4	Comparison total Q4 2019
East	40	7	47	3
Central	18	4	22	11
West	56	5	61	9
Total	114	16	130	23

4.2   2020/21 RIDDOR incidents reported to the Health and Safety Executive

For 2020/21 there have been 820 reports made to the HSE under RIDDOR, compared to the same period in 2019-2020, when 105 reports were made to the HSE. The significant increase is predominantly due to the numbers reported as Occupational Diseases following the requirement to report a person at work who has been diagnosed as having COVID-19 attributed to an occupational exposure to coronavirus. When comparing the non-COVID-19 related incidents reported under RIDDOR against the 2019-2020 figures, there has been a decrease of 30, with only 75 reports being made during this period. This is discussed in more detail further on in this paper.

Annual RIDDOR information from April 1st 2020 to March 31st 2021 compared with 2019/20

Report breakdown	2020/21 Total	2019/20 Total
COVID-19 related	745	0
Staff Injuries	57	88
Patient Injuries	18	17
	820	105

4.3   COVID-19 Staff Cases reported to the Health and Safety Executive

In the period 1st April 2020 to 31st March 2021, there have been 732 COVID-19 staff diagnosis reported as occupational diseases to the HSE under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

These break down into 86 identified COVID-19 staff clusters:
- 32 in East involving 235 staff,
- 31 in Central involving 243 staff and
- 23 in West involving 254 staff.

There were a 13 further COVID-19 related RIDDOR reportable incidents reported under the category of Dangerous Occurrences. Dangerous occurrences are unintended specified events that have the potential to cause harm and with COVID-19 the incident must or could have resulted in the release or escape of coronavirus leading to a possible or actual exposure to it. As an example all early staff COVID-19 clusters were reported as a Dangerous Occurrence under advice from the HSE and were later reported individually as Occupational Diseases when the guidance changed.

Annual Breakdown of COVID-19 staff cases reported under RIDDOR per month from April 1st 2020 - March 31st 2021
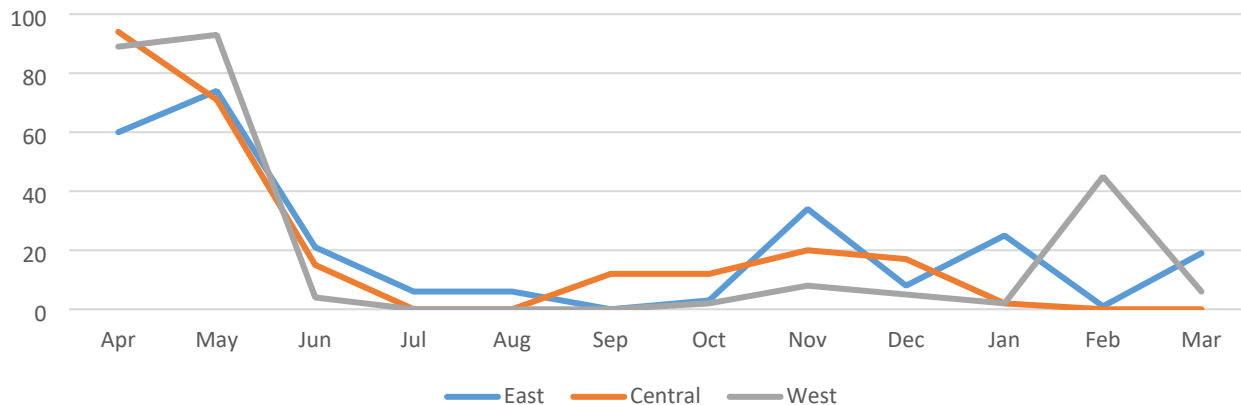
The total number of positive cases by week has been provided by the Workforce Information teams below:

Positive Cases by Week
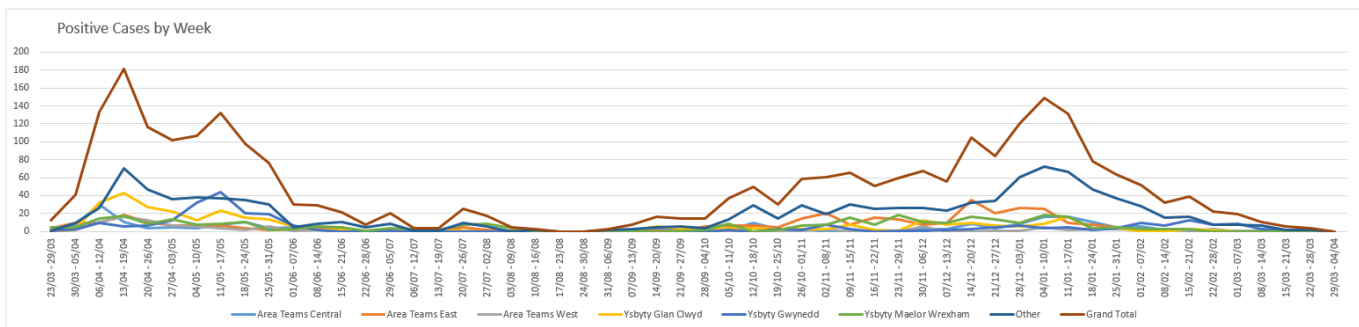
The Corporate Health and Safety Team supported the three area COVID-19 Outbreak Incident Management Teams (2 in East and 1 in Central). In July 2020, the team implemented a 72-hour review form to enable managers to collate the information required in a more structured way for reporting under RIDDOR to reduce the number being reported outside of the statutory timescale. The Corporate H&S team check all of the 72-hour reviews attached to Datix records to determine if the incident is reportable as an occupational disease.

In conjunction with the 72-hour reviews, the joint 'Make It Safe' (MIS) investigations that are held in conjunction with Clinical Services, Infection Prevention and Control (IPC), Public Health Wales (PHW) and H&S on all related COVID-19 outbreak clusters have identified a number of potential transmission sources.

These include:

- Potential breaches of Personal Protective Equipment (PPE) when providing hands on care, which includes caring for challenging patients
- Donning and doffing of PPE that is not of an appropriate standard
- Shortages of PPE in work areas
- Cramped staff rest/welfare areas making social distancing difficult
- Inadequate ventilation and air movement in work environments
- An absence of adequate changing facilities for staff

- Non-adherence to social distancing or the mandatory wearing of face coverings by both staff and patients
- Non-compliance with the Welsh Government recommendations regarding bed spacing
- Ineffective/insufficient cleaning regimes for high touch surfaces and equipment
- Inadequate COVID-19 Workplace or Workforce risk assessments for night and roaming staff
- Lack of supervisory visits and audits of PPE and social distancing compliance during all shifts

For these clusters, remedial action has been recommended and implemented to prevent reoccurrence. It is also now a mandatory requirement to have a COVID-19 Workplace Risk Assessment in place. A template has been developed by the Corporate H&S team to support managers for BCUHB wide communication and implementation. This is in addition to and compliments the All Wales COVID-19 Workforce Risk Assessment.

4.4   COVID-19 related Dangerous Occurrences reported to the Health and Safety Executive

In 2020/21 there have been 13 COVID-19 related Dangerous Occurrences reported to the HSE under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

At the beginning of the pandemic advice from the HSE was to report staff clusters as a Dangerous Occurrence. The advice was later changed and the staff involved in these clusters were later reported individually as occupational diseases, this considerably increased the workload for the H&S Team.

Annual break down of COVID-19 related Dangerous Occurrences reported under RIDDOR from April 1st 2020 – March 31st 2021

Incident details	Total
Staff clusters reported as Dangerous Occurrences	4
Inappropriate PPE worn by staff or failure of PPE	7
Incorrectly packaged or stored coronavirus contaminated samples/equipment	2
	13

4.5   COVID-19 Sharps related incident reported to Health and Safety Executive

In 2020/21, there has been one sharp related incident reported as a Dangerous Occurrence to the HSE under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). The appropriate Occupational Health management was followed and a Root Cause Analysis undertaken. The action implemented from this investigation was that an audit of compliance to the 'Insertion of a Central Line Checklist' will be undertaken. This action is ongoing.

4.6   Non-COVID-19 related incidents relating to staff reported to the Health and Safety Executive

In 2020/21, there have been 57 incidents relating to staff reported to the HSE under RIDDOR. This is a marked decrease of 53 compared to the same period in 2019-2020 when 110 reports were made. This can be attributed to an number of factors relating to the coronavirus pandemic; a reduction of staff at the work-place, lack of capacity in operational services to report incidents on Datix and a pre-occupancy of focus on COVID-19.

Each incident was deemed to be a 'work-related accident'. This means that the way the work was carried out, the machinery, plant, substances or equipment used or the condition of the site or premises where the incident happened was a contributable cause to the accident.

Annual Breakdown of staff-related incidents reported under RIDDOR from April 1st 2020 – March 31st 2021

	BCUHB Central	BCUHB East	BCUHB West	Total
Abuse of staff by patients	6	0	4	10
Musculoskeletal	6	6	5	17
Slip, Trip, falls of staff	6	5	10	21
Collisions	0	0	2	2
Equipment failure	1	1	5	7
Total	19	12	26	57

Annual breakdown of staff-related accidents per month reported under RIDDOR from April 1st 2020 to March 31st 2021
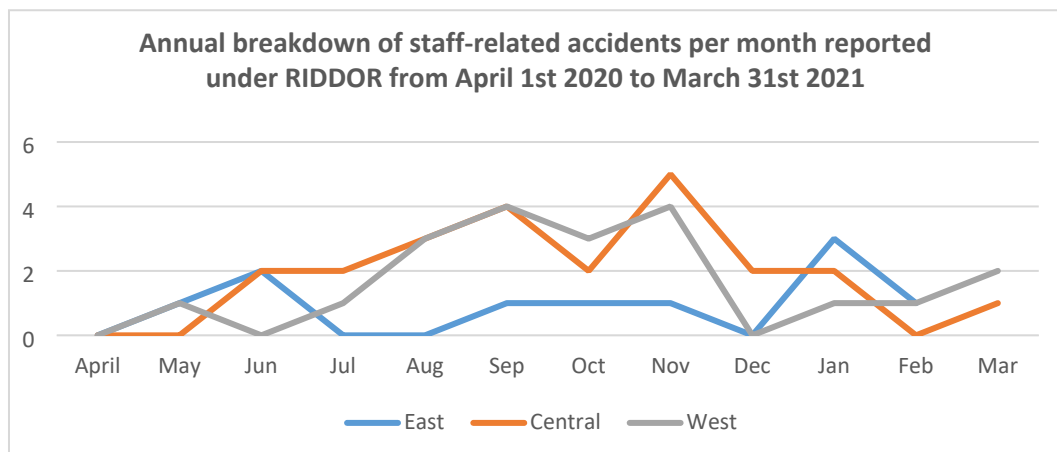
4.7 Root Cause Analysis

A Root Cause Analysis (RCA) is required to be carried out by the operational service for every incident that is reported to the HSE under RIDDOR. This is to identify the root causes of an incident and to ensure any lessons are identified and remedial action implemented to prevent a further occurrence.

Out of the 57 staff-related accidents reported to the HSE under RIDDOR from April 1st 2020 to March 31st 2021, 38 had RCAs completed. Similar to 2020-2021 the quality of the RCAs carried out were generally poor, which affected identification of lessons learnt. Closer scrutiny of RIDDORs is required and work continues to improve the RCA process and provide investigation training in order to improve overall safety within BCUHB.

4.8 Non-COVID-19 related RIDDOR incidents relating to patients reported to the Health and Safety Executive

In the period 1st April 2020 to 31st March 2021, there have been 18 incidents relating to patients reported to the HSE under RIDDOR. Each of these incidents involved a patient fall in which a specified injury was sustained. Each incident was deemed to be a 'work-related accident', either because there

had been insufficient assessment of the risk of falls, or non-compliance with identified control measures to mitigate against the risk of falls.

Annual break down of patient related incidents reported under RIDDOR from April 1st 2020 – March 31st 2021

Area	Total
BCUHB Central	4
BCUHB East	7
BCUHB West	7
	18

Just to note, the investigations relating to these accidents are undertaken by the Operational Governance Teams and scrutinised by the Patient Safety and Patient Experience Team, with identified lessons-learnt shared across the organisation

## 5.	HSE investigations 2020/21

### 5.1	HSE investigations Q4, Notification of Contravention

On the 23rd of February 2021, the HSE issued a Notification of Contravention letter to BCUHB. This letter identified contraventions of health and safety law identified during an investigation the HSE undertook following a staff member who contracted COVID-19 and sadly passed away. Although it could not be confirmed where the staff member may have contracted COVID-19, material breaches were identified that BCUHB are now required to rectify. A Task and Finish group was established to primarily complete an action plan based on seven overarching recommendations. The requirements include implementing a recorded daily monitoring system to ensure that staff have had a fit test, that they are fitted to the mask they have available and that they understand what can impact the fit so they know when to have another fit test. A suggested way of completing this was to use Fit Test Identification Cards and a trial is due to start on the week commencing 19th of April in three departments across BCUHB. A further requirement is to ensure that the controls implemented following the completion of the COVID-19 Workforce Risk Assessment are suitable and sufficient. A response to the HSE is required on the 14th of April 2021

### 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 led to an HSE investigation and subsequently BCUHB received an Improvement Notice on the 24th of August 2020. Details have been given in previous quarterly H&S reports but in brief the Respiratory Protective Equipment Task and Finish Group undertook a significant action plan to completely change the Fit Testing Program in BCUHB. Fit testing is now only undertaken using the Quantitative method using PortaCounts, 18 had been purchased by the end of October 2020 and in March 2021 a further six were purchased. There is an interim Fit Testing Co-ordinator team in place and all fit testers have undertaken the Competent Fit Testers training by an Accredited Fit2Fit trainer. The Fit Testing Protocol has been written to replace the original guidance document and is due to go for final ratification in the Strategic Occupational Health Group in May 2021. Training for the fit testers is recorded on the Electronic Staff Record (ESR) and the work is progressing on recording all staff who have had an appropriate fit test on ESR as well.

The HSE have now confirmed that BCUHB have complied with the conditions set out in the Improvement Notice which relates to Ysbyty Glan Clwyd (YGC). The refitting of all staff in high risk areas was delayed due to the shortages of the 1863 respirator stock and no other viable alternative at that time. The stocks of the 1863+/9330+ are stable and there are enough to undertake the full refit program.

5.3 Additional HSE investigations

The HSE have requested information on three COVID-19 staff clusters during 2020/21 and reports were provided for these. The team have also been required to collate further information for two patients who had falls working closely with clinical teams and the Patient Safety and Experience Team. One of the patient falls was in Wrexham and the other relates to two falls for the same patient in the West area.

The HSE have also undertaken an investigation into two staff members who contracted COVID-19 and sadly passed away. A full H&S investigation has been undertaken by the Corporate H&S Team and information passed to the HSE.

6.   Datix incidents (Personal Injury)

A total of 2,309 incidents were reported in Q4 under the datix category 'Accident that may result in personal injury incidents'. The figures for COVID-19 related have marginally dropped in Q4 from Q3 along with the non COVID-19 related.

	01.04.20 – 30.06.20 (Q1)	01.07.20 – 30.09.20 (Q2)	01.10.20 – 31.12.20 (Q3)	01.01.21 -31.03.21 (Q4)
Total	2,122	1,867	2,260	2,309
Staff	770	431	791	733
	257 Non C19	301 Non C19	375 Non C19	331 Non C19
	513 C19 related	130 C19 related	416 C19 related	402 C19 related
Patients	1,328	1,403	1,432	1547
Other	24	33	37	29

6.1   Breakdown of incidents by category

Slip, Trip, Fall and Collison Incidents involving staff reported via Datix
In 2020/21 there have been 296 slip, trip, fall and collision incidents involving staff reported via Datix.

BCUHB East	86
BCUHB Central	120
BCUHB West	90

Slip, Trip, Falls and Collison Incidents involving staff reported on Datix by area, per Month
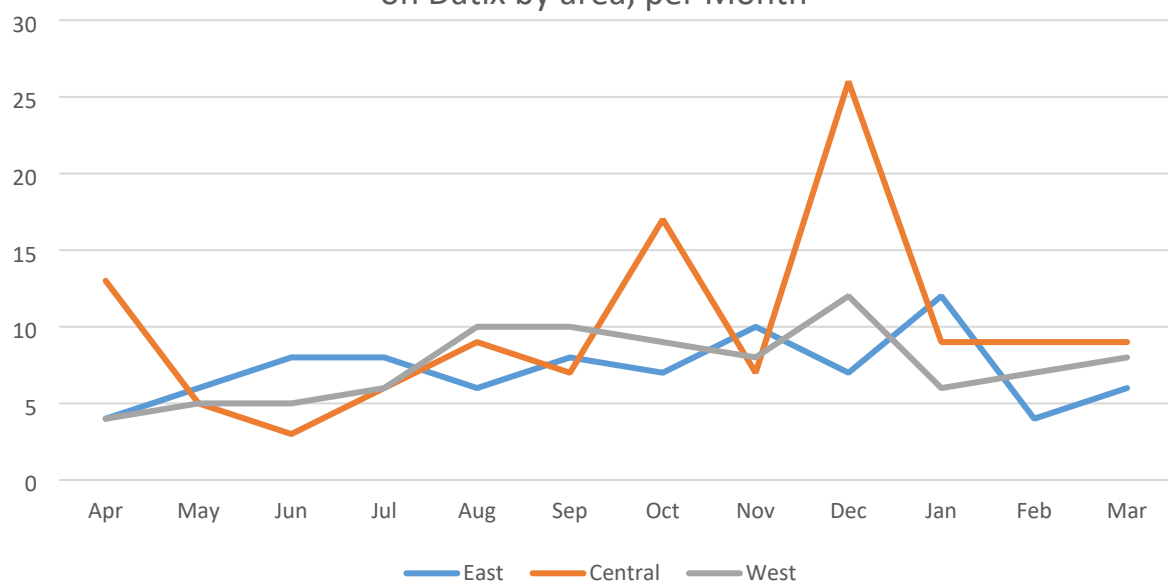
Lifting Incidents involving staff reported via Datix
In 2020/21 there have been 49 lifting incidents involving staff reported via Datix.

BCUHB East	18
BCUHB Central	16
BCUHB West	15

Lifting Incidents involving staff reported on Datix by area, per Month
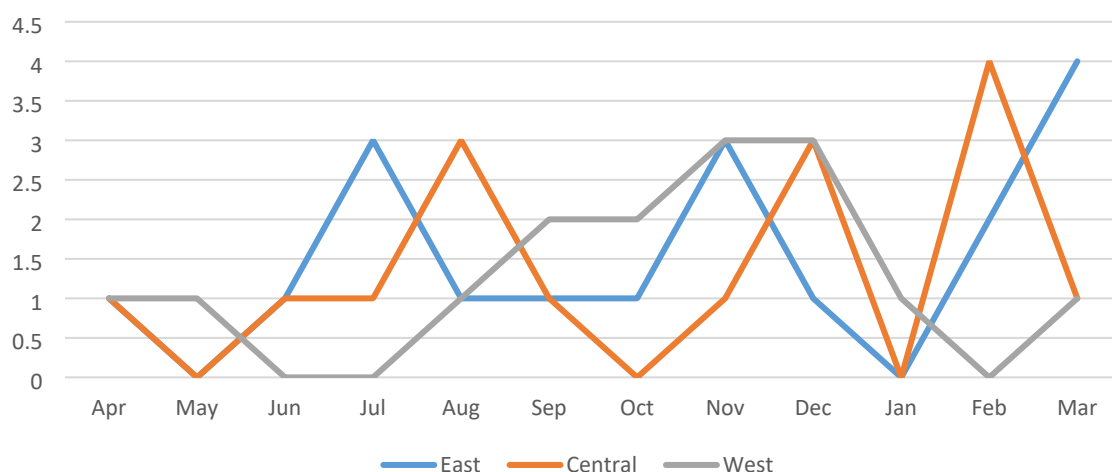
Injuries caused by physical or mental strain involving staff reported via Datix

In 2020/21 there have been 124 injuries caused by physical or mental strain involving staff reported via Datix.

BCUHB East	42
BCUHB Central	44
BCUHB West	38

Injuries to staff caused by physical or mental strain reported via Datix by area, per Month
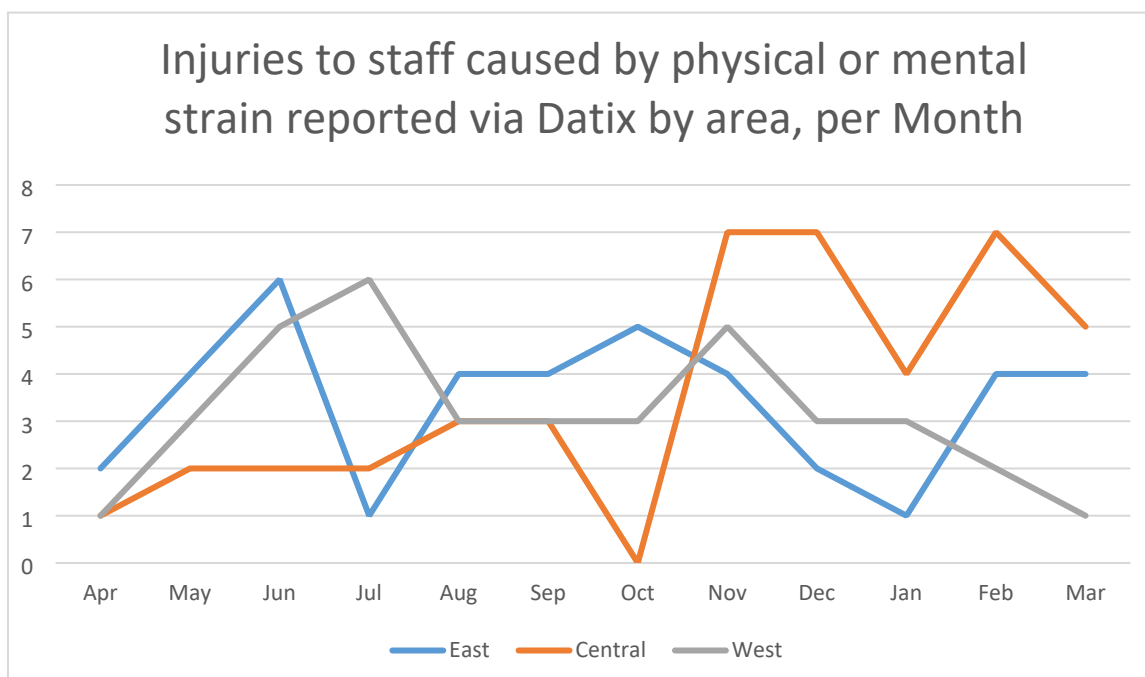
Needle-stick or sharps injuries caused involving staff reported via Datix

In 2020/21 there have been 320 needle-stick or sharps injuries involving staff reported via Datix.

BCUHB East	95
BCUHB Central	136
BCUHB West	89

Needle-stick and sharps injuries involving staff reported via Datix by area, per Month
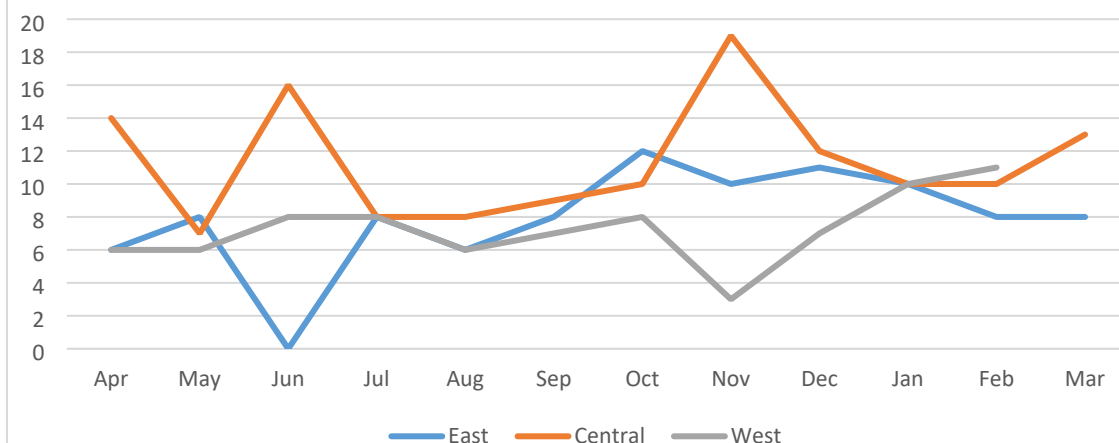
7.   Security

Effective security provision within BCUHB remains a significant challenge as reflected by its scoring within the risk register. Roles and responsibilities for service providers as well as individual job roles are unclear, however progress has been made with the development of a Business Case, which identifies and proposes strategies to address those concerns. Progress has been made with increased hours for security guard deployment at all three district general hospitals to allow for 24/7 cover to be achieved. The construction of three temporary hospital sites has required the deployment of security guards on those sites. There have also been a small number of guards required for local vaccination centres based in the community.

7.1   Reported incidents of Violence/Aggression & Security

During the period 1st April 2020- 31st March 2021 there were 3,479 incidents of violence & aggression recorded on the Datix system; there were 3,983 incidents the previous year.

V&A incidents by Category (date range 01/04/20-31/03/21)

Category	Number	Previous Year
Aggressive Behaviour	**1441**	1680
Verbal Abuse	**231**	286
Assault	**622**	940
Threatening Behaviour	**278**	225

835 incidents were recorded as 'other and unreported'. Aggressive Behaviour, Assaults and Verbal Abuse have fallen from previous year and could be explained by the fall in "footfall" onto hospital site during lockdown periods.

V&A Incidents by Result (date range 01/04/20-31/03/21)		
Result	Number	Previous year
Personal Injury	**739**	1116
No Injury or Harm	**2015**	2141
Near miss with intervention.	**573**	570

Near miss no intervention	**82**	106
Damage to Property	**49**	49

V&A Incidents "affecting staff"	
1st April 2020-31st April 2021	1st April 2019 - 31st March 2020
1668	**2257**

14 RIDDORs were reported compared to 22 in the previous year.

340 Incidents indicate that police were called increasing from 157 in the previous year.

Security Incidents	
1st April 2020-31st March 2021.	1st April 2019 - 31st March 2020
912	**1084**

The security Datix report will be reviewed during 2021-2022 to explore if more detailed data can be extracted similar to that of Violence/Aggression reports.

From the 16th of November 2020 all Violence/Aggression & Security datix incidents have been reviewed thanks to the additional staff resource of the Security/V&A advisor. 92% of all reported incidents indicate a review by Security/V&A advisor.

7.2   Obligatory Responses to Violence in Healthcare

The Obligatory Responses to Violence in Healthcare status was due to be enhanced by the issue of a Welsh Health Circular during 2019 supported by Welsh Government. This has been delayed due to Brexit and COVID-19 pandemic with an expected date due in spring 2021. Due to the pandemic, the information sessions with North Wales Police to promote the Obligatory Responses process were suspended but arrangements have been made to recommence in April 2021.

The Obligatory Responses to Violence in Healthcare process has had a significant positive impact upon those incidents in which persons with mental health issues engage in violence towards staff. There are continued attempts by Violence and Aggression Case Management to highlight the need for engagement within those areas which are volume generators of violent incidents where staff are victims. Information is now posted upon the Health Board's intranet system and automated links have been set up within the Datix incident reporting system in an attempt to signpost staff to support when required. It was hoped that information would be supplied during V&A training from April 2020 however; this has been delayed due to the pandemic.

7.3   Personal Safety Markers

Communicating a patient's past behaviour in relation to violent/threatening incidents is fundamental to reducing the risk of further violence. To this end, the aim of a personal safety marker is to assist in early alerting of individuals who pose a risk of violence towards BCUHB employees. Early identification and communication of this risk should assist in measures being taken to enhance safety. A BCUHB Working Group, chaired by Informatics Head of Clinical Systems, has been established, to explore the possibility of Personal Safety Markers (and Alerts/Allergies) being established across the Health Board using the electronic patient record systems. The Personal Safety Marker (for Violence/Aggression) is yet to be adopted, largely due to infrastructure and compatibility issues surrounding the electronic patient note system. Work in this area has remained static over several years due to the compatibility

issues experienced by the electronic note system. There continues to be no BCUHB Violence & Aggression Alert system in place. Attempts to incorporate an alerts system within the electronic patient notes will recommence in financial year 2021-2022

7.4   Changes in Legislation

The Welsh Government continues to review section 119 & 120 of the Criminal Justice and Immigration Act 2008, which makes causing a nuisance or disturbance on NHS property an offence and gives powers of removal using reasonable force to NHS employees. This may have training implications for BCUHB staff and potentially contracted security staff. The review was delayed by the pandemic and the Senedd will re-explore this aspect of legislation in the 2021-2022 financial year.

7.5   Policy/Procedure development/reviews

BCUHB procedure HS02 Procedure & Guidance Protecting Employees from Violence and Aggression has been reviewed and distributed for consultation and should be finalised by the end of April 2021. The CCTV and Security policies have been drafted and were due to be presented to the Strategic Occupational Health & Safety Group. This had been delayed due to the pandemic and changes to the proposed business case for security. The CCTV policy has been drafted but will require extensive review due to changes in CCTV equipment that will allow for Ysbyty Glan Clwyd to act as a "central hub" for CCTV monitoring/management from other sites and awaiting an extensive review of all CCTV systems by an external consultancy contractor as arranged by BCUHB Estates & Facilities division.

7.6   Resources

BCUHB security management service for consists of,

1x Fulltime Head of Health & Safety

1x 0,8WTE Violence & Aggression Manager/Security Manager

From October 26th 2020 this was complemented by

1x fulltime Security/V&A advisor on a Bank staffing basis

8.   Manual Handling

8.1   Training

Access to training rooms has been the greatest challenge faced this year over the three main sites, this is having an effect on accessibility for staff. This is particularly the case in the West due to a larger geographical area and no training room provision since January 2021. The nearest training location for these staff is in the Llandudno General Hospital. Temporary rooms were set up in all 3 Field Hospitals, along with empty ward spaces available due to COVID-19 displacement, to alleviate poor room accessibility and provide a service. The manual handling team remain under resourced from a combination of reduced working hour requests, shielding due to Covid-19 and maternity leave temporary Bank provision has supported the service.

At the start of 2020/21 the delivery of Manual Handling training changed. The department provides patient handling training for both BCUHB employees and Health Science Students from Universities and a total of 29 patient handling refresher courses (348 places) were cancelled. The team concentrated on Back to Floor sessions and completed 40 of these before being redeployed. At the end of June the team were brought back together and recommenced training using strict Standard Operating Procedures and under risk assessment. This year they have offered 544 refresher classes (3,624 places) however the Did Not Attend rate is around 35% for courses booked and many have had to be cancelled. The main reasons given for not attending have including concerns with travelling to training rooms and staff shortages meaning they are not able to be released. The current compliance in BCUHB for patient handling refresher training has decreased throughout this year and is now at 59%.

In addition to the patient handling refresher courses the team have provided 213 full day Foundation patient handling courses to complete the All Wales Manual Handling Passport. They have also provided videos on the most commonly used Patient Handling techniques used to support staff through the pandemic and introduced workbooks that can be completed prior to attending the courses.

Load handling training previously attended through mandatory training days in lecture theatres has stopped with no further plans from Workforce & Organisational Development (WOD) to reinstate following COVID-19. Whilst 11 Load Handling Workbooks have been marked and staff updated, a new interactive Microsoft Teams course has been
created to fill the void with 340 places through 18 classes provided and positive feedback received.

Manual Handling Champions course recommenced towards the end of the financial year, this 2-day course offered 26 places through the 6 courses, where staff are upskilled to ensure gold standard manual handling occurs in their workplace, reduce MSK's and Datix, and update peers. During this financial year the current Champions have updated a total 1,280 staff in their workplace, however due to resources the provision of regular support and group meetings for the existing Champions has not taken place.

8.2   Datix (Manual Handling)

There have been 115 Datix incidents where the incident relates to manual handling that affects staff. These are targeted to be answered within 7 days, advice offered and those highlighted with any training issues have direct input from the department, further training given and followed up to ensure targeted intervention provided is effective. There was a noticeable lull of reporting during the early months of the pandemic, during the last quarter the Datix numbers have increased, but are unlikely to be a true reflection of the actual number of incidents.

8.3   Assessments

The pandemic and lockdown caused disruption in the beginning of the year, where previously assessments were all undertaken in person, with the majority being performed through interactive means this year. All assessment requests are received via email and 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 financial year 134 assessments have been carried out, 86% of which are relating to DSE, this has increased due to agile working and a service set up for those struggling with their workstations whilst working from home has begun.

9.0. Recommendations

- Implement year 2 of the OHS Strategy.
- Ensure adequate staffing is available to provide an appropriate H&S security function to BCUHB.
- Ensure adequate staff and premises to provide Manual Handling training
- Establish a permanent fit test program
- Develop further policies and safe systems of work to provide evidence of practice.
- Establish monitoring systems from the Divisions and HMTs to measure performance including clear KPIs.
- Train senior leaders and develop further competence in the workforce at all levels
- Learn lessons from incidents and develop further the risk profile

The Committee is requested to note the position outlined in this report and support the recommendations.

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

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 6th July 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Mental Health – an update from the adult (MHLD) division and the child and adolescent service (CAMHs)
Cyfarwyddwr Cyfrifol: Responsible Director:	Teresa Owen, Executive Director for Public Health, (Executive Lead for Mental Health and Learning Disabilities) Dr Chris Stockport, Executive Director For Primary Care and Community Services (Executive Lead for CAMHs)
Awdur yr Adroddiad Report Author:	Mike Smith, Interim Director of Nursing, MHLD, and MHLD senior leadership team Bethan Jones, Area Director Central, Louise Bell & Fiona Wright, CAMHs
Craffu blaenorol: Prior Scrutiny:	• Divisional Directors Mental Health and Learning Disabilities • CAMHs Leadership team • Executive directors for MHLD and CAMHs
Atodiadau Appendices:	1. Narrative report
Argymhelliad / Recommendation:	

The Committee is asked to:
1. Note the update from both the Mental Health & Learning Disabilities Division, and Child and Adolescent Mental Health Services (CAMHs).
2. Discuss and agree the preferred reporting approach going forward.

Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	**X**	**Ar gyfer Trafodaeth For Discussion**	**x**	**Ar gyfer sicrwydd For Assurance**	**x**	**Er gwybodaeth For Information**	
Y/N to indicate whether the Equality/SED duty is applicable							**N**

Sefyllfa / Situation:
This is a joint 'exception' report from the Mental Health and Learning Disabilities Division (MHLD) and Children and Adolescent Mental Health Services (CAMHs). This report aims to highlight the key issues of significance to the Quality, Safety and Experience (QSE) Committee. On this occasion, the focus is on the management actions in place around the Targeted Intervention Improvement Framework (TIIF).

Cefndir / Background:
This report forms part of the regular series of updates to the QSE Committee on the Divisional MHLD QSE actions and performance. As requested, this is a joint report written alongside CAMHs colleagues. In this first joint report – • The two service areas (adults and children/adolescents) detail their key updates/issues

separately.
- The content has been written around the strategic priorities, and the Targeted Interventions Implementation Framework (TIIF) actions, alongside the key risks in each area, with the corresponding actions to mitigate or minimise risk.

This is the first 'joint' report to QSE, and this could potentially be a regular approach for the future. Should the QSE Committee require a regular joint report in the future, this could link to the TIIF maturity matrix, or a thematic joint approach could equally be explored.

Strategy Implications
None

Options considered
None appropriate

Financial Implications
A financial assessment has not been included within this exception report.

Risk Analysis
Risks are highlighted in each area reported, as are the corresponding mitigating actions where appropriate. This report relates to the risks from the key priorities and the emerging domains in the broader TIIF.

Legal and Compliance
This report provides data on compliance with the Mental Health Measure (MHM).

Impact Assessment
There are no proposed service changes within this report, and all policies follow due process for EQIA.

Appendix 1

Mental Health and Learning Disability Services

1.0	Purpose of report

This report provides an update on the actions and performance aligned to the four MHLD priority areas, which also include the areas of targeted intervention for the whole of MHLD. The report highlights the measures in place for assurance, key risks in each area, and corresponding mitigating actions taken to further manage the risk and deliver on the priorities (and now the targeted intervention implementation framework - TIIF).

The MHLD division has reduced its reporting on key issues of patient safety in this QSE report focusses upon MHLD division and CAMHs area services.

It should be noted that all previously reported exception data to this committee (not included this time), is reported to the Patient Safety and Quality Group (PSQG) chaired by the Executive Nurse.

CAMHs have provided a similar update on the TIIF priorities and their delivery actions.

The paper begins with the MHLD update, and then the CAMHs section follows.

2.0	Mental Health and Learning Disabilities - Key Priorities

The four priority areas are:
- Review of Capacity and Capability
- Stronger and Aligned Management and Governance
- Engagement with Staff, Users and Stakeholders
- Delivery of Safe and Effective Services in Partnership

Going forward, the MHLD division propose reporting jointly around the 12 key domains in the Targeted Interventions Improvement Framework (TIIF) which incorporate the above 4 strategic priorities. These 12 areas are:-

1. **Strategy and sustainability**

2. **Workforce**

3. **Care pathways for Crisis, Eating disorders and Early intervention**

4. **Accessibility of and to services**

5. **Involvement and participation**

6. **Improving access to psychological therapies**

7. **Transition to adult services from young peoples (and joint working)**

8. **MHLD Divisional Management**

9. **Effective internal relationship management**

10. **Effective external relationships**

11. **Risk, compliance and outcomes**

12. Organisational learning and timely adaptation of service delivery

We therefore suggest that this will be the last report from MHLD using the 4 key priorities framework.

2.1	MHLD Key Priority 1. Review of Capacity and Capability

2.1.1 Targeted Intervention 1. 'Embedding an organisational development approach to enable the service to effectively deliver service transformation, improved quality and outcomes'.

Measures in Place
- 'Wellness, Work and us' Strategy and Service Delivery Plan – to enhance leadership within the division and to support staff to maintain wellbeing
- Divisional Workforce meeting in place with reviewed and agreed Terms of Reference (TOR) to progress workforce priorities
- Organisational development to enable service transformation delivery is being discussed in the divisional Strategic Leadership team meetings
- Service transformation is an embedded part of the Senior Leadership Teams (SLT) meetings and there is commitment to progress this at pace.

Identified Risks
- Workforce recruitment
- Number of Interim posts
- Project Management support to all projects

Improvement Actions
- Ongoing progression with" Wellness Work and Us" year one priorities
- Transformational funding for Year 2 & Year 3 in place
- Programme Management Support enabled
- Full review of vacancy position and establishment requirements across the Division - both inpatient and community - has been completed in this period.

2.1.2 Targeted Intervention 3 'Strengthening leadership capacity within the mental health divisions for adults'

Measures in Place
- A significant focus has been placed on restoring managerial capacity, and this has been reported to the QSE committee since September 2020.

Identified Risk
- The division has potential long term stability risks due the number of interim positions as key substantive positions are not able to be yet restored.

Improvement Action
- The division appointed an Interim Director of Operations (Ms C Evanson) at the end of May 2021. The division has also appointed an Interim Head of Psychology (Dr B

Parry-Jones), and they plan to commence in role mid July 2021.   Further actions are in place to continue to address the long term stability of the triumvirate, and the other Senior Leadership Team.

2.1.3 Targeted Intervention 4 'Increased pace of service transformation in line with the Board's strategy, reflecting upon learning from the pandemic and current practice with partners'.

Measures in Place
- Divisional Clinical Pathway Planning is ongoing
- Enhanced Communication and engagement in place since phase 2– MHLD Briefings, Partnership meeting, staff side and external partners.
- Use of Digital technology i.e. Attend Anywhere and Silver Cloud
- A range of Transformational Initiatives are underway in the division

Identified Risk
- The availability of project support and programme management in the division.
- Competing divisional priorities potentially preventing transformational activity

Improvement Action
- Increasing pace of service transformation

2.2	MHLD Key Priority 2. Stronger and Aligned Management and Governance

2.2.1 Targeted Intervention 2 'Enhanced staff engagement and communication mechanisms with feedback being used to inform service change'.

Measures in Place
- MHLD Staff Briefing
- MHLD Communication and Engagement Plan
- 'Stronger Together' programme
- Partnership Group
- Wellness Work & Us (WW&U) Governance pathway
- MHLD Staff Survey
- WW&U 12 month questionnaire
- New starter questionnaires
- Reaffirmed exit interview process
- WW&U 6 month report
- Compassionate leadership report.
- Wellbeing champions/Listening leads
- MHLD Directory and Structure

Identified Risk
- Competing divisional operational priorities may distract attention from this necessary strategic work

Improvement Actions
- Continue to find ways to further enhance communication and engagement - following discussions with key partners/stakeholders.
- Continue to support and deliver the divisional contribution to the "discovery phase" of "Stronger Together" and the "let's talk" groups.

2.2.2 Targeted Intervention 7 'Good governance arrangements embedded within the Division"

Measures in Place
- Since December 2020, the divisional governance team has been re-aligned - and the team reports managerially and professionally into the Associate Director of Quality Assurance.

- Recognising the teams are part of local divisional/site, the divisional/site governance team has a "dotted line" reporting arrangement into the Director of Nursing, MHLD - who continues to set out and coordinate the day to day governance needs of the division.

- The Divisional team remain responsible and accountable for the governance of the services including all matters covered under the Putting Things Right (PTR) Regulations.

- The divisional governance team's primary role is to facilitate and promote good governance; and the divisional management team remain responsible and accountable for that activity. The Head of Governance continues to be an active and valued part of divisional/site management structure. The MHLD reflect that the arrangement is working very well.

Identified Risks
- The Division may act outside of or parallel to Board processes and not be aligned to them

Improvement Action.

- There will be further improvement and alignment of MHLD governance as a function within the board, and the sharing and improvement of skills and experience of governance professionals overseen by the Associate Director of Quality Assurance.

- There will be a focus upon Improving governance practice across the organisation by better integrating the work of the divisional/site governance teams and corporate governance teams;

- There will be a strengthening of the ward/team to board governance by enhancing the support to divisional/site governance teams directly from senior roles in the Board.

2.3	MHLD Key Priority 3. Engagement with Staff, Users and Stakeholders

2.3.1 Targeted Intervention 2 'Enhanced staff engagement and communication mechanisms with feedback being used to inform service change'.

Measure in Place

- The Discovery Phase for 'Stronger Together' has commenced, and the aim is to speak to 10% of staff to ensure a representative sample from across the workforce. The Division has provided details of staff groups who will participate in 1:1 meetings, focus groups and workshops.

Identified Risk

- There is a risk that not all staff have access to MS Teams, and given the three month period of work over the Summer months, some team members may be on leave.

Improvement Action

- Heads of Operations have been asked to identify any staff groups who do not have access to a computer/MS Teams to ensure that alternative arrangements are made to allow them to participate.

2.3.2 Targeted Intervention 6 'Strengthening quality metrics and feedback from service users demonstrating the positive impact of service changes'

Measures in Place

- CANIAD is contracted to support the division in seeking, using and optimising the service user/carer experience. The division has also been involved with the recent North Wales Community Health Council (NWCHC) Safe Space events to seek further patient/carer experience feedback. The Senior Leadership Team offered to meet with individuals who kindly shared their experiences. A meeting date was agreed but given a limited uptake of the offer, the meeting is being re-scheduled.
- The CANIAD contract will be reviewed during 2021-22 as per existing plans.

Identified Risk

- The feedback from service users may not be heard or responded to by the division

Improvement Action

- The scoping of opportunities to capture patient experience across the division is in process, and this will relate to the TIIF in future reports. Work is ongoing with NWCHC to improve joint working, and to better respond to issues raised, and this includes the Safe Space event activity.

2.3.3 Targeted Intervention 8 - 'Performance consistently meeting the standards set out in the Mental Health Act and Mental Health (Wales) Measure, for adult services'.

Measures in Place

- Local monthly performance reports are discussed in Divisional Finance and Performance with recovery actions in plans in place where required.
- Delayed Transfers of Care (DToC) Action Plan is being developed and being implemented with reductions evident
- Mental Health Measure (MHM) – A Divisional Project Action Plan has been developed and is being implemented
- Care and Treatment Plans (CTP) – A baseline audit has been developed and is being implemented across the Division
- Unscheduled Care (USC), - A report was presented at the BCHUB USC Group monthly meeting
- Quarterly Mental Health Act (MHA) - A report was presented to the MHA Committee

- A new MHA Audit programme currently being developed

Identified Risk
- The division may fail to achieve the targets in the mental health measure
- The division may fail to comply with the Mental Health Act or the MHA code of practice

Improvement Action
- Continue with regular monitoring and scrutiny of performance standards

2.3.4 Targeted Intervention 9 - 'Improve appropriate access to psychological therapies within reasonable waiting times'

Measure in Place
- The role of Head of Psychology has been absent, and the Division acknowledge that the input from the Psychology team is critical to the development of a long term model of care, the implementation of the psychological therapies review, and in providing advice to the SLT.

Identified Risks
- The waits for psychological therapies may be longer than necessary,
- The strategy to engage the whole workforce in psychologically minded therapies may not be implemented, and the professional psychology contribution to strategic activity may not be optimised.

Improvement Action
- An Interim Head of Psychology has been appointed in June 2021. Work is ongoing together with third sector partners, strategically to build capacity, to reduce waits and address short term demand.

2.4	MHLD Key Priority 4. Delivery of Safe and Effective Services in Partnership

2.4.1 Targeted Intervention 5 – 'Continued evidence of an effective strategic partnership for Mental Health overseeing the realisation of benefits from service transformation. Strategic direction for the service developed and refreshed in line with patients and staff through co-production and engagement'.

Measure in Place
- The Divisional Patient and Carer Experience Group is established to ensure co-production and engagement with patients and staff. The ICAN Steering Group activity is also supporting this agenda.

Identified Risk
- The refresh of the Together for Mental Health (T4MH) Strategy needs to align with the population needs assessment review process.

Improvement Action
- The Terms of Reference for the T4MH Partnership Board is refreshed and will be reviewed at the next meeting. The proposal for the refresh of the T4MH Strategy to be reviewed at the next meeting (9th July 2021).

2.4.2 Ligature Risk and Actions -There have been 2 fatal inpatient ligature incidents previously reported, the first on Cynydd ward in the Ablett Unit in December 2020, and the second on Aneurin Ward, Hergest Unit in May 2021.

Measures in Place

- The division identified changes in October 2020, given advice from the CQC to English trusts regarding ligature risk assessment.
- The MHLD Division has reviewed (through November and December 2020) the control documents used to assess risk from ligatures. The Division has raised this issue with the Welsh SUI network given the national implications.
- A refreshed review of anti-ligature assessments following these revised controls have now been undertaken across the whole of MHLD Division inpatient services.
- The assessments have been undertaken, consistent with the latest advice on low height of a ligature points. North Wales Adolescent Service (NWAS) were included as an inpatient Mental Health service provider in these assessments.

Identified Risk

- There is a risk to patient safety that the previous national advice may lead to false assurances from low ligature points in the estate. These were not removed in the extensive remedial estates action undertaken to remove the high level risks in 2018 - hence risks may remain in the environment.

Improvement Action

- The Division is now in the process of scrutinising the completed assessments to assure that all control measures are now in place and enacted. These include: ligature footprints in place; higher level scrutiny of higher scoring risks; a clear sign off process by the accountable officers in the areas on ligature risk; and each high risk ligature item subjected to the Health Board risk assessment process and mitigation. The Divisional control document on completing anti-ligature assessments is in the process of being formally approved.
- On a practical basis, the Division is replacing high risk items at low level (eg furniture/ beds) with lower ligature alternatives. Furniture has been ordered and some already delivered – ensuring risk assessments are in place for all patients regarding the bed type (lower ligature bed or traditional bed).
- The Division is sharing its learning across all of Wales. The Health Board is a key partner in the All Wales Serious Untoward Incident Group which is focussing on ligature harm. The Health Board has shared its revised control document, and this will be aligned to the recently received Patient Safety Notification.
- The behavioural and human elements of risk assessment and management are equally being reviewed and the Wales Applied Risk Research network (WARRN) risk assessment approach will be further embedded across Mental Health.
- The Division is mindful that people reside in our care environments and these cannot be completely sterile. The Division needs to maintain the appropriate balance.

- The Division has immediately progressed with reducing the high level risks (as currently identified) using the revised tool.

- The anti-ligature bed replacement programme across the inpatient services is in process. The Division is also progressing the order of furniture where this has been identified (as above) as requiring replacement.

- The Division has representation at the All Wales Task & Finish Group that will be working on anti-ligature controls document.

- The Division will develop an anti-ligature programme board to ensure management of anti-ligature risks as they emerge from the application of the above controls and coordinate remedial action in the Division. The Division is developing a more robust assessment process for the type of bed to be used in inpatient services.

- A risk has been created and described in the risk register for the division and has scored as a tier 1 risk. At this moment, the risk is being managed in the division with mitigating actions updated by the Interim Director of Nursing and Head of Governance . This has been escalated (as required) within the Board as a tier 1 risk.

3.0	CAMHS Key Priorities

Within the CAMHS Targeted Intervention Framework, 12 work-streams have been identified as priorities for the service under six key priority areas.

- Strategy and Sustainability
- Workforce Development
- Enhanced Care Pathways for Crisis, Eating Disorders and Early Intervention and Prevention
- Access
- Involvement and Participation – Service Users, Stakeholders and staff
- Transition

Each work-stream has an allocated Lead. Project initiation documents (PIDs); have been completed for each work-stream. Included within each PID are Project Aims, benefits, assumptions, range of scope, background and opportunity analysis, project delivery, resources required, project impact, interdependencies and key stakeholders. The overall priorities of the CAMHS Targeted Intervention Framework and associated timeframes are to be finalised.

3.1	CAMHS Strategy and Sustainability

3.1.1 **Service Improvement & Transformation –** To develop a shared vision and delivery plan for service improvement and transformation across the region that supports a whole system approach to deliver further improvements in children and young people's mental health outcomes
Key actions and aims are:
1. Recruitment of programme support
2. Development of project plan
3. Review of project aims and interdependencies with other work-streams i.e. Leadership & Governance and Service User Involvement

3.1.**2 Leadership & Governance** – To develop a CAMHS regional Leadership and Governance Structure which strengthens and supports current Area arrangements and provides assurance to the Executive Team and Board. Key actions and aims are:

1. Initial recruitment of dedicated TI Programme Leadership posts – Clinical Lead and Business Lead currently in temporary acting up roles
2. Initial Project plan and work-stream established – PID produced
3. Regional risk assurance framework to be put in place and enhanced governance embedded at regional level
4. Review to be undertaken to gain an understanding of current service leadership and governance structures
5. Develop proposed regional Leadership and Governance structure
6. Strategic direction for the service developed through co-production and engagement with key stakeholders

3.2	CAMHS Workforce

3.2.1 **Workforce Strategy and Plan –** To facilitate the delivery of a Workforce Strategy for BCUHB CAMHS that is aligned with organisational priorities and values and the broader local and national strategic objectives
Key actions and aims are:

1. Recruitment of specialist Workforce support
2. Increase clarity of local and national priorities to develop plans to support current and future service delivery and support the expectations of partners and the public
3. Development of clear service specification in line with local and national priorities
4. Analysis of current and future workforce needs
5. Production of workforce strategy to support delivery of agreed service specification aligned with organisational priorities and values and the broader local and national strategic objectives
6. Strategy will identify solutions to address the workforce capacity and skills gaps, and to secure a needs based future workforce supply to enable sustainable delivery of timely, safe, and evidence based care.

3.2.2 **Training, Recruitment and Retention** – To design a comprehensive strategy to meet the training, recruitment and retention objectives to promote a vibrant, enthusiastic and sustainable CAMHS service. Key actions and aims are:
1. Undertake a training gaps analysis
2. Review of national recommended standards (within an evidenced based approach)
3. Examination of current challenges and barriers to effective recruitment and retention

3.3	CAMHS Care Pathways for Crisis, Eating Disorders and Prevention and Early Intervention

3.3.1 **Crisis –** To develop and deliver a cohesive multi-agency integrated model of care for children and young people who may experience a mental health crisis with a focus on prevention, early identification, early intervention, assessment and support 24/7. Key actions and aims are:
1. Develop and identify funding for a model of care, underpinned by evidence base practice that will provide urgent and emergency access to crisis care as described within the Mental Health Crisis Care Concordat (Wales)
2. Ensure systems are in place to support the capture of data including performance, impact and outcomes
3. Develop partnership working across all agencies to ensure all needs are considered and provided for when a child or young person experiences a mental health crisis

3.3.2 **Eating Disorders** – To enhance the existing team with appropriately trained clinicians to continue developing the model to meet NICE (2017) guidance for Eating Disorders. Key actions and aims are:

    1. Recruitment of staff included within recent Welsh Government (WG) bid
    2. Development of dataset and outcome measures to be collated
    3. Enhanced Partnership working to ensure there is a broad, robust understanding of the service and treatments offered
    4. Develop relationships with Community Adult Eating Disorder Service (AEDS)/ transition

3.3.3 **Early Intervention and Prevention** – To ensure that there is a coherent and sustainable model of care in place for the CAMHS elements of early intervention and prevention with clear pathways, appropriately skilled and competent staff to develop and deliver the model, and taking into account the views of all service user groups. The focus is on the whole school approach, GP Cluster service and Early Years. Key actions and aims are:

    1. Develop clear pathways and Standard Operating Procedures (SOPs) in line with recommended evidence
    2. Clearly define the service offer for each pathway
    3. Deliver measurable outcomes associated with psychological health and wellbeing and develop a culture of using outcome measures

3.4	**ACCESS**

3.4.1 **Scheduled Care** – Improve access for children and young people in line with national targets. Key actions and aims are:

    1. Undertake tender for private provision of assessments and therapy
    2. Recruit to staff vacancies and additional posts supported by Workforce plan
    3. Recruitment of business/IT analyst to support reporting and provide analysis for business planning
    4. Review and further roll-out of Choice & Partnership Approach (CAPA) model

3.4.2 **Unscheduled Care –** Improve access to appropriate inpatient care. Key actions and aims are:

    1. Review current service provision for acute needs
    2. Review current escalation processes to ensure robust and consistent
    3. Review Tier 4 Inpatient service specification
    4. Explore the options and feasibility of the development of a High Dependency Unit (HDU) facility within NWAS

3.4.3 **Improve appropriate access to psychology therapies within reasonable waiting times.**

    Increase access in all areas to a range of psychological intervention models and approaches, aligned with 'Matrics Plant: Guidance on the delivery of Psychological Interventions for Children and Young People in Wales (2020)'/ Key actions and aims are:
    1. Develop and operationalise a shared understanding
    2. Ensure the offer is wider than those who are 'referred'
    3. Ensure equitable and timely access with measurable outcomes
    4. Engage proactively with partner agencies

3.5	**CAMHS Involvement and Participation**

3.5.1 **Service User Involvement –** Encourage the full and genuine participation of children and families in all aspects of services including planning, development, monitoring, evaluating and commissioning. Key actions and aims are:

> 1. Develop a three year implementation plan with levels of meaningful co-production to increase true engagement in patient standards
> 2. Develop, implement and embed a Children's Rights Charter based on the UN Convention of the Rights of the Child

3.6	**MHLD and CAMHS Transition to Adult Services**

Ensure consistency and adherence to policy across the region for young people who are transitioning from CAMHS to Adult Mental Health Services. Key actions and aims include:

1. Focus on transition being needs led not age led, working flexibly as per the policy
2. Monthly transition meetings are embedded
3. Correct documentation is completed and regularly audited and data collated
4. Joint training – MHM and young person's passport training

Given the request by QSE for a joint report, it is suggested that could be an area which Committee members may wish to receive further information on this arena of work in a future joint report.

4.0	**Analysis & recommendations**

Summary points:

- The MHLD division recommends to the committee that they accept this report as the last report in this format around the division's 4 strategic priorities that have been in place since 2020.

- The MHLD Division and CAMHs are making progress in a range of areas as can be seen in this report. Further joint reports may be helpful to the QSE Committee and feedback is welcomed in terms of preferences for reporting in the future.

- The Targeted Intervention Improvement Framework is common across the whole of Mental Health and is the obvious framework around which to deliver assurance to this committee on the actions. Both the mental health teams believe the TIIF will deliver quality improvement which can be measured and reported to this committee.

- Learning disability and Substance misuse services and other components of the Adult MHLD portfolio are not under targeted intervention. It is important for the committee to know that patient safety information is, and always has been robustly reported to the PQSG, and will continue to be reported as such.

- CAMHS report their patient safety information similarly to PQSG and by exception to this QSE.

The Committee is asked to note this update from both the Mental Health & Learning Disabilities Division, and Child and Adolescent Mental Health Services (CAMHs).

The Committee is asked to discuss and agree the preferred reporting approach going forward.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 6th July 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Primary & Community Care Quality Assurance Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Chris Stockport Executive Director Primary Care & Community Services
Awdur yr Adroddiad Report Author:	Clare Darlington Assistant Director Primary Care & Community Services
Craffu blaenorol: Prior Scrutiny:	The information included in the report has been provided by primary care and Area leads
Atodiadau Appendices:	No appendices are included with this report

Argymhelliad / Recommendation

The Quality, Safety & Experience (QSE) Committee is asked to:

1. Note the significant contribution to healthcare provision made across all primary care and community services during the pandemic;
2. Note the increased demands and challenges facing the primary care sector in particular, and actions being taken to support contractor services.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Sefyllfa / Situation:

The QSE Committee received a paper on 28th August 2020 outlining the provision of primary care services across the four contractor professions during the initial months of the Covid-19 pandemic.

The following paper provides a further update, noting the significant effort, response and dedication all contractors and community services have made in continuing to provide services to the population of north Wales, managing growing demand and more recently the implementation of the Covid vaccination programme.

As requested, the paper focuses particularly on:

- the recovery from Covid and associated risks (including care homes);
- how community services can support recovery in planned care;
- an update on urgent primary care centres including 111 'go live'.

The paper also reflects on the challenges that some patients are experiencing in accessing primary care services. It highlights the ongoing risk and mitigations in relation to the provision of primary care services, noting that 'Primary Care Sustainable Health Services' is identified as a key risk on the Health Board's corporate risk register, featuring in the Board Assurance Framework (risk reference BAF20-04), and defined as:

There is a risk that the Health Board will be unable to ensure timely access to Primary Care (GMS – General Medical Services) Services for the population due to growing demand and complexity, an ageing workforce and a shift of more services out of hospital. As a gateway to health care, this could result in a deterioration in the population health, impacting on other health & care services and the wellbeing of the primary care workforce.

In order to be able to meet the statutory requirements placed on the Health Board to ensure Primary Care services are available for the population of north Wales, focused work with our independent contractors needs to continue, ensuring the short and long-term sustainability of all Primary Care Contractor services.

Cefndir / Background:

The response to the COVID-19 pandemic has meant implementing considerable changes to the usual provision of Primary Care and community services. Whilst the pandemic has placed unprecedented pressures on the healthcare system it has also brought about innovative and valuable new ways of working, with many changes introduced at significant pace. We recognise the opportunity to take the learning from the COVID-19 response, capitalising on positive system changes to support the vision of *"A Healthier Wales"* and the implementation of our Primary Care Model for Wales.

At our recent Board meeting, an update report on Primary Care and the response to the pandemic was discussed. The report described the provision of services by the four primary care contractor professions over the last fourteen months, highlighting the challenges and how the Health Board and independent contractors have responded to ensure essential services continued to be provided, including innovations and new ways of working. However, the sustainability of primary care services continues to be a risk and features on the Board Assurance Framework, particularly focusing on workforce capacity.

The paper to Board clearly outlined the growing demand for primary care services, alongside the ongoing delivery of the covid vaccination programme, and specifically highlighted the need to address the backlog in planned care for those patients with one or more chronic conditions. The following report provides further detail in terms of the steps being taken to address the risks presented.

It also provides an overview to recovery of community services and associated medical specialities, along with support for care homes during the pandemic, with a renewed focus on Quality Assurance.

Asesu a Dadansoddi / Assessment & Analysis

GMS/GP Practices

The Board received a paper at their May meeting which highlighted the growing demand for GMS/GP practice services. It was noted that, with the introduction of new ways of accessing services, and more patients now contacting their practice, high levels of demand and activity are being reported. The additional contact activity provided using on-line platforms, email, telephone and video consultations was noted with an indicative study suggesting that activity in GP practices has increased as much as 20%, and this pattern has continued.

The current pressures on practices is of concern and the causes are multifactorial, such as:

- Responding to a wide range of access routes to services (as noted above);
- Ongoing need to comply with Infection Prevention & Control (IP&C) guidelines, including social distancing, which has an impact on the physical space to see patients and therefore face to face capacity;
- More patients contacting practices who have been deferring their concerns during the pandemic;
- Backlog in primary care planned care for patients with chronic conditions;
- Ongoing care and support for patients whilst they wait for their secondary care treatments;
- Ongoing delivery of the covid vaccination programme.

This also impacts on patients, who have concerns in relation to their health and timely access to services. Again the causes are mulitfactorial, such as:

- Understanding and having confidence in the new ways of contacting GP practices and receiving virtual consultations;
- Being familiar with other service options, such as enhanced services provided by community pharmacies;
- Being confident in the IP&C measures put in place and reassured when attending practices with health concerns and worries;
- Supporting patients with more complex, chronic health care needs, ensuring proactive care is provided;
- Providing care and reassurance to patients, as well as up to date information, whilst they wait for secondary care treatments.

It is therefore important that we keep the public informed of the ongoing challenges facing general practice, and other primary care services such as dental and optometry practices, due to the pandemic. A local communications plan is being rapidly developed to coordinate key messages and information for patients in relation to primary care services, with the challenges also highlighted to Welsh Government (WG).

Part of the Quality Assurance & Improvement Framework (QAIF) of the GMS contract relates to the achievement of access standards. The General Medical Services Contract changes for 2019/20 which came into force in September 2019, set new access requirements on GP practices under the QAIF, as well as placing additional responsibilities on Health Boards for monitoring and reporting on accessibility to GP practices. The standards have been measured against achievement at 31st March 2020 and 31st March 2021, with the intention that 100% achievement was reached across Wales by March 2021.

Whilst a small part of these requirements have been suspended during the pandemic, most are still reported upon. However, given that the unprecedented situation of the last year it has not been possible to conclude how the standards have improved access. It has therefore been agreed that a further year of the current standards would be maintained to 31 March 2022, to allow the standards to embed, with a clearer picture in terms of how effective they have been in improving access.

A final year end position was reported in mid June; one standard was suspended for 2020/21. The final year end position across north Wales demonstrated that, of the remaining seven standards, four showed improved performance, two stayed the same and one was slightly lower.

Many practices have invested in new telephony systems and alternative ways of access have opened up as described above. However, the results do suggest that there is still progress to be made in ensuring all patients can promptly contact their practice when there is a need.

In addition the Primary Care Contracting Team, together with multi-disciplinary colleagues from each Area team, undertakes a bi-annual 'five domains' assessment of the sustainability of GP Practices. This ensures that there is a consistent approach to risk assessment across the Health Board, reviewing clinical concerns, sustainability, contractual compliance, premises and patient focus. It provides an overall picture that can be used for planning the prioritisation of support and escalating issues as necessary to the Director of Primary and Community Services and the Executive Team.

The assessment is currently being revisited and will be considered at the next meeting of the Health Board's Primary Care Panel. The Area teams continue to work with cluster leads and individual practices to offer guidance and support where possible in term of immediate pressures and long term sustainability.

It is recognised that to address the backlog in planned care there is a need to build upon the collaboration between primary care and health board staff, the new ways of working, to review clinical pathways and jointly meet the needs of our population. There is need to ensure close working to support patients who are waiting for planned care procedures from our secondary care services, whilst recognising that Primary Care providers had an additional backlog challenge of their own, in the form of those patients whose chronic condition care is managed exclusively in Primary Care and the community. Good communication and collaborative working is essential as services move into the recovery phase of the pandemic.

As such the following priorities and actions have already been included in the Health Board's current draft Annual Plan and will be funded from Health Board allocations, subject to internal business case approvals:

- Ensure primary care involvement and engagement in the transformation of clinical pathways, to support recovery and address planned care backlog across the whole system, reviewing

the impact of any operational changes and provider capacity. This work is already being progressed in Orthopaedics, Diabetes, Dermatology, Rheumatology, Ophthalmology and Sexual Health. Going forwards, this will be supported by the Transformation Office of the Health Board which will be led by Dr Stockport. Whilst this will have growing longer term impact, there are some shorter term opportunities to ensure that capacity to address our backlogs is not wasted through the use of inefficient clinical pathways;

- Further invest in the Primary & Community Care Academy: supporting the delivery of the Primary Care Model in Wales, promoting new ways of working, including the training of a multi skilled advanced practice workforce, development of a further training hub, internship programmes for various practitioners including Physicians Associates and promoting recruitment initiatives across the region. This is already having a tangible positive impact upon staffing capacity within Primary Care in BCUHB;
- Continue to develop and evaluate urgent primary care centres, contributing to a whole system model of unscheduled care and integrating these with the 'phone first' development and roll out of 111, as well as feeding into the national Strategic Programme for primary care (further detail provided on page 7);
- Provide additional funding to ensure continued use of the accuRx and eConsult online platforms in GP practices, supporting improved access and demand management for general medical services. This was a specific request from primary care providers who are experiencing a number of workload efficiencies as a result;
- Encourage GP practices and community pharmacies to report their escalation levels, with Area teams taking proactive action to provide support where necessary;
- Continue to engage at a national level with the review of all primary care facilities, in order to refresh estates priorities, in line with current regulations.

In relation specifically to chronic conditions, diagnostics and screening the following proposals are now being advanced with our clusters, but will, in the main require additional resources to be identified:

- Chronic conditions monitoring and year of care programmes operating in a timely way through additional clinics and provision of protected resources in primary and community settings, in some cases on a cluster basis;
- Improvements to managing chronic disease registers in primary care by using a 'Year of Care' approach, which has been shared with clusters and the Local Medical Committee (LMC). This delivers a month of birth and year of care recall, making the service more efficient and in particular involves a clear personalised annual plan for patients, automatically created from patients care records, with an emphasise and support for more self-management. Work with Swansea University, and Diabetes UK is underway to further enhance this;
- Patients access screening programmes through resourcing additional clinics where necessary to undertake catch up, supported by a screening coordinator, linking to Velindre, to particularly target those patients who have not taken up their screening invitations and encouraging attendance through advice and support;
- Increased phlebotomy clinics also supporting 'Near Patient Testing' backlog, with the potential to pilot a service in community pharmacy settings being explored;
- Development of 'diagnostic hubs' to coordinate access to 24 hour Electrocardiogram (ECG) and blood pressure monitoring, phlebotomy, ABPI doppler (ultrasound to check for peripheral vascular disease), Spirometry and FeNO testing for diagnosis of asthma & chronic obstructive pulmonary disease (COPD), and cystoscopy examinations;

- Further roll out of community pharmacy independent prescribing services to support urgent primary care and contraception services.

These proposals are currently being developed in further detail by the Area teams working with their cluster leads, recognising that schemes need to be put in place over the summer months. The Area Directors, along with their medical and nurse directors are meeting on the 7th July to review and consolidate proposals. Delivery of additional services will be challenging in terms of workforce capacity and fatigue, and the detailed schemes will consider how to mitigate this risk, including more integrated provision across primary care and community services. In order to progress this work, dedicated project management support will need to be identified to support the local teams in the delivery of the schemes.

In the interim, independent contractors are being encouraged to adopt a triaged approach where chronic disease management backlogs exist, to ensure that those with highest need are prioritised.

The LMC have also been kept informed of the 'Once for Wales' approach to waiting list validation, with initial briefings to all primary care contractors circulated in early June. In addition, work is ongoing to improve information in relation to estimated waiting times, as well as initiatives to support patients to manage their condition whilst waiting.

Urgent Primary Care
Urgent Primary Care Centres
In March 2021, the Minister for Health & Social Services, outlined the WG's priority for 'transforming access to urgent and emergency care services in Wales' supported by additional £25m recurrent funding. One of the key deliverables outlined is the implementation of Urgent Primary Care Centre models to enable people with urgent primary care needs to more easily access advice, assessment and care closer to home.

As noted above, the Health Board continues to engage in the all Wales Urgent Primary Care Centre (UPCC) pathfinder programme, under the auspices of the Strategic Programme for Primary Care, with our local pathfinders feeding into the national programme to determine a future model of urgent primary care.

In 2020/21, the six clusters in the East Area received additional WG funding of £240K for the development of a pathfinder 'hub & spoke' urgent primary care centre. The main site (hub) opened in December 2020 and is co-located in the Wrexham Maelor Hospital to enable access to imaging, the Emergency Department (ED) and GP out of hours service (to provide 24/7 service). It provides on the day urgent care, freeing up GP time to focus on patients with more complex and/or chronic conditions. It also supports ED to redirect patients presenting with minor conditions. The 'spoke' site is at Mold hospital minor injury unit (MIU), again with access to imaging, as well as MIU staff. Both are supported by a multi disciplinary workforce including advanced practice nurses, physiotherapists and GPs, and around 1300 episodes of care are provided per month, 80% of which have supported GP practices manage their on the day demand.

A further pathfinder has been supported by WG in the North Denbighshire cluster. This is integrated with a mental health third sector provider and will become operational in 2021/22.

In addition, the West Area team are working on proposals to also develop a hub and spoke model, with Ysbyty Alltwen and Ysbyty Penrhos Stanley as hubs to Ysbyty Gwynedd. A workshop is

planned for 28th June to further develop the model and specification further, as well as formalise the steering group to progress.

111

The 111 service went live in north Wales at noon on 22nd June. This has been a significant step forwards in the whole system approach to managing unscheduled care. Following the awarding of WG funds and establishment of robust programme management arrangements, supported by a national 111 team, the roll out of the has been implemented at pace, with the implementation brought forward by around 12 months against the original all Wales plan.

The 111 service provides free telephone access to urgent out-of-hours care and round-the-clock medical support and guidance. The easy-to-remember number is free and provides access to both GP Out of Hours services and the health advice previously delivered by NHS Direct Wales. The number is available 24 hours a day, seven days a week with online advice, including symptom checkers and local services also available. The service helps patients get the right support, help and guidance in the right place at the right time.

The launch went smoothly and initial feedback has been very positive. Demand from north Wales is being monitored on a daily basis and is at expected levels. Operational and project leads are currently meeting every day to reflect on the previous 24 hours and agree any actions that are required to ensure the ongoing success of the service. Post project arrangements are in place to assess the impact and effectiveness of the service going forwards.

Optometry
Community Optometrist Practices have continued to offer EHEW (Eye Health Examination Wales) Services for Urgent/ Emergency care throughout the Covid-19 pandemic in line with WG requirements and guidance.

However, Practices are operating at 80% pre covid capacity due to social distancing and IP&C requirements, and like many services they are struggling to cope with demand. GP practices have been contacted to highlight the importance of Optometrist triage to help prioritise patients by clinical need.

Whilst there are capacity pressures, joint discussions continue in relation to the capacity of EHEW to support secondary care services to provide Optometric review and manage the long waiting lists. In addition the six independent prescribing Optometrists are supporting GMS and community pharmacies by being able to treat patients at their own practice, closer to home, and secondary care glaucoma patients continue to be seen at the six Ophthalmic Diagnostic Treatment Centres (ODTCs) continue to see. Furthermore, there are plans to extend the number of ODTCs in north Wales in response to the need to support recovery for secondary care diabetic and glaucoma patients.

In relation to chronic conditions management, a pilot community project has been proposed in Central & South Denbighshire Cluster with three Optometric practices having shown an interest to date. The British Heart Foundation project will trial Optometrists measuring blood pressure as part of the eye examination, where signs and symptoms suggest a need. As well as providing a screening service for patients, this would also support GP practices and aid in the refinement of referrals.

Dental Services
In July 2020, the Health Board commissioned eleven Urgent/Emergency Dental Centres specifically to provide Aerosol Generating Procedures (AGPs) during the initial phase of re-establishment of dental services. These were reduced to four in October and then to one from April 2021, as more practices fully re-established services.

The provision of access to "urgent" dental services has been re-established in all NHS high street practices, with support to improve ventilation. The Health Board has also commissioned additional 'urgent' access sessions for unregistered patients, with approximately 6,500 "new" patients have been treated in General Dental Services (GDS) practices during the first 2 months of the 2021/22. These sessions have been absorbed into the Emergency Dental Services (EDS) and access to them is coordinated via the Health Board's Dental Helpline.

During the pandemic the requirement for access to EDS changed in profile, and access to urgent dental care provision has been increased as noted above. In order not to lose the benefits of these changes, work is ongoing to look at EDS delivery and start a process of redesign to identify the ideal patient journey and service delivery model.

With regards to non-urgent treatment, WG guidance is for patient access to treatment to be based on clinical need. Consequently, patients seeking access to routine treatment may have to wait for an appointment if the practice is operating at capacity in meeting the treatment need for clinical priority patients. Capacity to meet the needs of patients is further compromised with the requirement for fallow times between patient, and Personal Protective Equipment (PPE) protocols, which has reduced the patient throughput of practices, further impacting on availability of treatment appointments.

All dental practices are required to complete an oral health risk and need assessment (ACORN) for each patient providing an invaluable information source for establishing the oral health of the patient base and enabling the practice to increase the recall interval of patients identified as healthy and hence create more appointment slots for patients in need.

Access to the orthodontic service is increasing as the backlog of "in-treatment reviews" is managed and new treatments can now commence. Similarly, orthodontic cases are on the basis of clinical need of the patient.

With regards to Community Dental Services (CDS), AGPs are now available at the majority of CDS sites with non-AGPs provided at almost all locations. The Estates department is continuing to address ventilation standards at a number of clinics to enable them to be able to carry out AGPs. However, the backlog of cancelled patients and waiting lists are of concern at some locations and a local communication to manage the expectations of the public regarding dental services is being updated.

Waiting lists have either already been or are in the process of being validated at all sites. Communication with GDS practitioners has been issued seeking their assistance in managing the patients they have referred until they can be seen. The CDS Therapist Direct Access protocol has been re-visited and expanded to support the management of the waiting list for children. All adult patents with learning disabilities or cognitive impairment are now in a re-assessment process and/or booked for treatment.

In accordance with Welsh Government guidance, the maintenance of clinic based urgent clinical care and the care of vulnerable patients according to need remains the priority for the service. Some remote management of cases continues, including the employment of 'Attend Anywhere' where appropriate.

Looking forward there are several key risks that need to continue to be managed, these include:

- the loss of Patient Charge revenue and the impact on budgets;
- stability of practices (private, private/NHS mix, NHS only);
- reduced activity and the effect on access across the region;
- capacity to see all patients with unmet need during the pandemic.

In order to improve longer term provision of services, the procurement of a Dental Training Academy was formally launched on the 28th April 2021 to secure interest from innovative individuals to host a training unit, with varied practitioners who have specialist interests providing opportunities for teaching, shadowing, supervision and placements. This will allow those attending the training unit exposure to a wider range of practice and specialism, as well as highlighting some of the challenges in the profession, but also the region.

In order to partly address the loss of dental provision in Bangor, Menai Bridge and Porthmadog areas, the main training unit facility will be located centrally within Bangor and will also host the CDS and a GDS practice which will support the training provision. There will also be the opportunity to offer access to the lecture and study space to the Health Board's Primary & Community Care Academy.

The closing date is imminent and there has been some encouraging interest, with a recommendation on preferred provider being made in mid-July.

The annual dental review meeting was held with WG colleagues on 23rd June, hosted by the Chief Dental Officer. The dental team were commended for the progress made in dental service provision, with recognition of the significant contribution dental practices and practitioners have made during the pandemic.

Community Pharmacy
As reported to the Board, the 152 community pharmacies across north Wales have provided services throughout the pandemic, and have reverted to pre covid-19 opening hours, with demand for enhanced services increasing.

There are some ongoing workforce challenges, for example the need for staff to self-isolate, and these are reported to the Area teams via the escalation tool. When a pharmacy reports a high level of escalation contact is made to provide guidance and support.

In terms of supporting the whole system in managing the increase in urgent demand, the common ailments scheme, emergency medicines service, and emergency contraception service are all available in the majority of our pharmacies to help support patients with urgent care needs. Furthermore the roll out of the independent prescribing service will expand capacity in primary care to manage acute conditions.

Pharmacy services are also supporting the 111 service in ensuring that the directory of service is accurate and that appropriate signposting of patients can be facilitated. In turn the 111 service are sharing the healthcare professional line with community pharmacists to enable them to get access to clinical advice and avoid the need to refer patients on to a GP practices or the GP out of hours service.

In support of care homes, the tier 1 of the community pharmacy service to care homes has be re-launched, to help identify and address any medicines management issues. The pharmacy team are also working on increasing provision of discharge medication reviews, including to care home residents.

Going forward the mandated Pharmacy Needs Assessment will be completed by October 2021, providing a reference for the planning and commissioning of future community pharmacy outlets and services.

Community Services
Community Services have continued to be provided throughout the pandemic, supporting some of the most vulnerable patients in our localites and working with GP clusters in integrating the local response. This has included regular multi-disciplinary team (MDT) meetings and coordinating care plans.

During the early stages of the pandemic, community hospitals were given a 'red' or green' status, to ensure safe care for covid positive patients. As the numbers of admissions have fallen the hospitals have been able to identify appropriate capacity to isolate covid postive or symptomatic patients, noting that due to the implementation of IPC guidance, with increased space between beds, the bed capacity in some community hospitals has reduced.

In June 2021, the Strategic Programme for Primary Care (led by the 24/7 workstream) have published a sequence of Step up/Step down Bedded Community Services Toolkits.

The NHS Wales Delivery Unit (DU) was commissioned to review bedded community facilities and the development of the toolkit bundles has been supported by:
- A literature review;
- The national stocktake of current bedded community facilities in Wales (September 2020);
- A series of workshops, exploring the reasonable service expectations for the five functions identified as core to bedded community services and attended by a cross-section of subject matter experts from health, social care and third sector organisations.

It was agreed following production of the toolkit documents, that they would be "road tested" with a test of their "operational" potential within three Health Boards. It was noted by the 24/7 workstream, that the work produced by the DU and the associated community of practice was of a very high quality and it has concluded that the product would be really helpful for Health Boards in assessing:

- How their Community Hospitals matched with best practice;
- How they could make them as efficient and effective with a whole system approach;
- How they could be used to remodel the services provided from them for the local population.

The Area Teams have only recently received these toolkits which will be reviewed locally to support the ongoing recovery and management of community hospitals. This will include a review of long

term bed capacity in line with current bed spacing requirements and engagement in a whole system approach with appropriate stakeholders regarding alternative pathways. The Area teams are also developing a frailty model, embedded within community services to increase the utilisation of step up beds.

A key ongoing development has been the implementation of 'home first' bureau, consolidating all the resources supporting discharges and working to the principle of 'get me home safely'. This has included Community Resource Teams (CRTs), therapies and the 'Discharge to Recover and Assess' (D2RA) programme.

The Health Board has also commenced the implementation of a £3m Stroke Improvement Plan in 2021, which is phased over two years. The plan includes improving stroke prevention, enhancing acute stroke services in the three acute hospitals, the development of Early Supported Discharge and increased specialist Stroke rehabilitation beds. A Programme Manager has been appointed and a recruitment and workforce plan is currently being developed to ensure maximum impact in year one of the plan.

Ongoing recovery continues for the specialties managed by the Area teams. A review of sexual health services is being undertaken, with regards to the likely increased demand and a trial virtual group physiotherapy clinic will commence in July within the rheumatology department. This will allow between 6-8 patients to be seen via a teams link for a group consultation. The review of pathways and triage continues within Dermatology and Rheumatology and where appropriate, GP are provided with advice and guidance to support the ongoing care of patients.

Outpatient clinic utilisation is under review, alongside the social distancing and IP&C requirements, to provide as much capacity as possible, ensuring that the appropriate patients have face to face appointments alongside telephone review appointments. This will include access at weekends and evenings. The teams are also linked to the overarching secondary care planned care programme, including the 'Once for Wales' waiting list validation processes.

Care Homes
During the pandemic there has been an increased risk for residents in care homes due to them being susceptible to the rapid spread of Covid-19.

A Care Home Cell was established as part of the emergency response to the pandemic. This group is made up of a strong representation from a wide range of disciplines and agencies including; BCUHB Area Teams, Primary Care, Medicines Management, Contracts, Continuing Health Care, Local Authorities, Care Forum Wales and Care Standards Inspectorate Wales (CSIW). It provides high level multi-professional tactical coordination and operational response to key issues in relation to the pandemic.

The three key objectives for the Health Board, as part of a multi-agency response, have been to:
- Support the implementation of the Welsh Government care home testing programme;
- Report robust, timely data on confirmed and possible cases of Covid-19 in care home settings;
- Ensure systems are in place that provide both proactive and reactive support for care homes, particularly in relation to Infection Prevention and Control.

Throughout the pandemic, support has been provided to care homes through a number of processes, outputs and actions across the partnership. This includes:

- Care home tactical coordination through a multi-agency Care Home cell;
- Development of an Infection control Standard Operating Procedure (SOP) with associated pathways supported by the six lead Environmental Health Officers (EHOs);
- Intense support visits for care homes under an outbreak situation, led by an Incident Management Team (IMT), providing focused daily support via community resource teams, including clinical leadership, medication management, and infection control and prevention;
- Access to remote consultations which includes urgent review of patients via telephone or video conferencing, the Local Continuing Health Care (CHC) Team and Practice Development Nurses offering telephone and email support and the GPs and Out of Hours Service offering virtual clinics with secure connection;
- Virtual training has been provided on a range of supportive treatments, including vital signs monitoring, infection control and the administration of oxygen therapy;
- Patients with cognitive impairment and dementia have been supported by the Mental health teams, offering advice for residents who 'walk with purpose' and on issues relating to challenging behaviour.
- Daily Care Home MDT meeting, with representatives from the BCUHB Care Home Team, Public Health, the six Environmental Health Officers and the Regional Test Trace Protect (TTP) hub. This group provides daily coordination support and advice on operational issues, as well as daily communication with the homes as required;
- Commissioning of the Care Homes Direct Enhanced Service (DES) from GP practices which includes providing care homes with a dedicated phone number in GP surgery's to ensure timely access;
- Timely and robust data collection, and development of a dashboard, supported by a partnership arrangement for making 'One Contact' to all care homes. The 'One Contact' model, provides a supportive and informative discussion with each care home, while also collecting a 'Minimum Data set'. All partners have access to the minimum data set, in order to fulfil the necessary regulatory, legislative and operational processes;
- Results for all tests undertaken for care home residents and staff made available to Health and the Local Authorities via a live platform;
- Implementation of the North Wales Care Home Escalation tool providing a consistent approach to escalation of concerns based on the intelligence gathered. This includes any early indicators of pressure in clear levels of escalation.
- Care Home access to the BCUHB nurse bank, which has been utilised during times of staffing crisis;
- Provision of emergency staffing support to homes, including medication rounds, and staff to cover shifts when there is a significant workforce gap in a care home;
- Regular communication across the partnership and care home sector including an Independent Provider briefing for care homes and domiciliary providers. Common themes and questions have been addressed such as PPE changes and testing in care homes;
- Care Home covid-19 testing, supporting care homes to comply with the Welsh Government testing programme for residents and staff;
- Prioritised vaccination programme for care home residents and staff, which commenced in December 2020;
- Financial and contractual support for homes;

- Admissions and transfer support and advice, through Home First bureaus, the Care Home MDT and Area teams to support safe hospital discharges and transfers.

The team that support Care Homes and CHC commissioning are now returning to more 'business as usual', with the main focus on developing a Quality Assurance Framework (QAF) for care homes as a priority. This is progressing well and following two workshops with partners, a draft QAF has been developed and will be ready for wider circulation and engagement in July.

As part of developing the QAF, quarterly assurance reports for care homes will be developed, with a first draft planned for August (Q1).

However, the partnership and supporting teams very aware that the pandemic continues and responses to support care homes must be in place, ready to step up as required.

At the peak of the first wave 80 care homes in north Wales were operating under covid restrictions, during the second wave this was up to 150. At the time of writing this report, there are 12 care homes with positive covid results for staff or residents, and work continues to monitor and support these homes as necessary.

Weekly asymptomatic PCR (polymelase chain reaction) testing of staff continues, enhanced by twice weekly LFDs (lateral flow device), with no plans to reduce testing for care home staff due to concerns associated with the current position. The team are also jointly developing processes to screen residents prior to attending hospital for planned interventions such as Chemotherapy or Dialysis. A communication, including FAQs, has been drafted for circulation to care homes planned at the end of June.

A number of care home staff have not yet had their covid vaccination and letters offering a range of options for them to book their vaccinations have been sent, with a further focus on this issue in the care home briefing.

Responses to a 'de-brief' questionnaire following the second wave are being collated and will be reviewed against the debrief report of the first wave, to identify trends, learning and good practice. In addition planning for the 2021/22 flu vaccination campaign for residents and staff, including domiciliary care providers has commenced.

Committee Report Requirements:
Strategy Implications
The current focus for primary care and community services is the ongoing recovery of service provision, addressing the backlog in planned care across the whole system, whilst managing the increasing demand and ongoing vaccination programme. Where possible and appropriate, consideration is given to the all Wales Primary Care model and Strategic Programme, as well as the Health Board's strategic priority of care closer to home.

Options considered
Options for service delivery have been considered in line with WG guidance and recovery plans.

Financial Implications
Related financial implications are considered in the Health Board's draft annual plan 2021/22, with business cases being developed where necessary and further proposals for addressing planned care backlog in primary care currently under development.

Risk Analysis
Risks associated with the delivery of primary care services and the implementation of the recovery plans are highlighted in the report.

Legal and Compliance
The Health Board must guide primary care contractors and care home providers in the implementation of recovery plans and any associated contractual requirements.

Impact Assessment
An impact assessment has not been undertaken as this is a report providing a summary of the current position. Impact assessments for individual schemes and developments will be undertaken as necessary.

Cyfarfod a dyddiad: Meeting and date:	Quality Safety & Experience (QSE) Committee 6th July 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Clinical Audit Forward Plan 2021/22
Cyfarwyddwr Cyfrifol: Responsible Director:	Prof A 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:	Clinical Effectiveness Group – April 2021 Audit Committee - June 2021
Atodiadau Appendices:	1. Draft Clinical Audit Plan - 2021/22 2. Tier 3 audits identified for services considered at increased risk

Argymhelliad / Recommendation:

The Committee is asked to approve the draft Clinical Audit Plan 2021/22 as the current working document.

[This report was presented to the Audit Committee in June as the approving Committee for the plan. However, it was agreed this would be the working draft because the plan did not adequately represent the risk profile of some services that the Committee would expect to see. In part, this is because individual service audits are considered within tier 3 unless identified by the relevant Executive as a local imperative (in line with the current policy).

The audit plan is supplemented here with Appendix 2 - the Tier 3 audits relevant to those service of concern to reassure the Committee that audit activity is planned in those services. Further review of the plan will be required to establish which of these require upgrading to tier 2 or to identify additional audits].

Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	x	Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	

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

Sefyllfa / Situation:

The Corporate Clinical Audit Annual plan for 2021/22 has not changed significantly between years due to the impact of the COVID-19 pandemic. Most audit activity was paused at national and local levels, and these are now gradually re-starting. There have been no additional Tier 1 requirements from Welsh Government.

Drive Cefndir / Background:

Clinical Audit is an important tool to provide assurance to the Board about the quality of services. It is an important mechanism to drive quality improvement and a vital part of our overall quality strategy, which is being developed.

Audit measures compliance against evidence-based standards, targets or through benchmarking. Tier 1 audits are those mandated nationally; in any year there may be data collection and/ or a report from the previous audit. The Clinical Audit lead for each Site or Area oversees the audit to ensure completeness.

Tier 2 audits are those considered necessary at a corporate level because of their risk profile or requirement to improve. These audits may be undertaken within the local services or through the clinical effectiveness department; the majority are completed within the services.

Clinical Audit has an annual planning cycle, although many audits are continuous across the year. There is quarterly reporting to QSE on progress against the plan, with an annual report at year end to the Joint Audit and QSE Committee.

Asesiad / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The clinical audit process will be embedded in the overall BCU strategy for quality and improvement. The ongoing process to develop the Quality Strategy [including the Clinical Effectiveness Strategy] will include the clinical audit strategy also going forward.

The draft plan includes the breadth of topics included in the Welsh Government's National Clinical Audit & Outcome Review Plan (NCAORP). The tier 2 audits have been chosen to reflect key risks and areas for improvement identified from the risk register, claims, regulatory compliance etc. Therefore, Tier 2 audits reflect the areas where improvement needs a focus and have been colour coded into themes.

Opsiynau a ystyriwyd / Options considered

Not required

Goblygiadau Ariannol / Financial Implications

There are two types of financial implications related to this plan:
• Direct costs of participation, much of which is opportunity costs within the services and an element is being included within the redevelopment of the clinical effectiveness service.
• Improvement costs identified following the audit - these will need to be managed at the time.

Dadansoddiad Risk / Risk Analysis

The Tier 1 element of the plan relates to mandatory projects prioritised by Welsh Government within the NCAORP.

Tier 2 includes some projects which are required for accreditation, regulation and licensing, alongwith management of risk, quality, safety, claims and patient experience.

Resources to support activity corporately has been reviewed and an option appraisal will be completed by the end of June for review by the Executive team. Risks have been mitigated by reducing the scope of activity of the corporate team for example introducing a digital solution to register tier 3 audits.

The Head of Clinical Effectiveness post is currently being advertised.

There is a risk of a lack of assurance for services where there is patchy or non-compliance with the plan. Actions to address this are predominantly with the secondary care Hospital Management Team (HMT) and include ensuring audit leadership is included within robust job planning, embedding audit reporting within the governance structures, whilst quarterly reporting will identify issues earlier for action.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

We are mandated to complete the national audit programme.

Asesiad Effaith / Impact Assessment

Not required

Reference:	Title of National Audit	East area Lead	Central Area Lead	West Area Lead	In year Data Submission	In year Report
NCAORP/2021/01	National Joint Registry	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/2021/02	National Emergency Laparotomy Audit	Mr Duncan Stewart (Consultant Surgeon) / Dr Sianedd Elliott (Consultant Anaesthetist)	Mr Richard Morgan (Consultant Surgeon) / Dr Magdy Khater (Consultant Anaesthetist)	Dr Stephan Clements (Consultant Anaesthetist) / Mr Nik Adullah (Consultant Surgeon)	Yes	Yes
NCAORP/2021/03	Comparative audit of critical care unit adult patient outcomes (casemix) ICNARC	Dr Andy Campbell (Consultant Anaesthetist)	Dr Richard Pugh (Consultant Anaesthetist)	Dr Karen Mottart/ Dr. Alison Ingham, (Consultant Anaesthetists)	Yes	Yes
NCAORP/2021/04	Trauma Audit & Research Network (TARN)	Dr Ben Sasi (Anaesthetics Associate specialist)	Dr Tom O'Driscoll (Emergency Medicine Consultant)	Dr Leesa Parkinson / Dr Rio Talbot (Consultants: Emergency Department)	Yes	Yes
NCAORP/2021/05	National Diabetes Foot care Audit	Dr Anthony Dixon (Consultant Physician) & Nicola Joyce (Podiatrist)	Dr Aye Nyunt (Consultant Physician)	No Medical lead at present Jamie O'Malley (Diabetic Podiatrist)	Yes	No
NCAORP/2021/06	Diabetes Inpatient Audit (NaDia)	Dr Stephen Stanaway (Consultant Physician) / Cheryl Griffiths (Diabetes Specialist Nurse)	Dr Thomas Dacruz (Consultant Diabetes & Endocrinology) / Kirstin Clark (Diabetes Specialist Nurse)	Dr Muhammed Murtaza (Consultant Physician) / Ceri Roberts (Diabetes Specialist Nurse)	Yes	Yes
NCAORP/2021/07	Pregnancy in Diabetes Audit Programme	Dr Lynda Vergheese (O&G Consultant), Dr Stuart Lee (Consultant Physician), Rao Bondugulapati (Consultant Physician), Gill Davies (Diabetes Specialist Nurse)	Dr Thomas Dacruz (Consultant Diabetes & Endocrinology), Kirstin Clark (Diabetes Specialist Nurse)	Dr Leela Ramesh (Consultant O&G), Dr Noreen Haque (Registrar O&G),Dr Tony Wilton (Consultant Physician), Ceri Roberts (Diabetes Specialist Nurse)	Yes	Yes
NCAORP/2021/08	National Core Diabetes Audit: (Primary / Secondary Care & Insulin Pump elements)	**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 Jin McGuigan (Area Medical Director) **Insulin Pump element**: Dr Muhammed Murtaza (Consultant Physician)	Yes	Yes
NCAORP/2021/09	National Paediatric Diabetes Audit (NPDA)	Dr Kamal Weerasinghe (Consultant Paediatrician),	Dr Helen Moore (Consultant Paediatrician)	Dr Michael Cronin (Consultant Paediatrician)	Yes	Yes
NCAORP/2021/10	National Asthma & COPD Audit Programme (NACAP): Children and Young People Asthma	Dr Liz Richards (Locum Consultant)	Dr Lee Wisby (Consultant Paediatrician)	Dr Mair Parry (Consultant Paediatrician)	Yes	Yes
NCAORP/2021/11	NACAP: Adult Asthma	To be confirmed by CD Medicine (1 July2021)	Dr Dan Menzies (Consultant Physician)	Dr Claire Kilduff (Consultant Physician)	Yes	Yes
NCAORP/2021/12	NACAP: COPD	To be confirmed by CD Medicine (1 July2021)	Dr Sarah Davies (Consultant Physician)	Dr Claire Kilduff (Consultant Physician)	Yes	Yes
NCAORP/2021/13	NACAP - Pulmonary Rehabilitation workstream	Michelle Owen (Clinical Specialist Physiotherapist / Pulmonary Rehab Coordinator)	Ann Ellis (Respiratory Occupational Therapist)	Tracy Redpath (Occupational Therapist) & Caerwyn Roberts (Physiotherapist)	Yes	Yes
NCAORP/2021/14	Renal Registry	Dr Stuart Robertson (Consultant Physician)	Dr Mick Kumwenda (Consultant Physician)	Dr Mahdi Jibani (Consultant Physician)	Yes	Yes
NCAORP/2021/15	National Early Inflamatory Arthritis Audit (NEIAA)	No lead agreed but audit in progress confirmed by Dr M Garton	Dr Alessandro Ciapetti (Consultant)	Dr Yasmeen Ahmad (Consultant Physician)	Yes	Yes
NCAORP/2021/16	All Wales Audiology Audit	**Adult Rehabilitation:** Anna Powell, Head of Adult Rehabilitation (East)	**Adult Rehabilitation:** Suzanne Tyson, Head of Adult Rehabilitation (Central)	**Adult Rehabilitation:** Heidi Turner, Head of Adult Rehabilitation (West)	Adult Rehab and Paediatric Audits conducted by external visits preceded by a period of data collection. Adult Rehab audited 2019 (report awaiting sign off by Scientific Committee). Paediatric Audit of 2020 postponed - awaiting rescheduling.	Yes
NCAORP/2021/17	Stroke Audit (SSNAP)	Dr Walee Sayed (Consultant Physician)	Dr Krishnamurthy Ganeshram (Consultant Physician)	Dr Salah Elghenzai (Consultant Physician)	Yes	Yes
NCAORP/2021/18	Falls & Fragility Fractures Audit Programme: National Hip Fracture database	Mr Ian Starkes (Consultant Orthopaedic Surgeon)	Mr Amir Hanna (Consultant Orthopaedic Surgeon)	Mr Ashok Goel (Consultant Orthopaedic Surgeon)	Yes	Yes

NCAORP/2021/19	Falls & Fragility Fractures Audit Programme: In-patient Falls Audit	Erin Humphreys (Interim Deputy Head of Nursing)	Dr Geralt Owen (Consultant Physician)	Eleri Evans (Interim Head Of Nursing For Medicine - YG)	Yes	Yes
NCAORP2021/20	Falls & Fragility Fractures Audit Programme: Fracture Liaison Service	No FLS Service	No FLS service	To be confirmed	Yes	Yes
NCAORP/2021/21	National Dementia Audit	Dr Sam Abraham (Consultant Physician)	Dr Indrajit Chatterjee (Consultant Physician)	Dr Conor Martin (Consultant)	No	No
NCAORP/2021/22	National Audit of Breast Cancer in Older Patients (NABCOP)	Mr Tim Gate (Consultant Breast Surgeon)	Miss Mandana Pennick, (Consultant Breast Surgeon)	Mr Ilyas Khattak (Consultant Breast Surgeon)	Yes	Yes
NCAORP/2021/23	National Audit of Care at the End of Life (NACEL)	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)	Yes	Yes
NCAORP/2021/24	National Heart Failure Audit (NAHF)	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/2021/25	National Audit of Cardiac Rhythm Management (NACRM)	Dr Rajesh Thaman (Consultant Cardiologist)	Dr Mohammad Aldwaik (Consultant Cardiologist)	Dr Mark Payne (Consultant Cardiologist)	Yes	Yes
NCAORP/2021/26	National Audit of Percutaneous Coronary Intervention (NAPCI)	N/A	Dr Paul Das (Consultant Interventional Cardiologist)	N/A	Yes	Yes
NCAORP/2021/27	Myocardial Ischaemia National Audit Project (MINAP)	Dr Richard Cowell (Consultant Cardiologist)/ Lucy Trent (Nurse Practitioner)	Dr Paul Das (Consultant Interventional Cardiologist)	Dr Mark Payne (Consultant Cardiologist)	Yes	Yes
NCAORP/2021/28	National Vascular Registry Audit (inc. Carotid Endarterectomy Audit)	Mr Soroush Sohrabi (Clinical Director)	Mr Soroush Sohrabi (Clinical Director)	Mr Soroush Sohrabi (Clinical Director)	Yes	Yes
NCAORP/2021/29	National Audit of Cardiac Rehabilitation (NACR)	Jacqueline Cliff (Cardiac Rehabilitation Nurse Lead)	Catrin Warren (Cardiac Rehabilitation Physiotherapist)	Lisa Carson (Community Cardic Rehabilitation Nurse)/ Iorwerth Jones (Exercise Physiologist- Cardiac Rehab)	Yes	Yes
NCAORP/2021/30	National Lung Cancer Audit	Neil McAndrew (Consultant Physician)	Dr Sakkarai Ambalavanan (Consultant Physician)	Dr Ali Thahseen (Consultant Respiratory Physician)	Yes	Yes
NCAORP/2021/31	National Prostate Cancer Audit	Mr. Iqbal Shergill (Consultant Urologist)	Mr. Kingsley Ekwueme (Consultant Urologist)	Mr Kyriacos Alexandrou (Consultant Urologist)	Yes	Yes
NCAORP/2021/32	National Gastrointestinal Cancer Audit Programme	**Bowel:** Mr Micheal Thornton (Consultant Surgeon) **Oesophago-gastric:** _Mr Andrew Baker (Consultant Surgeon) / Dr Thiriloganathan Mathialahan (Consultant Gastroenterologist)	**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/2021/33	National Neonatal Audit Programme (NNAP)	Dr Artur Abelian (Consultant Paediatrician)	Dr Geedi Farah (Consultant Paediatrician),Mandy Cooke (Neonatal Quality and Governance)	Dr Shakir Saeed (Consultant Paediatrician)	Yes	Yes
NCAORP/2021/34	National Maternity & Perinatal Audit (NMPA)	Maria Atkin (O & G General Manager & Business Lead)	Dr Niladri Sengupta (O&G Consultant)	Fiona Giraud (Director of Midwifery and Women's Services)	Yes	Yes
NCAORP/2021/35	Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People.	Dr Praveen Jauhari (Consultant Paediatrician)	Dr Gemma Macey (Consultant Paediatrician, Acute), Dr G Hamilton Grantham (Community Paediatric Consultant)	Dr Kathryn Foster (Consultant Paediatrician)	Yes	Yes
NCAORP/2021/36	National Clinical Audit of Psychosis	No EIP service	No EIP service	Louise Rosenthal, EIP Service Manager	Yes	Yes
NCAORP/2021/42	National Covid-19 Audit	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/2021/37	National Adult Cardiac Surgery Audit				
NCAORP/2021/38	National Congenital Heart Disease Audit				
NCAORP/2021/39	Paediatric Intensive Care Audit (PICaNet)				

Project Ref Number	Project Title	Infect guidance	Corporate policy	External review	Reaudit/continuous	Risk Register	Claims Audit	Which BCUHB priority does this support?	Proposed Start Date	Proposed Finishing Date	Objectives being met: please include	Accountable Lead(s)	Responsible Corporate Group	In year Data Collection	In-year Report	Risk Assessment (see key below)
Acute/21/01	Ward Manager Weekly Audit			Y	Y	Y		Highly reliable clinical care	Across financial yr 21/22	Ongoing - no end date	This audit complements the ward accreditation framework by monitoring standards across a number of areas. The topics are patient safety, harm free care, medication safety, infection prevention, record keeping, nutrition and hydration, toileting and hygiene, patient experience, dementia care and learning disability care.Data is owned by wards for own quality improvements. The Ward Manager Weekly audits are reported to site Quality and Safety meetings and quarterly to the Secondary Care Patient Safety and Quality Group as part of the Secondary Care Governance structure.	Site Directors of Nursing - Lead Debra Hickman	Secondary Care Quality Group	Yes	Yes	Critical
Acute/21/02	IV Morphine (compliance against guidelines and record keeping)		Y			Y	Y	Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Mar-22	Ensure Compliance with prescribing guidance	Lead Louise Howard Baker	Professional Advisory Group (PAG) / Safe Medication Steering Group	Yes	Yes	High
NEW Acute/21/03	Retrospective audit of compliance of completed DNACPR forms with All Wales DNACPR Policy in BCUHB		Y	Y	Y	Y		Highly reliable clinical care	Across financial yr 21/22	Mar-22	Ensuring compliance against All Wales DNACPR policy, which in turn will develop relevant pathways/standard operating procedures as appropriate. Improving documentation of DNACPR and communication with Primary Care	Dr Ben Thomas, Consultant Nephrologist, Renal	Secondary Care - Clinical Law and Ethics	Yes	Yes	High
BSQR/2021	Auditing compliance with the Blood Safety and Quality Regulations	Y			Y	Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Mar-22	These Regulations impose safety and quality requirements on human blood collection and storage. The requirements apply to blood transfusion services in England, Scotland, Wales and Northern Ireland. Many of the provisions of the Regulations also apply to hospital blood banks.	**Main Contact : Bernie Astbury.** Links for sites: Blood Bank Managers - Joe Leung (YG), Luke Hughes (YGC) and Tony Coates (WMH)	NWMCS Quality Committee	Yes	Yes	Critical
CORP/21/01	Record Keeping	Y	Y			Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Mar-22	Measure compliance with local policy to reduce patient harm	Site Medical Directors; Dr Steve Stanaway, Dr Emma Hosking, Dr Karen Mottart reporting to the Secondary Care Quality Committee and thereafter QSG	Secondary Care Quality Group/site CEG	Yes	Yes	Critical
CORP/21/02	Ward Accreditation Monthly Metrics	Y			Y	Y		Highly reliable clinical care. Reduce patient harms	Ongoing	Ongoing - no end date	This monitors standards across areas including the well led team, patient safety, harm free care, medication safety, infection prevention, record keeping, nutrition and hydration, toileting and hygiene, patient experience, dementia care and learning disability care. Data is owned by wards for own quality improvements. Again this complements to the ward accreditation framework.	Director of Nursing/by site	Senior Nursing Team	Yes	Yes	Critical
Corp/OMD/Consent/21/01	Informed Consent within Secondary Care – A Retrospective Re-audit of Consent review	Y	Y			Y	Y	Highly reliable clinical care. Reduce patient harms	Jan-22	Mar-22	Ensure compliance with the consent to examination or treatment processes to include completion of appropriate consent forms and compliance with the Welsh Language Regulations.	Site Medical Directors; Dr Steve Stanaway, Dr Emma Hosking, Dr Karen Mottart reporting to the Secondary Care Quality Committee and thereafter QSG	Consent and Capacity Strategic Working Group	Yes	Yes	Critical
HTA/HA/2021	Auditing compliance with the Human Tissue Act - Human application	Y			Y	Y		Highly reliable clinical care.	Across financial yr 21/22	Mar-22	Individual audits on a rolling schedule to monitor continual compliance	Chrissie Stringer (HTA / Jacie Quality Manager, Cancer Services) Trefor Roberts (Blood Science Site Manager, Pathology)	Pathology Management and Stem Cell Service	Yes	Yes	Critical

Code	Title						Category	Timeframe	Date	Description	Lead	Committee/Group			Priority
HTA/PM/2021	Auditing compliance with the Human Tissue Act - Post Mortem Sector	Y		Y	Y		Highly reliable clinical care.	Across financial yr 21/22	Mar-22	The HTA's remit is to ensure that post-mortem examinations are undertaken with appropriate consent or under the authority of the coroner and on suitable premises licensed for that purpose, which is a statutory requirement under the HT Act. It is also to ensure that post-mortem examination and the removal and retention of any organs or tissue samples, including those processed into wax blocks and microscope slides, comply with the requirements of the HT Act.	Dr Huyam Abdelsalam (Consultant Histopathologist)	North Wales Managed Clinical Services (NWMCS) Quality Committee	Yes	Yes	Critical
IP&C/21/01	Hand Hygiene audits	Y	Y	Y	Y		Quality and Safety. Reduction in healthcare associated infections	Across financial yr 21/22	Mar-22	Measuring complinace with the policy to support a reduction in healthcare associated infections	Andrea Ledgerton (cc Graham Yarlett)	Local IPG. Infection Prevention Strategic Group (IPSG)	Yes	Yes	High
IP&C/21/02	Decontamination Audits	Y	Y	Y	Y		Quality & Safety. Reduction in healthcare associated infections	Across financial yr 21/22	Mar-22	Compliance against policy to support a reduction in healthcare associated infections	Andrea Ledgerton (cc Graham Yarlett)	Exceptions to Strategic Decontamination Group then IPSG	Yes	Yes	Critical
ISO15189/2021	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	Across financial yr 21/22	Mar-22	.ISO 15189 accreditation underpins confidence in the quality of medical laboratories through a process that verifies their integrity, impartiality and competence. Assessments under UKAS accreditation ensure labs meet the relevant requirements including the operation of a quality management system and the ability to demonstrate that specific activities are performed within the criteria set out in the relevant standard.	Bernadette Astbury (Head of Pathology Quality and Governance)	NWMCS Quality Committee	Yes	Yes	Critical
MedPhys/2021	Certification of the Medical Physics ISO9001:2015 compliant Quality Management System	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Ongoing - no end date	Consistently provide products and services that meet our service users and applicable statutory and regulatory requirements	Mel Lewis, (Medical Physics Quality Lead)	NWMCS Quality Committee	Yes	Yes	Medium
MH&LD CEG/2021/01	Side effects of patients on long acting antipsychotic medication	Y		Y			Reduce patient harms. Quality and Safety.	Across financial yr 21/22	Ongoing - no end date	To monitor adherence to NICE standards and national comparison and ensure safe and efficient medicine management. The results and reports are distributed to prescribers and discussed in CEG	Dr Premraj Muthuvelu	MH&LD CEG	Yes	Yes	High
MH&LD CEG/2021/02	Physical health monitoring	Y	Y	Y			Reduce patient harms. Quality and Safety.	Across financial yr 21/22	Ongoing - no end date	Improving physical healthcare for people with mental disorder by following RCPsych documentation to be reported back through CEG	Dr Premraj Muthuvelu	MH&LD CEG	Yes	Yes	High
MH&LD CEG/2021/03	Introduction of scale to monitor depression	Y					Highly reliable clinical care. Reduce patient harms. Quality and Safety.	Across financial yr 21/22	Ongoing - no end date	Using NICE guidelines standards to Monitor the efficacy of antidepressants	Dr Premraj Muthuvelu	MH&LD CEG	Yes	Yes	High
MH&LD CEG/2021/04	PPE within MH&LD	Y		Y			Reduce patients harm. Quality and Safety. Infection Prevention and control	Across financial yr 21/22	Mar-22	Adherence to donning and doffing and to share findings through presentations training posters, mnemonics .	Dr Alberto Salmoiraghi	MH&LD Clinical Effectiveness Group	Yes	Yes	High
NEW MH&LD CEG/2021/05	Transition Patient Audit Tool	Y	Y	Y	Y		Safe Value-based health care	Across financial yr 21/22	Ongoing - no end date	Establish uniform process for transition across BCUHB	Steve Riley - CAMHS Nurse consultant	Children Division	Yes	Yes	Medium
NICE21/01	Compliance with NICE Quality standards/Clinical pathways linked to NICE guidance	Y		Y	Y	Y	Safe Value-based health care	Across financial yr 21/22	Mar-22	Ensure Compliance - this will be a prorgamme of work	Directorate CD's/CG leads	BCUHB NICE Assurance Group	Yes	Yes	High
NEW NICE -NSF LTNC 2021/01	UK Parkinson's audit		Y	Y			Highly reliable clinical care. Reduce Patient harms	Across financial yr 21/22	Mar-22	To review measurement of practice against evidence-based standards and patient feedback in a continuous cycle of improvement	Site Movement disorder clinical leads (Sam Abraham)	NeurologicalConditionsReview Board	Yes	Bi-annual	high

ID	Audit Title						Category	Start	Target	Description	Lead	Group			Priority
P&MM/21/01	Antimicrobial Point Prevalence Audit (Inpatients)			Y	Y		Safe, Clean, Care. Keeping People Safe from Avoidable Harm	Across financial yr 21/22	Mar-22	Monitors antibiotic use across all sites	Charlotte Makanga (Consultant Antimicrobial Pharmacist) Co-Lead cc KMottart	Antimicrobial Steering Group	Yes	Yes	High
P&MM/21/02	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	Across financial yr 21/22	Mar-22	Monitor use of check list and forced stop to support appropraite antibiotic use	Charlotte Makanga (Consultant Antimicrobial Pharmacist) Co-Lead cc KMottart	Antimicrobial Steering Group	Yes	Yes	High
P&MM/21/03	All Wales Inpatient Medication Safety Audit			Y	Y		Keeping People Safe from Avoidable Harm	Across financial yr 21/22	Mar-22	Monitoring compliance to enable safer prescribing	Assistant Directors of Pharmacy and Medicines Management (Susan Murphy, Bill Duffield, Louise Howard-Baker)	Safer Medicines Steering Group	Ongoing monthly audit	Ongoing monthly audit	High
P&MM/21/04	Safe and Secure Handling of Medicines in Clinical Areas	Y	Y	Y	Y		Keeping People Safe from Avoidable Harm	Across financial yr 21/22	Mar-22	Monitoring compliance to enable safer treatment	Judith Green Lead Governance Pharmacist - Policies, Pharmacy	Safer Medicines Steering Group	Ongoing	Yes	High
P&MM/21/05	Controlled Drugs: storage, handling and record keeping in pharmacies and clinical areas	Y	Y		Y		Keeping People Safe from Avoidable Harm	Across financial yr 21/22	Rolling 6 months	To audit compliance in relation to: Storage/Security/Record Keeping	Ass Directors of pharmacy and medicines management (Louise Howard-Baker, Bill Duffield, Sue Murphy)	Pharmacy Patient Safety Lead	Ongoing quarterly audit	Quarterly	Critical
P&MM/21/06	Compliance with the BCUHB Unlicensed Medicines Policy (MM42)	Y	Y		Y		Keeping People Safe from Avoidable Harm	Across financial yr 21/22	Mar-22	To audit compliance with MM42 regulations	Teena Grenier (Medicines Governance Lead Pharmacist)	Drug & Therapeutics Group	Yes	Yes	High
Q&S21/01	Compliance with relevant LocSSIPso be carried out in each specialty (safety solutions)	Y		Y	Y	Y	Y	Quality and SafertyAvoid never events	Jan-22	Mar-22	Ensure Compliance with local guidance - this is a programme of audits	Directorate CD's/CG leads(KM,TB,GK)	Q&S site leads	Yes	Yes	High
RES/21/01	2222 Audit	Y	Y	Y	Y	Y	Highly reliable clinical care. Reduce patient harms. Quality and Safety	Across financial yr 21/22	Ongoing - no end date	monitoring if emergency call responses across all sites of BCUHB are in line with existing BCUHB Resuscitation Policy	Christopher Shirley (Professional Development Lead : Resuscitation) Sarah Bellis Hollway (Resuscitation Services Manager)	BCUHB Resuscitation Committee, & Rapid Response to Acute Illness Learning Set (RRAILS), sepsis and Acute Kidney Injury (AKI) Steering Board	Yes	Yes	High
Research 21/01	Audit and monitoring of hosted studies (for high and medium risk categorised studies) following Assess, Arrange, Confirm process	Y		Y			Highly reliable clinical care. Reduce patient harm	Across financial yr 21/22	Mar-22	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 Manager (also Lynne Grundy)	Research senior management team group	Yes	Yes	Low

ID	Description						Objective	Timescale	Date	Aim	Lead	Committee			Risk
Research 21/02	Audit and monitoring of sponsored studies	Y			Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Mar-22	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 Manager (also Lynne Grundy)	Research senior management team group	Yes	Yes	Low
Research 21/03	Research policies and Standard Operating Procedures (SOPS)	Y			Y		Reduce patient harms	Across financial yr 21/22	Mar-22	Review and compare practice against the standards and procedures as detailed in the Betsi suite of research SOPs and any applicable research policies.	Research Manager (also Lynne Grundy)	Research senior management team group	Yes	Yes	Low
IRMER/PI/2021	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 21/22	Mar-22	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	Helen Hughes (Head of Quality & Governance: Radiology)	NW MCS Quality Committee	Yes	Yes	Critical
IRMER/PS/2021	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 21/22	Mar-22	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	Helen Hughes (Head of Quality & Governance: Radiology)	NW MCS Quality Committee	Yes	Yes	Critical
IRMER/RP/2021	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 21/22	Mar-22	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	Helen Hughes (Head of Quality & Governance: Radiology)	NW MCS Quality Committee	Yes	Yes	Critical
IRMER/RPD/2021	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 21/22	Mar-22	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	Helen Hughes (Head of Quality & Governance: Radiology)	NW MCS Quality Committee	Yes	Yes	Critical
IRR/2021	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 21/22	Mar-22	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	Helen Hughes (Head of Quality & Governance: Radiology)	Overarching Radiation Protection Committee	Yes	Yes	Critical
QSI/2021	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 21/22	Mar-22	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	Helen Hughes (Head of Quality & Governance: Radiology)Chris Lloyd (OMFS)	NW MCS Quality Committee	Yes	Yes	Critical
NEW IR(ME)R CE 2021	Ionising Radiation(Medical Exposures) Regulation compliance audit - ensuring orthopaedics formally document clinical evalustion of Iain film X-rays	Y	Y	Y	Y		Highly reliable clinical care. Reduce patient harms	Across financial yr 21/22	Mar-22	To ensure compliance in the field hospitals and within the radiology departments with current radiation regulations.	Site Orthopaedic Clinical Director (cc HH)	Radiation Protection Committee	Yes	Yes	Critical
Risk classification criteria:															

Introduction

These projects are registered as on-going audits or service evalautions in selected service areas.

They are registered electronically and it is the duty of the audit lead to ensure they are methodologically sound and completed. Many of these projects are undertaken by other members of the team, such as doctors in training.

The auditors are expected to upload a report on completion; this generates a letter for their portfolio.

The stance has been to discourage "tier 3" /local audits in favour of larger, more inclusive prioritised audits and those required by Welsh Government and there is no funded support for tier 3 audits.

Project Ref Number	Title of Project	Service Evaluation	Local Audit	Aim of the project	Audit Lead	Area - East	Area - Centre	Area - West	Date registered
20/007	Multi-centre prospective audit of home LUTS assessment in men unable to attend hospital due to COVID-19		x	To Assess the safety of following up lower urinary tract symptom patients at home and avoid bringing them in hospital during the Pandemic	Ahmed Moussa Endo-urology Fellow	x			06/05/2020
20/085	RESECT (transurethral resection and single instilliation intranesical chemotherapy evaluation in bladder cancer treatment)	x		Aim to measure current practice in TURBT surgery & compare this against recommendations made in Urology association guidelines	Professor Shergill Consultant	x	x		22/07/2020 (E) 06/11/2020 (C)
20/086	Review of erectile dysfunction services in North Wales	x		Aim to review the current provision of erectile dysfunction services in North Wales with focus on waiting times, primary & secondary care assessment and adherence to current NICE guidelines	Mr Chirag Patel Consultant	x	x	x	22/07/2020
42	Mitomycin use in treatment of TURBT		x	Assess if mitomycin is used post op. - How soon after surgery is it administered- Are we hitting the national standard	Mr Chirag Patel Consultant	x			11/09/2020
49	Outcomes of renal tract calculi treated conservatively	x		Identify the number of patients who do not meet the criteria for surgical intervention in a certain period.- Identify their management pathway for the stone and compare it against guidelines.-	Mr Chirag Patel Consultant	x			15/09/2020
50	Microbial investigations for patients presenting with urinary tract infectons		x	Improving patient care by identifying organisms causing UTIs and targeting antimicrobial treatments appropriately.	Mr Chirag Patel Consultant	x			15/09/2020
58	Compliance with medical/surgical clerking proforma regarding VTE risk assessment.		x	To assess compliance with the guidelines.	Vaikuntam Srinivasan Consultant		x		18/09/2020
66	Outcome after urethroplasty for urethra stricture	x		to determine the aetiology of urethra stricture,compare outcome of utrethroplasty to non surgical management of urethral sticture	Mr Chirag Patel Consultant	x			25/09/2020
89	How satisfied are patients with urology telephone consultations?	x		To evaulate pts satisfaction with urology telephone cosultations.	Mr Chirag Patel Consultant	x			09/10/2020
116	To review analgesia prescribing patterns for suspected acute renal colic admissions		x	Optimising analgesia prescriptions	K. Alexandrou Consultant			x	27/10/2020
129	Percutaneous Nephrolithotomy (PCNL) in Wrexham Maelor Hospital compare with the National audit	x		The aim of this audit is to compare the surgery, complication and outcome of PCNL in Wrexham Maelor Hospital to the standard practice and outcome of PCNL in many centres United Kingdom (UK).	Mr Mohamed Yehia Abdallah Consultant	x			04/11/2020
195	Outcomes for patients referred with haematuria		x	To investigate pt demographics and outcomes for haematuria investigations. Liked to large audit at Glan Clwyd.	Mr Chirag Patel Consultant	x	x		02/12/2020
236	Local anaesthetic Transperineal Prostate Biopsies	x		To assess the the outcome and safety of this new procedure	Mr.S.Kannan Consultant			x	13/01/2021
237	Template Prostate Biopsies	x		To assess the indication and safety and outcomes of the procedure	S.Kannan Consultant			x	13/01/2021
238	Prospective Audit of the Radical Cystectomy	x		To assess the indication and outcomes.	Mr.Mohamed Abdulmajed Consultant			x	13/01/2021
271	5 Years TURP outcome audit	x		To audit our TURP outcomes in the last 5 years	Prof Kingsley Ekwueme Consultant		x		27/01/2021
276	Clinical Records Documentation - Surgical Wards.		x	To improve the patient care and reduce the risk for doctors and patients by poor incomplete documentation.	Mr M Thangavelu		x		31/01/2021
280	An audit looking into the effectiveness of providing patients recieving ureteric stenting with a patient information leaflet, in reducing re-admission rates with stent related symptoms.	x		We aim to find out if giving patients information leaflets, informing them of symptoms they can expect to experience post ureteric stenting, will reduce the complaints of symptoms, and reduce admission rates for stent related issues.	K. Alexandrou Consultant			x	02/02/2021

285	An audit to improve management of urinary retention and avoid unnecessary hospital admissions.		x	Reduce admission from A+E with acute urianary retention	K. Alexandrou Consultant			x	04/02/2021
326	Bladder Cancer: Presentation to Treatment in WMH		x	To compare the practice in the management of patient with bladder cancer and the EUA guidance	Mr B. Jameel Consultant	x			04/03/2021
344	Waiting Times for Radical cystectomies	x		Analyzing retrospective data of invasive bladder cancers from August 2019 to September 2020	Mr M Abdul Majeed Consultant			x	15/03/2021
394	Cost Effectiveness and efficiency of management and surveillance of patients with Cysteinuria	x		To improve local management of this patient cohort.	Professor I Shergill Consultant	x			29/04/2021
395	Catheters		x	The aim of the project is to do an online survey and check how many doctors in training would like to learn how to insert/change urethral/suprapubic catheter. The results would dictate if teaching is required. This will be followed by a second online survey, for re-auditing. If there is a good response, we can set up more frequent catheter teaching throughout the year for the junior doctors.	Mr.V.Srinivasan Consultant		x		29/04/2021

Project ID Number	Title of Project	Service Evaluation	Audit	Please provide details of the aim of your project	Audit Lead	Area	Date registered
35	Discrepancy between MDT decisions and intraoperative findings and steps		x	Review actual procedures that differed from MDT decisions and impact on the outcome	Mr. Wissam Taha Consultant	BCU wide	07/09/2020
130	Amputation against the VSGBI QIF amputation guidance		x	To find areas of potential improvement	Mr Soroush Sohrabi Consultant	BCU wide	05/11/2020
159	Infections in the vascular patient: post admission or post intervention	x		Study the factors that facilitate and maximize the infection rate therefore attacking source of infection and minimizing infection risk to the minimum	Mr Faisal Sheikh Consultant	BCU wide	19/11/2020
168	Same Day Discharge Following Endovascular Interventions: Fact or Fiction	x		To evaluate the safety and feasibility of same-day discharge after endovascular procedures in North Wales hospitals.	Owen Rees Radiologist	BCU wide	26/11/2020
252	Efficiency of vascular discharge summaries		x	Safer practice Quality improvement	Mr. Wissam Taha Consultant	BCU wide	21/01/2021
259	Audit of service provision for AAA (abdominal aortic aneurysm) patients after centralization of Vascular Services.		x	Treatment timeframe for operable size >5.5 cm AAAs and outcomes.	Laszlo Papp Consultant	BCU wide	25/01/2021
260	An analysis of the vascular theatre times	x		This analysis will help to improve on theatre L efficiency and prevent delays	Hans Desmarowitz Consultant	BCU wide	25/01/2021
261	Analysis of the timeline of major vascular from the allocation date to the date of surgery		x	This audit will help to understand the compliance of the North Wales vascular department with the national guidelines on performing major vascular procedures within the recommended timeframe	Hans Desmarowitz Consultant	BCU wide	25/01/2021
262	A review of below knee to above knee amputation conversion	x		Understand the potential factors contributing to the conversion of below to above knee amputation	Mr Soroush Sohrabi Consultant	BCU wide	01/02/2021
264	North Wales Vascular MDT ProForma completion audit		x	to improve the MDT data supplied for the MDT discussions and for the patient records.	Hans Desmarowitz Consultant	BCU wide	21/04/2021
266	Analysis and audit of aneurysmal sac expansion after endovascular abdominal aortic aneurysm repair among the surveillance cohort in North Wales		x	Determine the rate of aneurysmal sac expansion after endovascular abdominal aortic aneurysm repair among the surveillance cohort in North Wales	Hans Desmarowitz Consultant	BCU wide	26/01/2021
267	Carotid intervention in North Wales following centralization of vascular services.	x		The purpose of this audit is to analyze the carotid intervention pathway and its outcome in North Wales and to compare with the national guidelines. To evaluate the efficiency of delivery of Carotid intervention in patients referred from stroke and ophthalmology units in North Wales. To compare the complications encountered per-operatively and post-operatively in patients undergoing Carotid intervention with the standard UK practice. To assess the 30-day mortality / stroke rate post-carotid endarterectomy. To compare our results with the national set standards in UK and shorten any delays in the delivery of standard surgical treatment if encountered	Hans Desmarowitz Consultant	BCU wide	26/01/2021
328	To determine the accuracy of antimicrobial prescription in the drug chart.		x	1)To compare adherence to hospital antibiotic policy using microguide.2)To assess whether the antibiotic prescribed is of appropriate dosage, route and duration.3)To find out whether the indication of the prescribed antibiotic is mentioned in the drug chart.	Sivakumaran Sabanathan Consultant	East	05/03/2021

| 444 | Vascular Consent form Audit | | x | To ensure policy is followed. Identify areas for improvement | Mr Ahmed Abdaldayem ST3 Trainee | BCU wide | 10/06/2021 |
| 446 | Time frame for vascular intervention for emergency patients with critical limb ischaemia | | x | Is the time frame within acceptable guidance and if any significant difference since vascular service centralisation | Mr Aidas Raudonaitis Consultant | BCU wide | 14/06/2021 |

Project ID Number	Title of Project	Service Evaluation	Audit	Please provide details of the aim of your project	Audit Lead	Area East	Area Centre	Area West	Date registered
20/066	An effectiveness evaluation of telephone primary mental health assessments across East CAMHS	x		An evaluation of how helpful the adapted telephone Primary Mental Health Assessments are from the family's perspective, enabling an informed decision to be made regarding whether telephone Primary Mental Health Assessments can continue to be offered, longterm, post COVID-19, as an affective option for young People	Emma Louise Woolfall Clinical Psychologist	x			02/07/2020
20/084	Evaluation of response to Covid-19 pandemic by Central (Denbighshire and Conwy) Child and Adolescent Mental Health Services (CAMHS).	x	x	To evaluate the changes in service provision in response the the Covid-19 pandemic from the perspective of CAMHs staff, associated stakeholders, and young people and parents	Jonathan Williams Principal Clinical Psychologist		x		20/07/2020
152	Can including client-rated outcome measures facilitate the delivery of person-centred psychological interventions?	x		To assess efficacy of interventions and to determine correlation between outcome measures to assess benefits of both	Jonathon Williams Clinical Psychologist		x		18/11/2020
390	Where oh where have the choice to partnership tasks disappeared to		x	To ensure Choice to Partnership tasks are being set at initial choice appointments and followed up when picked up at partnership.	Judith Reed Screen		x		23/04/2021
431	An Evaluation of a Child and Adolescent Mental Health Service's (CAMHS) Virtual Dialectical Behaviour Therapy (DBT) Group	x	x	To evaluate the Child and Adolescent Mental Health Service's (CAMHS) Virtual Dialectical Behaviour Therapy (DBT) Group from the perspective of attendees.	Dr Louise Woolfall Clinical Psychologist	x			27/05/2021

Project ID Number	Title of Project	Service Evaluation	Audit	Department	Please provide details of the aim of your project	Audit Lead	Area - East	Area - Centre	Areas - West	Date registered
20/014	Audit of the weekly safeguarding meetings held in the three Emergency Departments in the Acute Hospitals		x	Corporate Safeguarding	A 3 month pilot has been conducted in YGC and is now being rolled out in the other two sites - YM and YG. The evaluation of the pilot incuded : • Greater aware of safeguarding policies and procedures • Increased engagement with the Safeguarding Team, both in person and by telephone • Awareness of the escalation process when concerns are identified • Increased quality of referrals being submitted, although these may not necessarily be relating to cases forming part of the weekly ED Safeguarding review process • Assurance that YGC ED are complying with Recommendation 3 of the C&V CPR This audit, on a regional basis will hoefully have similar outcomes for children and improve patient care	Chris Weaver Head of Safeguarding Children	x	x	x	07/05/2020
20/061	Management of fractures of the neck of femur in the Emergency Department		x	Emergency Department	Improve the management of patients overall care in line with national standards	Brigid Hughes Consultant		x		29/06/2020
20/077	Compliance with OTTAWA ankle rules for appropriate radiological investigations in ankle injury		x	Emergency Department	Identify those patients with ankle injuries that require radiological investigations appropriately by using recognised clinical assessment tools; aloow more focused reporting of the xrays with better clinical information as part of the request form; reduce unnecessary investigations, thereby reducing waiting time and improving saftey of patients and safer clinical evaluation	Brigid Hughes Consultant		x		15/07/2020
7	Procedural sedation in the emergency department		x	Anaesthetics	Investigate safety and documentation of procedural sedation in the Emergency Department.	Dr Jen Dinsdale Consultant		x		31/08/2020
13	Blood product use and Major Haemorrhage Protocol activations in the Emergency Department		x	Anaesthetics	We hope to identify patients who might have benefited from MHP activation when emergency blood was used, and to gather evidence that may support better access to emergency blood products and POC testing in the ED.	Dr Jen Dinsdale Consultant		x		03/09/2020
88	Extra dural haemhorrage in the Emergency Department.	x	x	Emergency Department	Ascertain how many patient attended ED YG with Extradural Haematoma in a 12 month period. Ascertain how many of those may potentialty have meet criteria for an emergency cranial burr hole. Ascertain the outcomes of these patient (full recovery/ partial recovery/ died).	Dr Tofe Alaakel Consultant			x	09/10/2020
91	Appropriate Patient Identification on ECG tracings in the Emergency Tracings		x	Emergency Department	To ensure appropriate patient identification on ECG tracings so as to help promote and ensure patient safety.	Dr Roy Hilton Associate Specialist		x		10/10/2020
247	Management of paracetamol overdose in the EQ		x	Emergency Department	* Reduce patient journey in hospital * Cost effectiveness for patient's journey *Compare to introduce the SNAP protocol,if approved for national use	Dr Seramanperuman Sivaraman Consultant		x		19/01/2021
293	Chaperone documentation practice in YGC ED department		x	A&E	1.To identify the appropriate use of chaperone for sensitive area examination within the ED department 2. To identify if standardised ED documentation is being used in the department 3. To identify whether the offer and refusal of a chaperone is being documented in the ED clerking.	Dr Seramanperuman Sivaraman Consultant		x		10/02/2021
410	Re-audit: Catheterization in Hip Fracture Patients		x	A&E	to see the recommendations put forward after the completion of first cycle were effective/implemented	Dr V Adhiyaman Consultant Ortho-geriatrician		x		10/05/2021

Project ID Number	Title of Project	Service Evaluation	Audit	Please provide details of the aim of your project	Audit Lead	Area - East	Area - Centre	Area - West	Date registered
76	Anticholinergic burden on the ageing brain.		x (QI)	Polypharmacy is a big issue in the elderly hospitalized population, leading to falls, confusion, metabolic disturbances and placing anticholinergic burdens on the ageing brain. Our aim is to introduce the STOPP-START tool kit to look at medication optimization in our in-patient Dementia ward.	Dr. Akshey Nair Consultant Psychiatrist			x	02/10/2020
90	Improving completion of falls risk assessments on a COTE ward		x	Our aim for this project is to improve the number of inpatient falls pathways that are completed fully and correctly. 'Fully' indicating that a falls pathway has been completed if indicated by the falls decision tool, with no information missing. 'Correctly' indicating that the information stated on the falls pathway is accurate and up to date. In doing this, we hope to improve the completion rate and quality of the falls pathways in the ward which, in turn, may benefit vulnerable patients by identification and correction of modifiable risk factors for falls if appropriate.	Dr Indrajit Chatterjee COTE consultant		x		09/10/2020
142	What factors do Occupational Therapists face in current falls prevention strategies in older adults living in the community.		x	To explore the factors that Occupational Therapists face when looking to reduce falls within the individual's community home setting.	Rachel Wylie OT lead	x			13/11/2020
346	Post-Covid Numerous Falls Audit for all inpatients in OPMH across BCUHB (March 2020- February 2021)		x	To see the effect of Covid-19 on with inpatients numerous unwitnessed falls in patients with dementia	Rakesh Kumar Clinical Specialist Physiotherapist			x	17/03/2021
389	It is an observation that we are using the care pathways incorrectly and inadequately in Obstetrics emergencies. To find out this objectively, I am planning an audit on this.		x	It is an observation that we are using the care pathways incorrectly and inadequately in Obstetrics emergencies. To find out this objectively, I am planning an audit on this. I am doing a retrospective study, looking at the Care pathways. For example, the correct label of the patient, Procedure, Indication, Blood loss, WHO checklist and over all use of the pages by the health professionals.	Mr. Adremi Alalade Consultant		x		21/04/2021
418	Evaluating whether medication reviews with respect to falls risk are carried out for inpatients at the Wrexham Maelor Hospital		x	1. To determine how many patients admitted with to the Acute Frailty Unit with a falls risk of Level 1 or above (based on the 'Enhanced Care Risk Assessment' documentation completed by nurses (see appendix 2)) have had a documented falls assessment, in relation to medication, completed by a pharmacist. 2. To assess whether these patients are prescribed any medication which can contribute to falls as per the RCP, 'Medicines and Falls in Hospital: Guidance Sheet', and if so, whether they are classified as Red, Amber or Yellow. 3. To determine how many patients included in the audit were admitted with a fall.	Sheila Doyle Medical Lead Pharmacist		x		19/05/2021

GIG
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Betsi Cadwaladr
University Health Board

Reporting

Reviewing

LEARNING
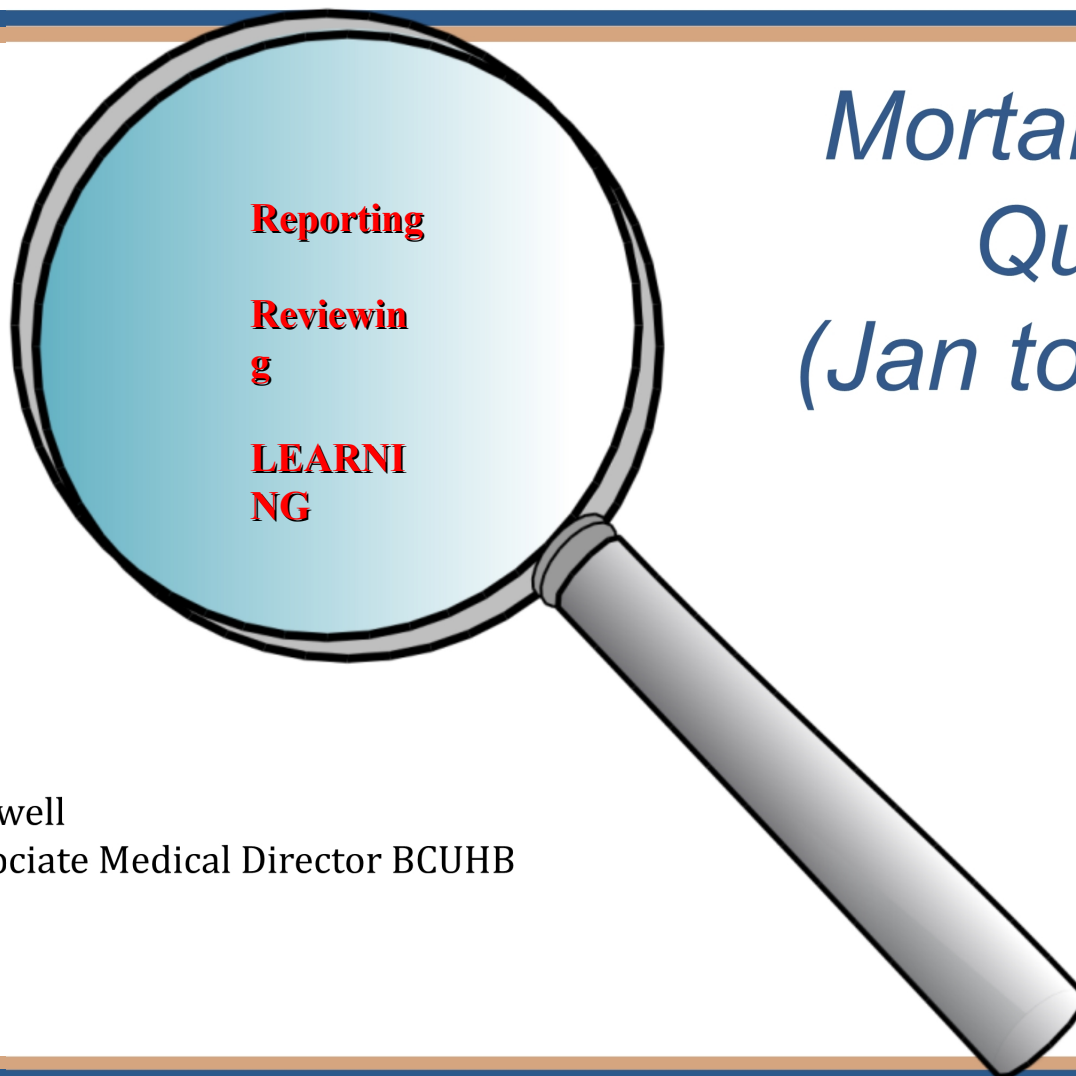
Mortality Review
Quarter 4
(Jan to Dec 2020)

Dr M J Maxwell
Senior Associate Medical Director BCUHB
June 2021

Introduction:

- This is a cumulative quarterly report and included the data for all of 2020, populated by the divisions reflecting the death review process activity, identified good practice and learning.

- Putting Things Right escalation are those deaths where following stage 2 review, there remains a concern that care given may have contributed to the death or caused harm, and require further multidisciplinary review.

- Learning and action taken should include the dissemination of the learning; this information is shared within and across Divisions through the Clinical Effectiveness governance structure.

- This report is developmental and will provide additional learning and assurance as other processes move forward. For example, the roll out of the Medical Examiners service and the subsequent primary care reviews that will follow.

- Where themes start to emerge across services, they provide an opportunity for organisational improvement and learning. These will be highlighted in this report along with the planned action.

Surveillance - INPATIENTS

BCU:

- had an inpatient Crude Death Rate (CDR=2.25), which is lower than the Welsh peer (2.62) but higher than the CHKS Top Hospitals 2019 (These are predominantly English Trusts and do not include community inpatient beds)
- changes seen in the last year relate to the COVID19 pandemic. Deaths have increased in the frail elderly and patients with dementia.
- had the lowest risk adjusted mortality (Jan-Dec20) in Wales (RAMI 2019) (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 and socio-economic factors associated with higher COVID 19 mortality seen in that community. Further work is needed to determine the significance of this.

BCUHB Crude mortality rate compared to Welsh and Top hospital 2019 peer

RAMI (Risk adjusted mortality index) 2019
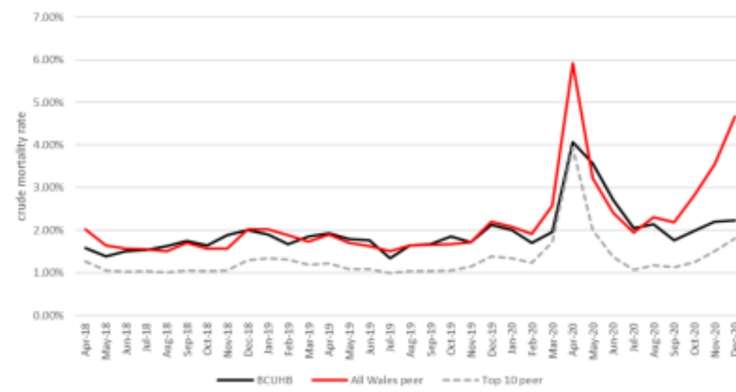
BCUHB Crude mortality rate by area
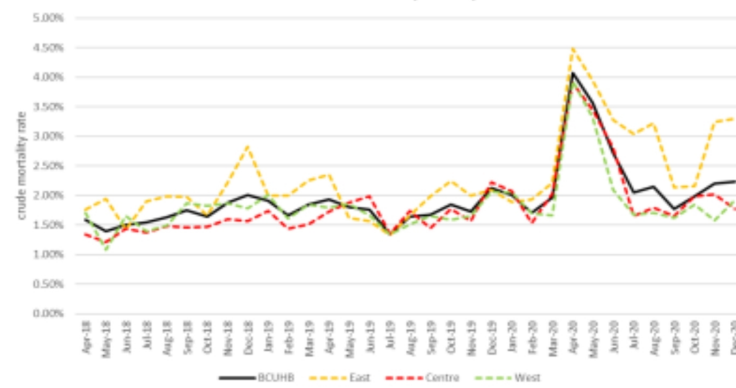
MEDICAL EXAMINERS

Activity	Nos
Referral to the Coroner	73 (29%)
Referral for further review by division:	84 (34%)
•Acute	83
•Mental Health	1
•Area East	0
•Area Centre	0
•Area West	0
Reason for review:	
•Concern about medical care	22
•Concern about nursing care	6
•Concern raised by the family	23
•Communication issues	3
•Delay in treatment	15
•HAI COVID-19	16
•Other includes Poor record keeping; falls; Pressure Ulcers	4
Reported in advance to incidents/ concerns& complaints team	N/A

Medical Examiners Service Activity 2020
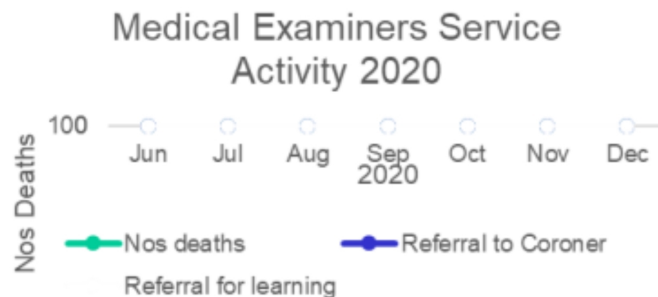
This service started to operate from late June 2020 within YGC; this will be rolled out to other sites when we are able to provide scanned notes. 250 deaths had been reviewed by year end; mostly in the last quarter.
The expectation of the ME service is 20% referral to stage 2. Scrutiny on the site has shown some do not require stage 2 reviews (15 - referred to the concerns team/ ward investigation/ service issue outside the site). If these and HCAI COVID deaths are removed- the referral to stage 2 is 20%.
We are trying to see if comparative Welsh data is available

REPORTING

OUTLIER REPORTS From EXTERNAL SOURCES

Quarter 2020	Report – Source/Content	Investigation agreed
Jan-Mar	None	None required
Apr– Jun	None	None required
Jul – Sep	National Bowel Cancer Audit •Outlier for 2 year survival	• Palliative procedures were not classed as such. • Staging was inaccurate • Patients were generally a group with late presentation. • There was no systematic issues identified with the treatment & care around the time of procedure. • Note: Information was not available on cause of death.
Oct – Dec	National Lung Cancer Audit 2020 •Low rate of referral for Chemotherapy	Note: this was a historic report delayed by the pandemic. The issue had been raised and resolved earlier in the year. •Missing data field entry led to inaccurate reporting; this has been rectified by the service and the care standard is consistently met.

Mortality Reviews – INPATIENT DEATHS – ACUTE SITES

QUARTER 2020	Adult Inpatient Deaths	UMR1/ ME screen completed	UMR2 Referred	Completed	PTR Escalation
Jan-Mar BCU	**786**	**758** (96%)	**117** (15%)	**30** (25.6%)	
WMH	261	250 (96%)	42 (16.8%)	23 (54.8%)	2
YGC	293	285 (97%)	45 (15.8%)	7 (15.5%)	1
YG	232	223 (96%)	30 (13.5%)	0 (0%)	0
Apr– Jun BCU	**797**	**751** (94%)	**129** (17%)	**38** (29%)	
WMH	296	264 (89%)	50 (19%)	23 (46%)	2
YGC	333	332 (100%)	44 (13%)	14 (32%)	0
YG	168	155 (92%)	35 (22.6%)	1 (2.8%)	0
Jul – Sep BCU	**614**	**524** (85%)	**141** (27%)	**52** (37%)	*
WMH	243	214 (88%)	69 (32%)*	30 (43%)	
YGC	208	201 (96%)	42 (21%)	22 (52%)	
YG	163	109 (67%)	30 (27%)	0 (0%)	
Oct – Dec BCU	**718**	**529 (73.7%)**	**262 (49.5%)**	**104 (39.7%)**	*
WMH	293	216 (73.7%)	106 (49.1%)	37 (34.9%)	
YGC	253	223 (88.1%)	105 (47.1%)	67 (63.8%)	
YG	172	90 (52.3%)	51 (56.7%)	0 (0%)	
Total	**2915**	**2562 (88%)**	**649 (22%)**	**224 (35%)**	

Avoidable Mortality:

WMH – 4 Deaths
YGC – 5 Deaths
YG- Information not available as no new reviews completed. This is being taken up with the MD at YG

PTR escalation has increased due to the requirement to investigate all Healthcare Associate Infections for COVID 19. This information has not been reported by the sites in Q3 and 4 as this will be misleading in the context of this report. This report is trying to identify if we have a delay in recognising harms that require PTR escalation.

Wrexham - 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

There has been an increase in activity during the final quarter of the year; clinicians were not required to complete reviews (other than those with known harm) during the surges

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	Nil
Apr– Jun BCU EAST CENTRE* WEST*	35	35	Nil	Not required	Nil
Jul – Sep BCU EAST CENTRE* WEST*	51	51	Nil	51	Nil
Oct – Dec BCU EAST CENTRE* WEST*	20	20	Nil	20	Nil

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

REVIEWING

* Centre and West Community beds in centre from COTE are in the hospital acute sites process for reporting currently in progress.

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	72	42 MRG stage 1&2 (58%)	30 (71%)	0
Oct – Dec	83	44 MRG Stage 1 10 MRG Stage 2	29	0

Avoidable Mortality: 0

Positive Findings

End of life care given was appropriate and involved palliative care colleagues where required.

NB: MRG is Mortality Review Group

REVIEWING

Mortality Reviews – WOMEN'S SERVICES

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

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	**8** •3 Stillbirths •2 Stillbirths 1 maternal death in the community •2 Stillbirths	8 rapid reviews	8 PTR reviews (maternal death to have a second PTR review following the release of notes seized by the police)	16
Oct - Dec BCU EAST CENTRE WEST	**2** •Nil •2 Stillbirths 1 maternal death in the community •Nil	2 MIS	2 concise reviews	4

<u>Avoidable Mortality</u>: 0

<u>Positive Findings</u>

- Plans of positive care were well documented
- Excellent documentation in one of the incidents with regards to fetal movements and routine enquiry (safeguarding) questions

REVIEWING

Mortality Reviews – CHILDRENS SERVICES

Quarter 2020	Area	Deaths	Nos reviewed	Nos PTR review	Total 1reviews
Jan-Mar	**BCU** EAST CENTRE WEST	**18** 10 6 2	**18** 10 6 2		**18**
Apr– Jun	**BCU** EAST CENTRE WEST	**7** 4 3 0	**7** 4 3 0	 1	**7**
Apr– Jun	**BCU** EAST CENTRE WEST	**9** 2 5 2	**9** 2 5 2		**9**
Oct – Dec	**BCU** EAST CENTRE WEST	**6** 1 3 2	**6** 1 3 2	1	**6**
Total	EAST CENTRE WEST	17 17 6	17 17 6	1 1	**BCU** **40**

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.

Positive Findings

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

REVIEWING

INPATIENT DEATHS – ACUTE SITE – Speciality Learning and Actions

		Themes	Action	By whom	Assurance	By when
1		NEWS scores not always completed, nor actioned appropriately (YGC)	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 Included in ward audits for local action	ongoing
2		DNACPR: not countersigned by Consultant; incomplete or missing (YGC & WMH)	Audit to be completed – piloted on WHM site and then rolled out to other sites. Review of policy	Doctors in training (Supervisor Dr Ben Thomas) Consent & Capacity Group	Audit reporting	Dec 2021
3		Issues with notes: large untidy volumes of notes; loose sheet (WMH & YGC)	Process in place to scan last admission to support Medical Examiner Service requires case notes to be reordered and therefore better able to abstract information required.	Health Records + clinicians	Improve score by 5%	July 2021
4		Patients and/or their families not made aware of Hospital acquired Covid 19 (WMH)	Reinforce with Clinical Teams Case note audit	Internal communication - Medical Director Associate Medical Director Q&S/ Clinical Director Medicine	Email reminder to all Consultants Audit report – widely shared Process in place with PALS	October 2020

LEARNING

INPATIENT DEATHS – COMMUNITY SITES – *Speciality Learning and Actions*

East	Themes	Action	By whom	Assurance	By when
1	Appropriate and timely admission to hospital for end of life care	Appropriate Hospital admissions for end of life care	Mortality Review Panel - Richard Waterson	Mortality review panel process Area East weekly Harms review with Matrons and service leads	Monthly
2	Robust and focused adoption of end of life and palliative care principals	Appropriate use of Last Days of Life document in Community Hospitals	Mortality Review Panel – Richard Waterson	Mortality review panel process Area East weekly Harms review with Matrons and service leads	Monthly
3	Medical records on occasion are untidy and forms/documents not filed	Accurate record keeping	Mortality Review Panel - Richard Waterson	Mortality review panel process Area East weekly Harms review with Matrons and service leads	Monthly
4	DNACPR documents appropriately completed and filed at front of medical records	Clearly documented DNAR forms	Mortality Review Panel – Richard Waterson	Mortality review panel process Area East weekly Harms review with Matrons and service leads	Monthly
5	To ensure that all patients receive a senior review within 12 hours of admission	Clear record of senior review upon hospital admission	Mortality Review Panel – Richard Waterson	Mortality review panel process Area East weekly Harms review with Matrons and service leads	Monthly
6	To ensure family and relatives are kept updated and informed	Clear record around family engagement	Mortality Review Panel – Richard Waterson	Mortality review panel process Area East weekly Harms review with Matrons and service leads	Monthly
7	To ensure there is a clear records of COD and if Coroner has been notified or discussed	Cause of death clearly documented	Mortality Review Panel – Richard Waterson	Mortality review panel process Area East weekly Harms review with Matrons and service leads	Monthly
8	To ensure there is a clear records of COD and if Coroner has been notified or discussed	Open engagement with the coroner where appropriate	Mortality Review Panel – Richard Waterson	Mortality review panel process Area East weekly Harms review with Matrons and service leads	Monthly
9	Continued use of Last Days of Life document	Engagement with GPOOH	Mortality Review Panel – Richard Waterson	Mortality review panel process Area East weekly Harms review with Matrons and service leads	Monthly

LEARNING

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

		Themes	Action	By whom	Assurance	By when
1		COVID deaths	All deaths related to COVID have been subject to MRG Stage 2, including LD COVID 19 related deaths		MRG Stage 2 meeting held 4.11.2020 noting excellent standards of care benefitting from end of life care via the commissioned GP and District Nursing Team	04/11/2020
2		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.	Legislation reviewed and legal opinion obtained.	MHLD Medical Director	Confirmation received that if the criteria for detention under the MHA is not met to consider discharge.	19/11/2020

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

LEARNING

WOMENS SERVICES – Task & Finish Group has been set up to develop an improvement plan to address education for women about altered fetal movements; to development local management guidance, in the absence of an updated national policy. This is work in progress.

CHILDRENS SERVICES - It has been noted that external and medical causes of death need to be better documented by staff to support panel reviews to enable trends and patterns in child deaths to be explored so avoidable factors can be reduced.

LEARNING

Emerging Themes

Emergent themes triangulate across the different review processes and actions are underway to address these:

Division	Theme	Action to be taken	By Whom?	By When?
Inpatients Community (East)	Appropriate hospital admission for symptom management	Key lessons around: Appropriate hospital admissions by GP's for end of life care Appropriate use of Last Days of Life document in Community Hospitals Accurate record keeping Clearly documents DNAR forms Clear record of senior review upon hospital admission Clear records around family engagement Cause of Death clearly documented Open engagement with the Coroner where appropriate	R Waterson	ongoing
Medical Examiners	DNACPR second signatures missing	Audit tool piloted in WM hospital to audit DNAR paperwork. Review in Strategic P&EOLC meeting. Roll out to other sites in progress. Pilot reminder sticker in WMH	B Thomas	May 2021 June 2021 Sep 2021 Jun/Jul 2021
	Conditions of case notes (misfiled, difficult to negotiate)	Process in place to scan case-notes; need to recruit staff to deliver the service. This will ensure paperwork is filed in the correct order	W Hardman	July 2021
	PAN WALES - Awareness of need for Coroner's referral (legal requirements)	Case by case discussion with the ME Service Awareness raising - ME presentations held at grand rounds	ME Service	Ongoing
	HAI COVID-19	Process being agreed with Patient Safety team to ensure mortality reviews are completed as part of the wider HCAI reviews. Requires resources	M Joyes /M Maxwell	Ongoing within the existing process.

LEARNING

Cyfarfod a dyddiad: Meeting and date:	Quality Safety & Experience Committee 6th July 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	BCUHB Corporate Safeguarding Annual Report 2020-2021
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris - Deputy Chief Executive Officer (CEO) /Executive Director Nursing And Midwifery Michelle Denwood - Associate Director of Safeguarding
Awdur yr Adroddiad Report Author:	Frances Millar – Head of Safeguarding Adults Chris Weaver – Head of Safeguarding Children Chris Walker – Head of Safeguarding Adults Mental Health & Learning Disabilities Division (MHLD) Supported by Michelle Denwood Associate Director of Safeguarding
Craffu blaenorol: Prior Scrutiny:	• Gill Harris - Deputy CEO/Executive Director Nursing And Midwifery • Debra Hickman – Secondary Care Nurse Director • Patient Safety and Quality Group • Safeguarding Governance and Performance Group

Atodiadau
Appendices:
	Appendix 1. Corporate Safeguarding Annual Report 2020-21
	There are three further appendices providing detailed information aligned with this report:
	  Appendix i) – Corporate Safeguarding Adults at Risk
	  Appendix ii) – Safeguarding Children at Risk, Safeguarding Midwifery and Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)
	  Appendix iii) – Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)
	
	These are structured in line with the National Safeguarding Maturity Matrix (SMM) five (5) key standards

Argymhelliad / Recommendation:
The Committee is asked to receive the Annual Report for the period of 2020-2021 noting the progress, assurance and the innovative work led by the Corporate Safeguarding Team to implement learning throughout the organisation to help keep our patients, staff and organisation safeguarded.

Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance	X	Er gwybodaeth For Information	X
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	

Sefyllfa / Situation:
The Corporate Safeguarding annual report 2020/21 is presented as part of the annual Board

reporting schedule.

This year has seen an unprecedented increase in both the complexity and intensity of Safeguarding activity across BCUHB.

The changes to the overall service delivery is a result of the COVID – 19 pandemic which has seen a reduction in the face to face access to services by our service users.
Corporate Safeguarding have proactively responded to these challenges and implemented a variety of mechanisms and adapted our ways of working to ensure we have continued to deliver the safeguarding agenda and drive our organisations safeguarding objectives, to protect those who are at risk of harm or who are deemed to be vulnerable.

We have implemented all of the Safeguarding Priorities for 2020-2021 with the progress and achievement monitored by the Safeguarding Governance and Performance Group and the Patient Safety and Quality Group, formerly known as Quality and Safety Group.

The improved compliance with safeguarding reporting and the identification of risk and harm has strengthened by the implementation of the Social Services Wellbeing (Wales) Act 2014 and the Wales Safeguarding Procedures 2019, which came into force on the 3rd November 2020. The legislation not only strengthens the legal footprint of children's safeguarding for the first time in history, in Wales a legal duty is placed upon the reporting of adults at risk.

Learning and implementing safeguarding legislation has a significant impact upon the health, and wellbeing of the service user and family. A Human Rights approach is at the forefront of our practice and engagement with service users and their families. Learning from incidents and practice enables us to reinforce best practice, gain assurance and deliver a service, which reduces risk and harm.

Examples of the implementation of key strategic and clinical initiatives.

Adult Case Study 1 – Learning from practice.

A 75 year old patient was admitted to an Acute Care Mental Health Unit (Patient A). The Ward was traditionally an inpatient admission ward for Adult Mental Health Patients. Patient A did not have capacity and had impaired hearing and vision. Due to the nature of illness, including sensory needs and cognitive difficulties, Patient A would spend long periods mobilising along the floor; this caused friction to the particularly vulnerable pressure points. As a result, Patient A's skin integrity was a high risk and subsequently developed wounds.

Case Learning

On admission, a body map was completed which indicated wound areas. Risk Assessments, with intervention and equipment was in place. Evaluation of risk identified the measurement of risk and risk management was incorrect. The outcome was the Pressure Ulcer was avoidable which instigated the Adult at Risk Report process. Actions taken included:

1. Memo was circulated regarding the pressure ulcer pathway
2. Tissue Viability Champions were identified from each of the Wards
3. Identified staff undertook enhanced training for identifying and grading pressure ulcers.
4. Audit of clinical records and risk assessments, best practice and omissions were included within revised guidance.

5. Clinical managers review the outcome of Fundamentals of Care audits to ensure areas of concern are actioned.
6. Corporate Safeguarding continue to monitor and triangulate Datix Reports and Adult at Risk reports to identify themes and trends and/or omissions.

Assessment and Analysis

- There have been no further incidents of this nature recorded.
- For assurance, the identified key areas of learning have been implemented as they were included within the 2020 – 2021 safeguarding strategic priorities.
- Clinical Case supervision, reflective learning, enhanced training and intervention have supported the reduction of risk and harm.

Violence Against Women Domestic Abuse Sexual Violence (VAWDASV)
Case Study 2 - Learning from practice.

The Police responded to an attempted suicide. During contact with the police, they disclosed a history of physical abuse, sexual abuse and controlling/coercive behaviour. The assessment indicated a risk of; very high risk of harm or homicide, for many reasons the client returned to the perpetrator.

Case learning

There was a lack of opportunities to make safe contact with the client. Agencies collaborated to co-ordinate a safe meeting at a pre - arranged hospital appointment. The client was offered refuge and offered the protection of the police should she wish to pursue a police complaint, both options were declined. This opportunity enabled the Independent Domestic Violence Advocate (IDVA) to complete a safety plan with the client, including code names where she could ask for immediate assistance or arrange a safe exit plan.

After leaving the pre-arranged hospital visit and on the same day the client followed her safety plan and used the code name that suggested she needed to enact a safe exit plan.

The police, IDVA and health were able to coordinate another meeting to take place at the hospital and made a further covert appointment.

Assessment and Analysis

- Client now feels safe, and is residing in a refuge and is now starting her recovery journey.

- Client feedback, "I am so thankful for all the support. I saw no way out and believe my partner would have killed me or I would have taken my own life. I did not realise until that first hospital appointment that there was a way out for me, thank you so much".

- This case study demonstrates good communication, assessment of risk, and multi-agency working. The importance of early intervention and safety planning in the prevention of further harm to the victim are recognised themes from Domestic Homicide Reviews (DHRs). This case evidences best practice and a positive outcome.

- The North Wales Violence Against Women, Domestic Abuse and Sexual Violence Strategy 2018-2023 and the VAWDASV (Wales) Act 2015 provides an improved public sector response to VAWDASV providing a strategic focus and consistency of preventative, protective and supportive mechanisms in the delivery of services. BCUHB is actively engaged in the Strategy.

- This evidences the improvement and application of clinical safeguarding supervision, Domestic Abuse training and embedding guidance into clinical practice and the impact it has on the reduction of risk and harm.

Asesu a Dadansoddi / Assessment & Analysis

This report and supporting appendices underpins the Board's stratgic direction around delivery of service.

Opsiynau a ystyriwyd / Options considered
Not Applicable

Goblygiadau Ariannol / Financial Implications
Not Applicable

Dadansoddiad Risk / Risk Analysis
Not Applicable

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
The Safeguarding legislative requirements are set out in the Social Services and Well Being (Wales) Act 2014, and supporting safeguarding legislation and statutory guidance.

Asesiad Effaith / Impact Assessment
All Policies, Procedures, documentation and safeguarding activity that impacts upon patients, staff or the organisation are in line with a supporting EqIA. Consultation and engagement will take place with both internal and where appropriate external stakeholders.

Corporate Safeguarding
Annual Report
2020 - 2021

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Appendices

(i) BCUHB Corporate Safeguarding Team Safeguarding Adults Annual Report 2020 -2021

(ii) Safeguarding Children at Risk, Safeguarding Midwifery and Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Annual Report 2020-2021

(iii) BCUHB Corporate Safeguarding Team Deprivation of Liberty Safeguards Annual Report 2020 –2021

Foreword

This year has seen an unprecedented increase in both the complexity and intensity of Safeguarding activity across BCUHB.

The changes to the overall service delivery as a result of the COVID – 19 pandemic has seen a reduction in the face to face access to services by our service users.

Corporate Safeguarding have proactively responded to these challenges and implemented a variety of mechanisms and adapted our ways of working to ensure we have continued to deliver the safeguarding agenda and drive our organisations safeguarding objectives, to protect those who are at risk of harm or who are deemed to be vulnerable.

The ability to respond so quickly is because of the continued passion from the Corporate Safeguarding Team members and from the wider organisation. They have supported the implementation of enhanced safeguarding activities, enhanced supervision, revised training modules and the development of pathways to ensure we remain informed and a community that is eager to learn and adapt our practices due to change and build upon our knowledge.

I would like to take this opportunity to thank the independent service users who have engaged with and supported the Safeguarding Team. Their involvement and contribution has benefited the service and informed safeguarding practice and training programmes resulting in the implementation of real change to evidence service progress.

The safeguarding agenda is a multi-agency approach that requires true collaboration, engagement and mutual respect and we remain passionate in our partnership working and engagement with the North Wales Safeguarding Adults Board and North Wales Safeguarding Children Board and supporting forums to ensure we fulfil our statutory and legal requirements and remain high achievers in this field of work.

Michelle Denwood Associate Director of Safeguarding

Key Achievements and Progress for 2020-2021

1. Introduction

Safeguarding people at risk and their families forms part of everyone's core business.   Employees of BCUHB, commissioned services, providers and contractors must engage, support and as necessary escalate with the ultimate aim of promoting well-being, to reduce risk and ultimately harm.

The annual report 2020 -2021 provides an overview of progress made by the Corporate Safeguarding Team in relation to safeguarding adults, children and young people at risk, Violence Against Women, Domestic Abuse, and Sexual Violence (VAWDASV), Deprivation of Liberty Safeguards (DoLS), Dementia and the overarching safeguarding activities under the remit of the Harm agenda.

Deprivation of Liberty Safeguards reports directly to the Mental Health Act Committee and is integral to the patients' journey and clinical pathway.

The preceding 12 months have presented significant challenges for the Health Board, and this year has seen an unprecedented increase in both the complexity and intensity of Safeguarding activity across BCUHB. The changes to the overall service delivery as a result of the COVID – 19 pandemic has seen a reduction in the face to face access to services by our service users.

Corporate Safeguarding have proactively responded to these challenges and implemented a variety of mechanisms and adapted our ways of working to ensure we have continued to deliver the safeguarding agenda and drive our organisations safeguarding objectives to protect those who are at risk of harm or who are deemed to be vulnerable.

The improved compliance with safeguarding reporting and the identification of risk and harm has been strengthened by the implementation of the Social Services Wellbeing (Wales) Act 2014 and the Wales Safeguarding Procedures 2019, which was came into force in November 2020. The legislation not only strengthens the legal footprint of children's safeguarding, but for the first time in history in Wales' they place a legal duty to report adults at risk.

Learning from and implementing safeguarding legislation has a significant impact upon the health, and wellbeing of the service user and family. A Human Rights approach is at the forefront of our practice and engagement with service users and their families. Learning from incidents and practice enables us to reinforce best practice, gain assurance and deliver a service, which reduces risk and harm.

The three appendices that accompany this report identify in detail the significant activity and progress made by BCUHB to ensure progress in made, there is evidence of learning, and assurance with further actions to improve our safeguards highlighted. The report also sets out the strategic priorities of the Corporate Safeguarding Team for 2021-2022, demonstrating our commitment to continual improvement.

2. Quality, Assurance and Governance

We have implemented all of the Safeguarding Priorities for 2020-2021 with the progress and achievement monitored by the Safeguarding Governance and Performance Group and the Patient Safety and Quality Group, formerly known as Quality and Safety Group.

The Safeguarding Maturity Matrix (SMM) is a quality outcome monitoring tool with the aim of capturing and collating a national SMM providing assurance, shared practice and drive improvements towards a 'Once for Wales' consistent approach to safeguarding.

The SMM is a self-assessment of safeguarding arrangements by each Health Board/Trust. The five standards assessed are Governance and Rights Based Approach, Safe Care, ACE Informed, Learning Culture and Multi Agency Partnership Working. The highest achievable score is five (5) for each standard giving a total score of 25.

BCUHB achieved a score of 14 in 2018, a score of 23 in 2019 and a score of 25 in 2020. This demonstrates continued progress and by evidencing service quality improvements, full engagement in multi-agency arrangements in addition to demonstrating good examples of evidenced based learning.

BCUHB are able to inform the national picture by reporting through the NHS Safeguarding Network to the Chief Nursing Officer in Welsh Government.

In 2021-2022, an All Wales Task and Finish Group will review the Safeguarding Maturity Matrix to ensure it remains fit for purpose.

3. Adult at Risk

During the first COVID – 19 lockdown in March 2020, there was an initial decline in Adult at Risk Reporting. Adult Health and Social Care services recognised this was a national trend.

The Corporate Safeguarding Team identified the potential risk of hidden abuse, and reinforced the Adult at Risk and Safeguarding agenda during this period through enhanced communication and engagement with the workforce. Staff welcomed responsive supervision; in addition, both virtual and face to face bespoke training was safely undertaken. This training provided confidence to the staff and assurance to the Health Board that the knowledge and skills to safeguard were in place and embedded into practice.

3.1 Figure 1 - Number of Adult at Risk Reports (2020-2021) with the Welsh Government COVID-19 Lockdown periods highlighted.

Figure 1

BCUHB Adults at Risk Reports
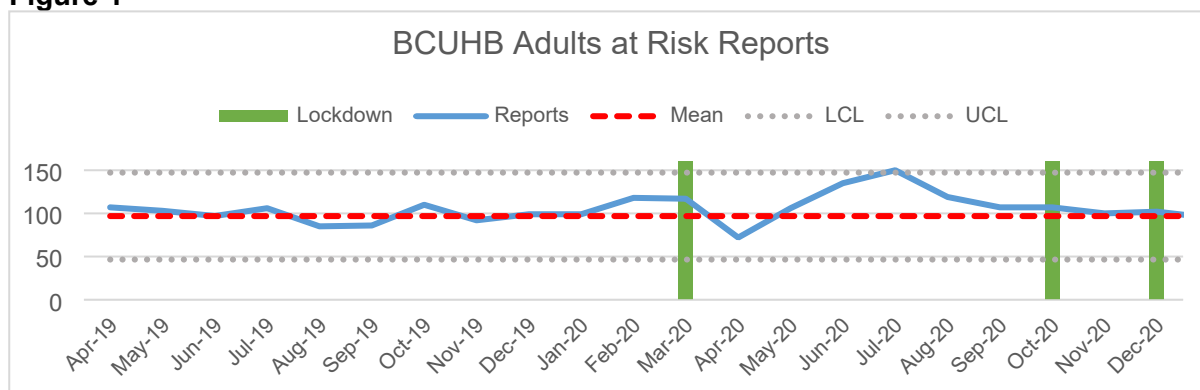
Figure 1 provides a timeline with the number of adult at risk reports by month from April 2019 to March 2021. The chart has lower and upper control limits with a median line to depict average limit. This enables the identification of a reduction of reporting at the onset of lockdown and the significant increase at the point of July 2020. A result of a relaxation in lockdown rules and increased face-to-face service delivery may have affected the data.

Assessment and Analysis

Other contributing factors may include the increase in safeguarding support, responsive supervision and training for staff enabling the improved identification of risk and harm.

3.2 Heddfan Safeguarding Improvement Plan

The acuity and provision of care of the MHLD Heddfan Unit changed during the COVID-19 Pandemic. The unit became the BCUHB Older Person's Mental Health Admissions unit. There was an increase in safeguarding reporting activity, which resulted in the increase of Adult at Risk Reports.

The Executive Director of Nursing and Midwifery commissioned a Safeguarding Peer Review, to attain assurance of patient safety and staff well-being.

Assessment and Analysis

- A Heddfan Unit Safeguarding Improvement Action Plan was developed and learning implemented, which considered three main areas of improvement, Training and Learning, Supervision and Support and Patient on Patient Physical Abuse.

- The Corporate Safeguarding Team identified a Single Point of Contact (SPoC) for the unit. The implementation of a designated SPoC has evidenced a reduction of safeguarding incidences, improved quality of reporting and the reduction of risk. This supports the proposed requirement of dedicated safeguarding specialist to enable the implementation of the Single Point of Contact on a permanent basis to dedicate time within the MHLD Division.

- A benchmarking exercise has commenced which will gain assurance of wider organisational learning against the themes from the Heddfan Safeguarding Improvement Plan.

- Local Authority, North Wales Safeguarding Board and Health Inspectorate Wales identified the Safeguarding Single Point of Contact as Best Practice.

- The improvement plan is monitored by the Safeguarding Forum MHLD Division and the Safeguarding Governance and Performance Group.

3.3 Deprivation of Liberty Safeguards (DoLS) and Liberty Protection Safeguards (LPS)

The reporting of the Deprivation of Liberty Safeguards agenda is directly to the Mental Health Act Committee.

This activity engages with the wider safeguarding agenda, due to both the vulnerability of the client group and the associated risks relating to harm and must be a consideration within the patient pathway.

In 2020-2021, the DoLS team received a total of; 1162 applications'. Since the implementation of the framework, this is the largest number of applications. Over the last four (4) years' DoLS applications have increased annually.

Audit activities have initiated a review of training packages with greater emphasis upon basic documentation and the assessment of capacity as these we key findings.

Table 1.

Year	West	Central	East	England	Other	Applications	
2018-19	89	257	343	55	0	743	
2019-20	177	282	483	72	0	1014	
2020-21	208	322	550	82	0	1162	

3.4 The Health and Social Care Advisory Service (HASCAS – Rec: 12) and the Donna Ockenden (Rec: 9)

The review acknowledged DoLS as a high-risk area and identified key recommendations. The HASCAS Implementation Group monitored implementation. In January 2021, the appointment of additional Best Interest Assessors (BIAs) was completed.

Assessment and Analysis

- A further and comprehensive review of the service has taken place due to the increase in clinical demand, lack of out of hours' service provision and new legislation, specifically the pending implementation of the Liberty Protection Safeguards (LPS) on 1st April 2022.

3.5 Liberty Protection Safeguards (LPS)

Work has commenced to prepare the organisation and key stakeholders of the intended challenges, it is proposed BCUHB will have in excess of 3000 applications under LPS, this is an additional 1800 applications based upon the current data.

Assessment and Analysis

- A priority action identified for 2021-22 is to create a Task and Finish Group to support the implementation of the LPS framework across the health board. Work has commenced and Terms of Reference drafted.

- DoLS and the mitigation of risk is monitored by the Safeguarding Risk Register, the Safeguarding Business Case supports and identified resource requirements to mitigate risk and implement Liberty Protection Safeguards (LPS).

4. Children at Risk

Child at Risk Reporting

4.1 Figure 2 - Number of Child at Risk Reports (May 2019 – March 2021)) with the Welsh Government COVID-19 lockdown periods highlighted.

Figure 2

BCUHB Child at Risk Reports
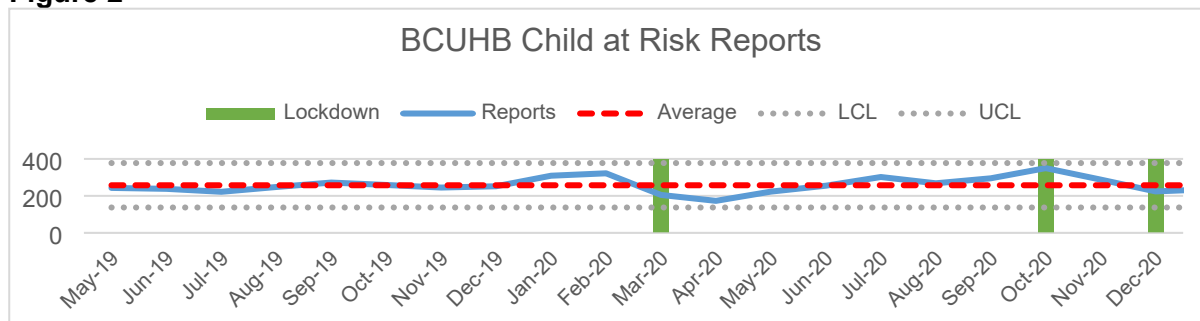
Following the first COVID – 19 lockdown on the 23rd of March 2020, there has been a reduction in the number of child at risk reports from within the West and Central Area. The East area has seen an overall increase in child at risk reports. The decrease in child at risk reports were attributed to a reduction in the number of children accessing the Emergency Departments, a reduction of face-to-face working arrangements and the closure of schools, nurseries and other social facilities.

The highest reports to children's safeguarding in 2020-21 were from Emergency Department (ED) at 29%, the Midwives at 17%, from Health Visitors at 16% and CAMHS at 8%. In comparison to last year, ED saw a reduction of reporting, which was from 35%, Midwives, Health Visitors and CAMHS remained much the same.

It is reassuring to report that Health Visitors and CAMHS reporting figures remained the same as the previous year despite a reduction in face-to-face working during the lockdown periods. The local findings follow the national picture, with many agencies voicing the impact of COVID-19 and social distancing measures as a rationale. The activity also highlights the potential risks for children and young people during the lockdown periods, which reduces the number of available contacts with other people and key services.

Outcome of Child at Risk Reports

886 Child at Risk 'outcomes' from the Local Authority Children's Services have been received in 2020-21.

282 (32%) Child at Risk 'outcomes' were assessed under the following categories: child already open to Children's Services, advice/assistance was given, referred to other agencies, allocated for an 'at risk' investigation or referred for a Care and Support assessment. A retrospective audit reviewed the quality of child at risk reports received from the Western, Central and Eastern areas.

Assessment and Analysis

- A review of a random selection of 30 reports from 173 reports in April 2020. Twelve were classed as good, 10 satisfactory and 8 (eight) of a poor quality.

This is an improved position and evidences individual feedback and training supports learning and improved practice.

Failure to complete all the relevant sections on a child at risk report could fail to further safeguard children and young people and BCUHB staff will fail in their statutory duty to report under the Wales Safeguarding Procedures 2019. In 2021 – 2022, a larger scale audit of child at risk report will take place.

4.2 Deprivation of Liberty (DoL) 16/17 year old

In 2019, case law to supported 16 and 17 year olds who lack capacity to consent to their hospital accommodation, care and treatment came into force.

Assessment and Analysis

- This new legislation has had an impact upon the number of cases reported to the Court of Protection (CoP), resulting in increased legal costs and the potential for the unlawful detention of a young person.

- A workshop event enabled 68 staff to discuss complex cases relating to young people and their capacity to refuse. This enabled staff to embed the new case law into clinical practice by discussing real life cases.

- The importance of the informed practitioner and the development of training packages to support learning significantly reduces harm and unlawful detention.

- It is evident this case law has had an impact upon care and treatment of young people, especially those who refuse treatment or abscond from acute settings.

4.3 Routine Enquiry Domestic Abuse (REDA) during Pregnancy

This audit was the result of recommendations from a number of Domestic Homicide Reviews. The methodology for this audit was a retrospective case note audit. The bar chart demonstrates the findings and comparison against each of the 3 area teams across BCUHB.

Table 2

Routine Enquiry Audit Findings 2020-21
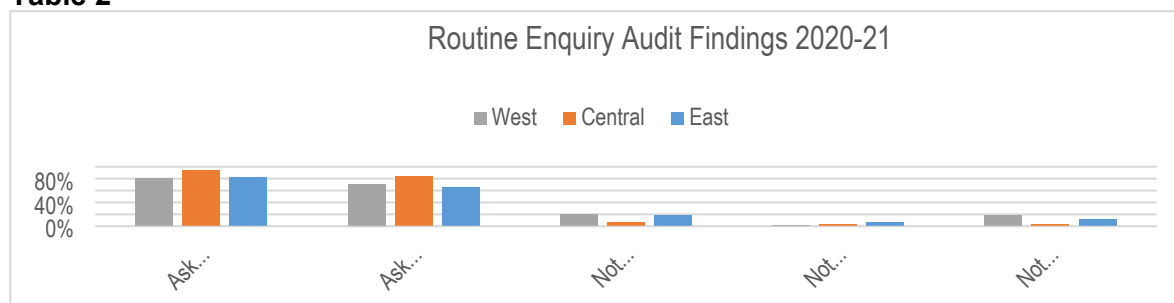
Assessment and Analysis

- The proportion of women being asked the routine enquiry questions at least once at their antenatal appointment has shown improvement; 70% in Q1 (2019-2020) and 89% in Q4 (2020-2021)

- The proportion of women being asked twice or more is also improving; 41% in Q1 (2019-2020) and 80% in Q4 (2020-2021), which is the highest it has been to date.

- In Q1 (2019-2020) 30% of women had not been asked about REDA but this compliance has significantly improved to 11% in Q4 (2020=2021) with 1% mitigation (accompanied) given with 10% no reason given.

The overall improvements could be attributed to the intensive support given by Corporate Safeguarding but could be also be a result of the restrictions in visiting/accompanied within the Women's Division during the COVID-19 pandemic, which has allowed midwives an increased opportunity to see women alone.

Completing REDA gives women an opportunity to disclose domestic abuse and referral to specialist services for support. The risks of not asking reduces this opportunity and potentially increases the risk of further abuse, harm and death.

4.4 Routine Enquiry Domestic Abuse (REDA) Primary Care Services and Emergency Department

Corporate Safeguarding have engaged with both Primary Care Services and Emergency Departments across all localities to support the promotion of the REDA. The REDA is an assessment tool to identify those who are at risk of violence or domestic abuse.

Assessment and Analysis

- Domestic Abuse enquiries are recorded within the 'symphony' IT system and is available at all three DGH sites as well as some locality minor injury units with others due to go online during the first and second quarter of 2021-22.

- The ability to electronically record Domestic Abuse enquiries allows for the identification of risk and supports the assessment process.

4.5 Multi Agency Risk Assessment Conferences (MARAC) for Domestic Abuse Victims

There have been 177 MARAC referrals from health, in 2020-2021.

Assessment and Analysis

- This is an overall reduction from the previous year. Measures are in place to strengthen the Routine Enquiry Domestic Abuse (REDA) and identify opportunities to enquire in high risk areas.

- The overall reduction is of concern, as reported by the National picture and supported by the findings of a number of recent Domestic Homicide Reviews (DHRs) evidenced an increase in abuse and harm but early identification through enquiry did not take place. The Routine Enquiry Domestic Abuse Audit 2021-2022 will support this activity.

4.6 Safeguarding Children Clinical Supervision

Individual safeguarding supervision has continued virtually with an average compliance of 80.5-92% across all Health Visitors and School Nurses during the pandemic.
Due to the redeployed of staff to other service areas and due to those who were shielding due to COVID-19 100% compliance was not achieved in 2020-2021.

Assessment and Analysis

- A regional evaluation audit of safeguarding group supervision took place. Health Visitors, Looked After Children's (LAC) nurses, School Nurses and Midwives, received 332 questionnaires, with a return rate of 63 (21.2%).

- Audit findings included; staff said they had the opportunity for reflection, opportunity to share good practice, aided communication, gained insight into other services from guest speakers and an opportunity to discuss cases.

This feedback clearly reiterates the importance and impact supervision has upon BCUHB employee's wellbeing and the opportunity for learning to reduce risk and harm.

5. Safeguarding Midwifery

Health Pre-Birth Assessment Audit (HPBA) 2020-21

Health Pre – Birth Assessment support the identification of potential risks and inform our Local Authority colleagues to complete the assessment and inquiry process. Child Practice Reviews identified omissions in this practice, which has required targeted safeguarding intervention.

Assessment and Analysis

The audit found;
- Targeted compliance was reported, 85% of HPBA's were completed between 12-30 weeks of pregnancy.

- Written consent for completion and information sharing has improved significantly in 2020-21 to 93% compared to 41% in Q1 2019-20.

- Recorded improvements evidencing the three Local Authorities had received the HPBA to support the identification of risk. All three areas still require further improvements and activities remain in place.

6. Learning from National Reviews

Learning from National Reviews Cardiff and Vale Safeguarding Board published an extended CPR in 2016. The review recommended that Emergency Departments (ED's) must hold weekly safeguarding meetings, to consider head injuries and burns in children aged under one and fractures in children aged under two years.

From the 1st January to 31st December 2020, an audit of 371 clinical case notes took place to gain assurance relating to the outcomes for Children. The Key findings are:

- 270 (73%) of the cases were children presenting with head injury
- 68 (18%) of the cases were children presenting following a fracture
- 33 (9%) of the cases were children presenting with a burn

Assessment and Analysis

- Between July and December 2020 27% (n=48) of the cases had no documented evidence that safeguarding was considered. Between January and June 2020 this had improved by 41% (n=78) of the notes audited.

- The improved identification of safeguarding concerns, improved documentation and the opportunity for peer review and case discussion has evidenced learning and supported the reduction of risk of harm to children, and reduced the omissions in safeguarding clinical practice.

7. Child Practice Review (CPR), Adult Practice review (APR) and Domestic Homicide Review (DHR)

There is currently 1 CPR awaiting publication, the Child Practice Review Sub Group – Flintshire, Conwy and Wrexham, has commissioned 3 new cases. The incidents include two (2) child hangings and death of a baby by drowning.

Key themes from recent CPR's include disguised compliance and the lack of professional curiosity from all professionals, coping with crying, parental substance misuse and its impact on parenting capacity and documentation.

Key themes from five (5) Adult Practice Reviews identified common themes, which highlighted Communication, reduced training compliance in key areas and poor quality of documentation being the highest three.

There are currently four (4) ongoing DHR's across North Wales with a further three (3) new cases. Key themes from recent DHR's are the lack of routine enquiry domestic abuse (REDA) being carried out by BCUHB staff in high-risk areas, such as Emergency Departments. This lack of opportunity for a victim to disclose abuse increases the potential risk of continued abuse and/or death.

Assessment and Analysis

- Key themes are actioned by improvement and learning priorities, implemented by a variety of communication and engagement methods. These include seven minute briefings, case learning, quiz activities and by the Safeguarding monthly Bulletin.

8. Safeguarding Practice Development, Learning and Training

Safeguarding training has adapted a blended delivery methodology during this 12-month period to ensure BCUHB employees have the skills, knowledge and competencies to safeguard adults and children at risk. Safeguarding training compliance has increased to an overall average percentage of 78% (Q4) compared to previously 76.1% in Q1 & Q2. Some departments exceed the 85% BCUHB mandatory compliance rate.

Assessment and Analysis

- A review of all BCUHB Safeguarding Policies, Procedures and Guidance has taken place, which ensures BCUHB is fully compliant with the revised legislation and Wales Safeguarding Procedures 2019.

- Feedback and evaluation of the training and learning activities have provided assurance of the training methods used and the improvements in the application of the learning.

- There are currently over one hundred (100) trained safeguarding ambassadors across BCUHB. They support engagement and the implementation of the safeguarding agenda within their service area. This provides additional assurance and continues to embed best practice and learning in both clinical and non-clinical areas.

- Joint working with the Ward Accreditation Programme has enabled the Safeguarding Activity Report to provide a robust evidence based approach. This enables consistency, appropriate challenge and the identification of both commendable practice and improvements across the organisation. This triangulation of information is to provide early alert, continued education and embed best practice.

9. Trauma Risk Management TRiM

Following the introduction of TRiM in May 2020 to March 2021 there have been 28 incidents that meet the TRiM criteria. Eighty Seven (87) BCUHB employees who have witnesses a traumatic event have attended a Trauma Incident Briefing (TIB) with a further 13 staff requiring an individual TRiM assessment.

Assessment and Analysis

- A quantitative and qualitative evaluation has taken place. Findings included 80% attending a TIB found it beneficial, 60% attending a further assessment found it beneficial and 100% would recommend the service to a colleague.

- Examples of qualitative findings included: "*comforting to know that I wasn't grieving on my own, would have gone off sick without the support, given opportunity to access other support services, good explanation of feelings discussed'.*

- Eight (8) further Corporate Safeguarding Team members have completed the TRiM Practitioner training in May 2021 providing additional resource.

- The Corporate Safeguarding Team have sixteen trained practitioners who have successfully responded to traumatic incidents experienced by BCUHB staff. Early identification of staff exposed to trauma aids to promote a healthy workforce by supporting the welfare needs of staff.

10. Conclusion

The level of activity to both progress and evidence improvements including the review of current practices in light of COVID -19 are evidenced within this report and supporting appendices.

We have fully implemented the priority actions for 2020-2021 with periods of review to ensure they remain embedded within the organisation.
From the data and audit findings, we continue to see progress and areas that we have evidenced the need for support, we have the ability to mobilise safeguarding team members to mitigate risk and to provide enhanced support. The Safeguarding Single Point of Contact (SPOC) clearly evidenced enhanced engagement and we identified a significant improvement in quality reporting and the identification of harm.

The Safeguarding Business Case is a key priority for 2021-2022 due to the recognised National challenges regarding the current and future safeguarding activity, which is a result of new and revised legislation.

The reporting of the new Liberty Protection Safeguards (LPS) as a result of the Mental Capacity (Amendment) Act 2019 has National recognition of the challenges organisations face to support this implementation. The development of the BCUHB LPS Implementation Task and Finish Group will report to the Mental Health Act Committee and other BCUHB Quality and Governance Forums, this activity will be supported by the Safeguarding Governance and Performance Group. It is envisaged this will be a substantial piece of work.

Clear leadership and a real emphasis on priorities for 2021-2022 will ensure that the improved trajectory within BCUHB continues and continues to be embedded in clinical practice. The impact of the COVID -19 pandemic not only on the physical health of our population but the impact upon societies' mental health and wellbeing are coming to the forefront. The priorities of the team are driven by activity and data and we will remain responsive and proactive throughout 2021-2022.

Corporate Safeguarding Risk Register June 2021

	Risk Description	Mitigation	Initial Score	Current Score
1	**There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014.** There is a risk that the Health Board does not discharge its statutory and moral duties in respect of Safeguarding with regards to Safeguarding Adults / Children / Violence Against Women, Domestic Abuse, Sexual Violence [VAWDASV] including the wider harm agenda and Deprivation of Liberty Safeguards [DoLS] recognising the activities of the Managing Authority and Supervisory Body. This may be caused by a failure to engage and implement appropriate safeguarding arrangements, develop an engaged and educated workforce and provide sufficient resource to manage the demand and complexity of the portfolio. This could have an impact upon those persons at risk of harm to whom BCUHB has a duty of care with particular reference to the added challenges of reduced face-to-face contact due to COVID 19. The impact of redeployment of the workforce and those within key departments may result in the reduction of engagement with vulnerable people and therefore the identification of those at risk of harm.	1. Safeguarding People at Risk of Harm Reporting Data and the position during COVID 19 and Action Log was an agenda item at QSG on 07.05.20. The Action Log is a live document and is a standing agenda item on the Safeguarding Governance and Performance (SGPG) meetings. 2. A standardised data report which includes escalated activity with standardised reporting against; Adult at Risk, Child at Risk and DoLS is a standing agenda item at the Safeguarding Forums in for data to be scrutinised and risks identified. 3. Risk Management was embedded into the processes of the Reporting Framework and is included as a standard item on the Safeguarding Governance and Performance Group and Safeguarding Forums Agendas. Triple A reports require risks to be identified and reported on record mitigating action. 4. Bespoke training continues to be delivered to key high priority areas, compliance is monitored by Safeguarding Forums in line with the Safeguarding Governance Reporting Framework. 5. Training to implement new legislation relating to 16/17 yr olds who may be / or experience a deprivation of their liberty as a result of a Supreme Court Judgement [26.9.19] continues to be delivered and compliance monitored. 6. The development and implementation of the Safeguarding COVID Action Plan is monitored by the Safeguarding Governance and performance Group.	20	16

	In addition the Single Unified Safeguarding Review (SUSR) which is reviewing and amending the National Procedures relating to APR/CPR/DHR and will result in greater involvement and accountability for the Corporate Safeguarding Team. The Safeguarding Boards will hold accountability for Domestic Homicide Reviews instead of CSP's. The Named Doctor Children at Risk (Safeguarding Children) retired 1st May 2021 there is currently no substantive replacement. There is no appointed Named Doctor for Adults at Risk The risk rating has been determined as 4 x 4 and described as:- (likely) Will probably happen/recur, but it is not a persisting issue	7. All mandatory training has been amended to ensure compliance with the SSW [Wales] Act 2014 and National Safeguarding Procedures 2019, which came into force in November 2020. 8. Mandatory training continues to be delivered using a variety of IT platforms. 9. Statutory multi-agency meetings and safeguarding forums / groups in line with the Safeguarding Reporting Framework and statutory legislation / guidance have continued to take place and have full engagement from all relevant parties. 10. The recruitment process is ongoing and internal processes ensure cover arrangements are in place to support the vacant posts. 11. To support the increased organisational activity due the pandemic, the Safeguarding Performance and Scrutiny Task Group has been temporarily disbanded in January 2021 and all activities have been redirected to the Safeguarding Forums to ensure all performance / APR, CPR, DHR activates remain under scrutiny. 12. Escalation and reporting to QSE (January 2021) and to PSQG as a standing item post the Safeguarding Governance and Performance Group is in place. This also includes escalation as required and escalation as a result of North Wales Safeguarding Board activities. 13. The Children's Division BCUHB are managing the recruitment process for the replacement of the Named Doctor.		
2	**There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.** This may be caused by the new Case Law of Cheshire West, which widens the parameters of activity resulting in more patients requiring	1. Internal audit has identified key areas in which enhanced training is required to improve compliance with legislation to reduce unlawful detainment. 2. Safeguarding Forums monitor and escalate non-compliance against key requirements identified within the legislation. Audit activities are co-	16	20

assessment for deprivation of liberty. This could lead to and result in an increased risk of unlawful detention resulting in harm to patients and unlawful actions taken as a result by the Health Board. BCUHB is at risk of unlawfully depriving young people (16/17 year olds) of their liberty. Due to: The Supreme High Court Judgement in September 2019 which removes the consent of parents when detaining a young person for care and treatment within NHS settings. This will lead to young people requiring formal assessment and an increase in legal costs and activity through the Court of Protection. New legislation and guidance, which updates and amends the current requirements of Deprivation of Liberty Safeguards (DoLS), will come into force during 2021/22 it will be known as Liberty Protection Safeguards (LPS). There is a risk that this will lead to approximately an additional 1700 assessments per year, which could lead to a greater delay in the assessment due to the current capacity and expertise within the Team. There is a risk due to the complexity, continual changes to procedure due to case law and the amendments to the MCA and future MHA that will require full implementation at an Organisational level which will have an impact upon multiple services. There is an increase in Court of Protection Activity (COP) which has resulted in greater operational pressures and an increase in financial cost.	ordinated by the safeguarding forums and are monitored by Corporate Safeguarding who hold the legal role of Supervisory Body. 3. An Authorisers (signatories) training package remains in place. The development of a Governance Framework ensures authorisers undertake this role within a period of review. 4. A pilot of the new DoLS Mental Capacity Assessment Tool has been implemented to improve the quality of applications received; this reduces court challenge and unlawful detainment. 5. The revised DoLS Procedure (SOP) was ratified at QSG on the 12.6.20. This provides a clear process and guidance, reduces legal challenge [21a], delay in process resulting in unlawful detainment. This was a recommendation from the internal audit of the service. 6. A position paper and proposed revised Safeguarding structure and DoLS structure in line with HASCAS / DO recommendations, 8, 6, 11 was presented to QSG on the 10th of January 2020. Due to the amendments to the new legislation [LPS] and the delay of the Code of Practice, a further review of the current structure has resulted in an updated business case. 7. An updated structures paper was presented to the Seniors Group meeting highlighting the increased activity, organisational challenges and mitigation. The revised business case is to be presented to the Executive Team in Q1/2 2021. 8. Key controls have been implemented by increasing the number of DoLS Authorisers (Signatories), development of a Governance Framework and the delivery of Specialist training. 9. Formal reporting and escalation of activity, mandatory compliance and exception reports are shared with the Mental Health Act Committee,	

| | There is a risk that the organisation will not have sufficient expertise within the safeguarding team to implement the revised legislation for DoLS which will be known as LPS, resulting in unlawful detainment of patients and negative media interest.

The risk scoring was determined by 4 x 5:- (almost certain) Will undoubtedly happen/ recur, possibly frequently | Patient Safety Quality Group and Safeguarding Forums identified within the Safeguarding Governance and Reporting Framework.

10. DoLS COVID 19 Interim Guidance and supporting Flow Chart was ratified at QSG on the 7.5.20. This supports interim arrangements during reduced face to face contact but ensures this activity takes place.

11. BCUHB training has commenced, for key departments for 16/17yr old DoL cases. Additional finance was secured to support COP activity, this will require ongoing monitoring.

12. DoLS training has been reviewed and updated and is delivered using IT and learning tools to enable training to take place due to COViD 19 Restrictions

13. A DoLS position paper was an agenda item on the Mental Health Act Committee on the 20th October 2020 and December 2020.

14. To support the preparation and implementation of LPS Corporate Safeguarding remain fully engaged with the National Task Group who are engaged with Welsh Government in the development of the revised legislation and Code of Practice.

15. Due to the vacant DoLS Manager position and lack of senior positions and expertise within the current structure, the Head of Safeguarding Adults and operational support has been utilised from within the wider Corporate Safeguarding Team.

16. This risk is linked to Risk ID 3766 and Risk ID 2545. | | |
| Both risks are 'being developed' with recommendation for escalation to Tier 1, which is reflected in the current scoring.

Risk Management Division will agenda the escalation at the Quality, Safety and Experience meeting July 2021 | | | | |

SAFEGUARDING GOVERNANCE & PERFORMANCE REPORTING FRAMEWORK

BCUHB Links:

- Primary Care Clusters
- Quality and Safety Forums – Leadership Meetings
- HMP Berwyn
- Suicide/Self Harm Forum
- Capacity & Consent Group

BCUHB Reporting:

- AAA Report to PSQG
- Direct reporting to the Board for:-
  - Annual Report / Update
  - Immediate access for 'Significant Events'
- Independent Member Children /Adults & Safeguarding Ambassadors
- Mental Health Act Committee

BOARD
Chair: Chairman

Quality, Safety & Experience Committee (QSE)
Chair: Independent Member

Patient Safety Quality Group (PSQG)
Chair: Executive Director of Nursing

Strategic Safeguarding Governance & Performance Group
Chair: Associate Director of Safeguarding
Vice Chair: Named Doctor for Safeguarding Children

Escalation as necessary to Executive Director of Nursing & Midwifery to Executive Team & Board

Reporting Arrangements to and from Statutory Forums:

Multi Agency

- North Wales Safeguarding Adult Board
- North Wales Safeguarding Children Board
- Community Safety Partnership
- Strategic MAPPA Board
- SARC
- National Safeguarding Network

Multi Agency:

- Safeguarding Children Delivery Board (East/Central/West)
- Safeguarding Adults Delivery Board (East/Central/West)

MHLD Safeguarding Forum
Chair:
AD Nursing MHLD / Safeguarding

Secondary Care & Area Forums

Safeguarding Forum: EASTERN
Chair: DIRECTOR Area/Secondary Care Safeguarding Leads:

Secondary Care & Area Forums

Safeguarding Forum: CENTRAL
Chair: DIRECTOR Area/Secondary Care Safeguarding Leads:

Secondary Care & Area Forums

Safeguarding Forum: WESTERN
Chair: DIRECTOR Area/Secondary Care Safeguarding

BCUHB Safeguarding Training Task Group
Chair: Safeguarding Practice Development

BCUHB Performance and Scrutiny Task Group
Chair: Safeguarding
(Temporarily Suspended)

BCUHB Safeguarding Policy & Procedure Task Group
Chair: Safeguarding

Multi Agency Safeguarding Sub Groups & Forums

Corporate Safeguarding Action Plan 2020-2021

Actions Log

Red	Incomplete
Amber	Partially complete
Green	Complete

	Action	By Who:	By When:	Updated Position	RAG Status
Safeguarding Adults					
1	Successful recruitment of all vacant posts within Corporate Safeguarding and consideration of the Service Review.	Heads of Safeguarding	December 2021	Business Case will be complete when the financial information has been completed. Four vacancies remain in recruitment process	AMBER
2	Review Adult Safeguarding Database to inform quality data of the Performance and Governance activity across BCUHB.	Head of Safeguarding Adults Head of Safeguarding Adults MHLD	March 2022	First meeting has taken place. Draft version with changes will be shared at the Senior Leads meeting on the 30.6.21 for approval.	AMBER
3	On recruitment of the Regional Safeguarding Adult/ Dementia Lead, commence mapping and scoping of patients within acute and community services	Head of Safeguarding Adults	December 2021	Successful appointment within initial discussions of work plan taken place	AMBER
4	To support the Sexual Safety Group with training and evaluation of the co-produced MHLD guidance for patients and staff	Head of Safeguarding Adults MHLD	March 2022	Caniad remain the lead on this meeting. Following further consultation it was agreed that an updated draft will be produced Plan for training dates remains outstanding	AMBER
5	Provide Safeguarding contribution to the development of the Quality Assurance Framework for both residential and nursing homes. Corporate Safeguarding to continue attendance to the CHC local operational meetings.	Head of Safeguarding Adults	June 2021	Corporate Safeguarding fully engaged in supporting and contributing to this development. Workshop has taken place with work streams identified some to include Safeguarding support.	AMBER

6	Consultation with MHLD Services to fund additional 3 x Band 7 Safeguarding Specialists for MHLD across the Region	Associate Director of Safeguarding	October 2021	Associate Director of Safeguarding in discussion with Director of Nursing MHLD. Discussed at a previous SGPG	AMBER
7	Review of Phase 1 of Adult at Risk and Safeguarding Documentation audit tool	Head of Safeguarding Adults	June 2021	To ensure the quality of AAR and identify areas that may require additional support revision of audit tool is undertaken. Terms of Reference completed. Meetings taken place with revised edition being presented for approval at Senior Leads meeting 30.6.21	AMBER
8	Robust quarterly audit sampling of Safeguarding Documentation across Acute and Community Services	Head of Safeguarding Adults	Quarterly	Agreed plan in place. Q1 audit is on track to commence in July	AMBER
9	Implement recommendations from Adult & Child Practice Reviews and Domestic Homicide Reviews and embed in safeguarding training	Corporate Safeguarding Team	October 2021	Learning from Reviews is embedded and regularly reviewed and reflected in the safeguarding training. Bespoke procedural guidance is to be developed to standardise activities within identified KPIs It is a standing agenda on the BCUHB Safeguarding Training Task Group	AMBER
10	Monitor Emergency Staff medical staff safeguarding compliance across the organisation to obtain the KPI of 85%.	Area Safeguarding Managers	Quarterly	Training compliance data is provided on a quarterly basis from Data Analyst. Safeguarding Managers share areas of concern with relevant Operational Managers / Heads of Services presenting the information as a risk at Safeguarding Forums. This is also escalated to the Safeguarding Governance and Performance Group	AMBER

11	Monitor BCUHB Managed GP practices safeguarding compliance across the organisation to obtain the KPI of 85% and engage with Clinical Director of Primary Care.	Area Safeguarding Managers	Quarterly	Training compliance data is provided on a quarterly basis by the Data Analyst. Safeguarding Managers share areas of concern with Heads of Clinical Primary Care Governance. Key areas of concern are presented during risk discussions at Safeguarding Forums. This is also escalated to the Safeguarding Governance and Performance Group	AMBER
12	Monitor ward safeguarding training compliance, which is below 70% in 3 or more safeguarding modules and Divisions to provide position statement at SGPG.	Area Safeguarding Managers	Quarterly	Training compliance data is provided on a quarterly basis from Data Analyst. Safeguarding Managers share areas of concern with relevant Operational Managers / Heads of Services presenting the information as a risk at Safeguarding Forums. This is also escalated to the Safeguarding Governance and Performance Group	AMBER
13	Monitor BCUHB Estates & Facilities Safeguarding Training compliance to obtain KPI of 85%.	Area Safeguarding Managers	Quarterly	Additional Safeguarding input to continue in order to support this service area. There is evidence of regular improvement in compliance.	AMBER
14	Corporate Safeguarding to implement an internal process for the approval, review and internal evaluation of all safeguarding programmes.	Corporate Safeguarding Team	September 2021	Discussions commenced with the Practice Development Lead	AMBER
15	Evaluate the effectiveness of Safeguarding Bulletins in promoting safeguarding skills, knowledge and competence.	Safeguarding Practice Development Lead	September 2021	Safeguarding Practice Development lead has commenced plans to utilise Teams to undertake survey for evaluating the Bulletin but also training.	AMBER
16	Corporate Safeguarding to continue to contribute and support as, Chairs, Reviewers and Panel Members as required.	Corporate Safeguarding Team	March 2022	Corporate Safeguarding Team staff continue to be panel members, reviewers and chairs to APR/CPR and DHRs. This also extends further to internal BCUHB reviews.	AMBER

17	Corporate Safeguarding to continue to support and mentor BCUHB staff who are Reviewers and Panel Members to include sharing key themes from the reviews and producing 7 minute briefings to share for learning across BCUHB Safeguarding Forums and Governance meetings alike.	Corporate Safeguarding Team	March 2022	Process is in place and currently being formalised to a Standard Operating Procedure (internally) to ensure this action is undertaken for each review. This SOP is presented for initial approval on 30.6.21 Senior Leads meeting.	AMBER
18	Undertake Desktop Reviews as required in line with the Safeguarding Escalation SOP. Learning from internal reviews to be shared at Safeguarding Forums both Area and MHLD	Head of Safeguarding Adults

Head of Safeguarding Adults MHLD

Safeguarding Managers | March 2022 | Reviews and escalation process continue to be undertaken in areas of concern. Learning is shared across the Health Board and presented in Safeguarding Forums | AMBER |
| 19 | Benchmark recommendations from National/Regional Adult Safeguarding Reviews and investigations. | Head of Safeguarding Adults

Head of Safeguarding Adults MHLD | March 2022 | University of Cardiff have undertaken a Thematic Review of Adult Practice Review shared June 2021. Plan in place for both Heads of Safeguarding Adults / Adult MHLD to cross-reference to the learning reviews recommendations in North Wales. | AMBER |
| 20 | Corporate Safeguarding to review work plan of Adult Safeguarding Group and Individual Supervision for 2021-2022 | Head of Safeguarding Adults

Safeguarding Managers | June 2021 | Discussion of plan will take place on the 30.6.21 at senior leads meeting. | AMBER |
21	Corporate Safeguarding to promote and provide further training to recruit up by 25% further Safeguarding Ambassadors for BCUHB	Safeguarding Managers	October 2021	Training dates to be distributed via Safeguarding Bulletin, ABH and additional flyers.	AMBER
Safeguarding Children					
22	Implement the initial findings from the retrospective audit of child at risk reports 2020-2021	Head of Safeguarding Children/Safeguarding Specialists	December 2021	Rationale and update position to mitigate any identified learning or risk.	AMBER
23	Conduct a larger scale regional retrospective audit of the quality of Child at Risk Reports	Head of Safeguarding Children/Safeguarding Specialists	March 2022	Quarterly audits in place to allow immediate learning to be implemented.	AMBER

				Annual audit will ascertain progress throughout 2021-22.	
24	Develop a Task and Finish Group to implement the findings of the Regional Audit of Safeguarding Children Supervision	Area Safeguarding Managers/Safeguarding Specialists	June 2021	Review the delivery of current supervision sessions as restrictions are lifted following the COVID-19 lockdowns. The content and structure of the sessions will also be reviewed with a responsibility on staff to present cases to the group. This will enhance engagement and participation.	AMBER
25	To develop a Strategic Implementation Group with supporting working groups, to drive the agenda forward for the Children (Abolition of Defence of Reasonable Punishment (Wales) (Act) 2020, ensuring BCUHB will be compliant with their statutory duties	Head of Safeguarding Children/Safeguarding Specialists	February 2022	The legislation gained Royal Assent and became an Act on the 20th March 2020. The Act is to be implemented on the 21st March 2022. This Act removes the defence of reasonable punishment if cases reach court. The Head of Safeguarding Children attends the National Operation, Guidance and Training Group, looking at reviewing processes and updating guidance/training within the organisation.	AMBER
26	Women's Division to lead, with support/engagement from the Safeguarding Midwifery Lead, on an audit of compliance with the Coping with Crying Guidance	Head of Midwifery/Safeguarding Midwifery Lead	December 2021	The timescale was a recommendation from a CPR and is monitored by the NW Safeguarding Children's Board. Meeting planned with Women's Division for 02.07.21 to review guideline and set up task and finish group. Audit to commence in October 2021.	AMBER
27	To review the safeguarding supervision database, monitor and demonstrate an improvement in safeguarding supervision compliance for midwives	Safeguarding Midwifery Lead	March 2022	The timescale was a recommendation from a CPR and is monitored by the NW Safeguarding Children's Board.	AMBER

					Meeting planned with the Women's Division for 02.07.21 to review guidelines and set up a task and finish group. Audit to commence in October 2021.	AMBER
28	To review the safeguarding midwifery service with full staff engagement	Head of Safeguarding Children/Safeguarding Midwifery Lead	March 2022	Safeguarding Midwifery lead met with the Director of Midwifery and Women's Services to discuss the model of supervision and proposal of revised model	AMBER
29	To undertake the Routine Enquiry Domestic Abuse Audit During Pregnancy for 2021-2022 to provide continued assurance of improvement and compliance	Safeguarding Midwifery Lead	March 2022	Head of Safeguarding Children/Safeguarding Midwifery Lead to meet to begin this process.	AMBER
VAWDASV					
30	Corporate Safeguarding to continue with their support to the implementation of the IRIS Pilot	Head of Safeguarding Children	March 2022	Meetings remain to take place whilst awaiting outcome detail of funding.	AMBER
DoLS/MCA/LPS					
31	Corporate Safeguarding to create a BCUHB LPS Implementation Group.	Heads of Safeguarding Adults DoLS/MCA/LPS Manager	April 2022	To include strategic and operational membership to ensure the full implementation of the new Mental Capacity (Amendment) Act (2019) and Code of Practice relating to the Liberty Protection Safeguards.	AMBER
32	Refreshed dissemination to promote the Training MCA/DoLS booklets during 2021-2022.	DoLS/MCA/LPS Manager	April 2022	Increase in DoLS/MCA and LPS awareness across BUCHB services where access to IT systems is limited to allow all staff access to the legal framework under MCA.	AMBER
33	Confirm and engage with the BCUHB Mental Capacity Act Lead.	Heads of Safeguarding Adults	April 2022	Recruitment into the vacant DoLS/MCA/LPS Manager role. Business plan agreed and submitted to support the required increase in demand faced by BCUHB in relation to LPS and to ensure a robust operating framework and governance process is in place.	AMBER

34	LPS Paper update reports are to be presented to the MHA Committee as required	Heads of Safeguarding Adults DoLS/MCA/LPS Manager	April 2022	Agreed reporting framework on the LPS implementation updates to provide assurance and highlight BCUHB engagement across all services.	AMBER
Corporate Safeguarding Team					
35	Full engagement in the development and implementation and monitoring of both CAMHS and MHLD Maturity Matrix	Corporate Safeguarding Team	MHLD/Children's	The Corporate Team are in attendance at key forums to progress the identified programmes of work. Reporting and progress is to be shared with the Safeguarding Governance and Performance Group	AMBER
36	Engagement and organisational oversight relating to:- a) Falls b) Pressure Ulcers c) Dementia	Corporate Safeguarding Team	September 2021	The post of the Safeguarding Adult/Dementia lead has been appointed to, awaiting a start date. Head of Safeguarding Adults is a member of the Falls Forum Review of APRs will inform the PU activity	AMBER

Appendix (i).

BCUHB Corporate Safeguarding Team
Safeguarding Adults
Annual Report 2020 -2021

1. Introduction

1.1 This annual report for 2020-2021 provides an overview of all Adult Safeguarding performance data held by the Corporate Safeguarding Team of Betsi Cadwaladr University Health Board (BCUHB). It also identifies progress made in relation to the activities and priority actions described in the 2019- 2020 Corporate Safeguarding Annual Report.

1.2 The report provides detail obtained from learning and the assurance in line with the 24 set Strategic Priorities.

1.3 Within the main body of this report, there is evidence of change and impact on Safeguarding service delivery. This reflects the requirements of services during the COVID-19 pandemic to safeguard all patients, staff and the organisation.

1.4 Despite challenges due to the COVID-19 pandemic, there have also been achievements for noting and celebrating.

1.5 The reporting structure of this report is in line with the five (5) key elements of the National Safeguarding Maturity Matrix (SMM).

2. Governance and Rights Based Approach

Rationale

2.1 There is requirement to have a clear line of accountability, without doubt or ambiguity about who is responsible at every level for the well-being and protection of adults at risk of abuse and neglect.

2.2 The five (5) key elements of the SMM reporting structure includes:
- Government and Rights Based Approach
- Safe Care
- ACE informed
- Learning Culture
- Multi Agency Partnership Working.

2.2.1 SMM is a quality outcome-monitoring tool to provide assurance, share good practice and learning to determine what is required to implement safe and high standards of practice. This supports the implementation of the forthcoming 'Once for Wales' Safeguarding module for 2021-2022.

2.2.2 The highest achievable score is five (5) for each element. There has been excellent progress within BCUHB where the maximum score of 25 is achieved for 2020 thus evidencing the achievement and improvements for each of the elements and their respective indicators.

2.2.3 BCUHB SMM self-assessment, alongside other Health Board and Trusts in Wales, provide a collective report through the NHS Safeguarding Network who reports to the Wales Chief Nursing Officer at Welsh Government.

2.3 The HASCAS Investigation and Donna Ockenden Review

2.3.1 The HASCAS Improvement Group monitors the implementation and progress of all recommendations (Table 1) across BCUHB. The Associate Director of Safeguarding is a standing member of this group and reports on progress, and compliance.

2.3.2 Table 1 demonstrates that all of the Safeguarding elements of the recommendations have been implemented.

Table 1.

Reference	Recommendation	Recommendation Position
HASCAS 4	Safeguarding Training	Completed
HASCAS 5	Informatics, and Documentation	Completed
HASCAS 6	Policies and Procedures	Completed
HASCAS 7	Tracking Adult at Risk across North Wales	Completed
HASCAS 8 / Ockenden 6	Review and implementation of the Corporate Safeguarding Team Structure	Completed
HASCAS 12 / Ockenden 9	Review of the Deprivation of Liberty Safeguards (DoLS) work plan identified in 2017-18 for implementation in 2018-19 into 2019-2020	Completed

2.3.3 HASCAS 8 / Ockenden 6 recommendation was completed and a further four Best interest Assessor's (BIAs) were appointed. Due to the increase in safeguarding activity, complexity and new legislation a further of the Safeguarding Team Structurer review has taken place. This has resulted in the development of a Corporate Safeguarding Business Plan, which includes additional posts within the structure to strengthen BCUHB's safeguarding commitments and implement the new Mental Capacity (Amendment) Act 2019 and Code of Practice for the Liberty Protection Safeguards.

Priority Action – 8 (2020-2021)

Successful recruitment of all vacant posts within Corporate Safeguarding and consideration of the wider structure.	December 2021

2.3.4 Stakeholder engagement has continued successfully throughout 2020-2021 to ensure transparency and true partnership working; this has included stakeholder attendance at Safeguarding training during and stakeholder reviews of Adult Safeguarding policies and procedures.

2.4 Safeguarding Governance and Reporting

2.4.1   To ensure organisational reporting, escalation and engagement the Corporate Safeguarding Team continue to work using an agreed Safeguarding Governance Reporting Framework.

2.4.2   This BCUHB Safeguarding Governance Reporting framework fully supports internal escalation, multi-agency and partnership working. In addition, it supports the implementation of the statutory and legislative framework for engagement at both a strategic and operational level.

2.4.3   During 2020 - 2021 Corporate Safeguarding have reported 100% compliance for attendance at the Board and supporting sub groups. This supports the multi-agency approach to safeguarding across North Wales and facilitates learning and information sharing across all partner organisations.

Priority Action – 4 (2020 -2021)

Review Adult Safeguarding Performance and Governance activity across BCUHB.	March 2021

Priority Action – 1 (2021-2022)

Review Adult Safeguarding Database to inform quality data of the Performance and Governance activity across BCUHB.	March 2022

2.4.4   The Once for Wales Concerns Management System (OfWCMS) has included a 'safeguarding module' for report in Adults and Children at Risk. In preparation for the implementation of the system Corporate Safeguarding have continued with engagement within local and national meetings. There is ongoing consultation in relation to the potential implementation and impact of the new system, promote multi-agency engagement to ensure partner agencies are fully aware of any changes, and review all training packages due to impact of the changes.

2.5 Safeguarding Policies, Procedures and Standard Operating Procedures.

2.5.1 Table 2 evidences the increase in the development and revision of safeguarding policies, procedures and protocols, which supports the organisation to protect patients, service users, staff and their families.

Table 2.

Safeguarding Policy/Procedure/SOP	2017- 2018	2018-19	2019-20	2020 - 2021	Trajectory
Number In Date	3	8	14	15	↑
Number Under Review	0	6	2	6	
Number out of Date	10	0	0	0	
Total Number	13	14	16	21	

2.6 Wales Safeguarding Procedures (Adults)

2.6.1   The Wales Safeguarding Procedures are reflected within BCUHB's Adult Safeguarding Policy and all other Safeguarding aligned Policies and Procedures. The new National Safeguarding procedures 'went live' in September 2020.

Priority Action – 2 (2020-2021)

Raise awareness and compliance of the new Wales Safeguarding Procedures for Adults.	December 2020

2.6.2   The Wales Safeguarding Procedures have been promoted across BCUHB. Adapting to the COVID-19 pandemic has resulted in a new way of delivering services and communicating with colleagues.

2.6.3 Online videos, presentations, and digital meetings have all contributed to Corporate Safeguarding's approach to ensuring that BCUHB staff are fully updated and aware of safeguarding legislation.

2.7 Adults at Risk – Performance and Activity

2.7.1 Within the reporting period of 2020-2021, the Corporate Safeguarding Team received 1284 adult at risk reports from BCUHB (this includes reports in relation to individuals who are commissioned by BCUHB but receive care out of county). There has been a continuous increase in the annual number of adult at risk reports from 2016 to date with an increase of 5.3% from 2019-2020.

2.7.2 Table 3 illustrates the activity from each of the areas within BCUHB. It identifies that West and East saw an increase in adult at risk reporting and a reduction from the Central area. Increased reporting from the East was as a result of increased activity and a change in service specific to Older People Mental Health within the MHLD Division. Whereas in the West an increase are associated to safeguarding concerns within Care Homes.

Table 3.

Year	West	Central	East	Out of Area	Total
2019-20	387	448	378	6	1219
2020-21	463	358	444	19	1284
% Change	↑ 19.6%	↓ 20.1%	↑ 17.5%	↑ 216.7%	↑ 5.3%

Figure 1 - Number of Adult at Risk Reports (2020-2021) with Wales's COVID-19 lockdown periods highlighted.
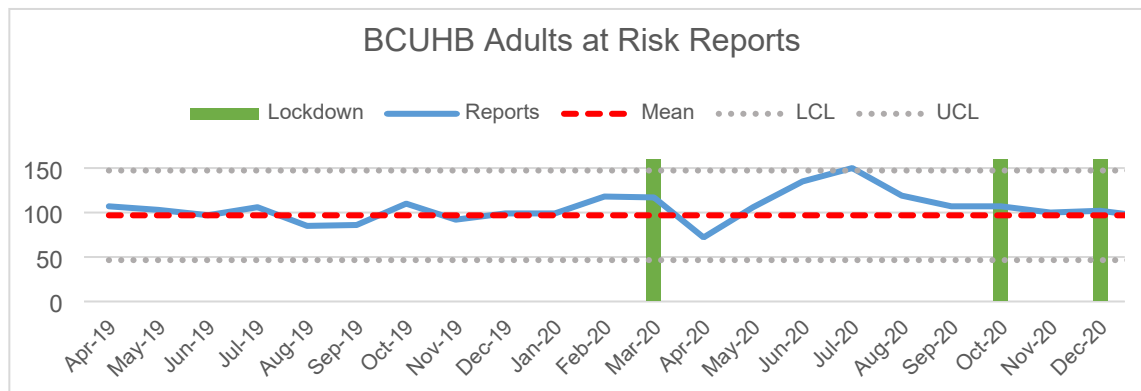
2.7.3 Figure 1 provides a timeline of the number of adult at risk reports by month from April 2019 to March 2021. The chart has lower and upper control limits with a median line to depict average limit. This enables the identification of a special cause variation such as the point of July 2020 within the first lockdown period.

2.7.4 During the first COVID-19 pandemic lockdown a reduction in reporting was identified significantly for March and April 2020. This was in line with the national picture across Health Boards and Trusts in Wales and our partner agencies. It is considered the cause was a result of social distancing rules affecting face-to-face service delivery.

2.7.5 In response, Corporate Safeguarding undertook a direct approach to the promotion of reporting abuse and/or neglect across the Health Board. The Corporate Safeguarding Team supported staff across BCUHB by driving the need to be vigilant and to report any safeguarding concerns.

2.7.6 A Safeguarding COVID-19 Action Plan supported activities to enhance and continue to engage with service users, colleagues and external partner agencies. Engagement and communication with the workforce has continued utilising the monthly Safeguarding Bulletin, the Safeguarding Web Page, bespoke training both face to face and virtually.

2.7.7 Safeguarding Specialists also worked closely with staff, ensuring that on receipt of the copy of the adult at risk report they immediately request the details for assurance in relation to the safety of any individual(s), with updated care and treatment plans, risk assessments and where necessary more detailed interventions. The Local Authority retains the statutory responsibility for the Adult at Risk process with the decision-making completed as part of a wider multi-agency group. This would include those directly engaged and involved with the individual and the concern raised.

2.7.8 The positive effect is evident in the immediate increase in reporting during May 2020 and as shown in Figure 1.The Corporate Safeguarding team have promoted training to ensure the BCUHB staff are aware of their statutory duty to report alleged abuse or neglect under the Wales Safeguarding Procedures.

2.7.9 The introduction of the Designated Safeguarding Person at the point of reporting alleged abuse or neglect would ensure that staff who are reporting concerns are supported at the earliest stage. This will allow the correct and immediate actions to make safe the individual/situation and determine the appropriate safeguarding framework. This is in line with the Wales Safeguarding Procedures.

2.7.10 Other key areas of change undertaken by the Corporate Safeguarding Team to ensure BCUHB continues to comply with statutory legislation during the COVID-19 pandemic includes:

- Raising staff awareness of the Wales Safeguarding Procedures and the Adult at Risk process,

- The implementation of individual and group adult practitioner supervision,

- The development and implementation of a revised Level 3 Adults Safeguarding Training modules.

- Continued attendance at Local and Divisional Governance, Quality and Performance meetings across Adult services, to include the MHLD

- Division, Emergency Departments, and Commissioning Services

2.7.11 The main themes and trends taken from Adult at Risk reporting over during 2020-21 include:

- Increased number of reports from care homes, 326 recorded in 2019-2020 in comparison to 419 in 2020-2021 (= ↑ 28.5 %)
- Increased number of neglect reports, 358 in 2019-2020 in comparison to 488 in 2020-2021 (it should be noted that self-neglect is also highest category of abuse reported). (= ↑ 36.3 %)
- Increased number of reports from the Adult at Risk's 'own home', 335 in 2019-2020 and 339 in 2020-2021. (= ↑1.2 %)
- 96% of patient on patient recorded alleged physical abuse have been reported from within the MHLD inpatient units. However, it is noted that there is a decrease from 403 to 317 reports from 2019-2020 to 2020-2021.

2.7.12 In mitigation of the increased Adult at Risk reporting activity Corporate Safeguarding have moved towards a greater level of scrutiny and assurance prior to Adult at Risk Reports being raised. This is to ensure that actions have been taken to make safe those involved and to confirm the rationale for reporting based upon the new legislation. The Designated Safeguarding Person within the team undertakes this role.

2.7.13 All activity is reviewed and evaluated within the respective multi-agency Safeguarding Board Delivery Groups as well as internal (BCUHB) Safeguarding Forums. The benefit of multi-agency engagement allows for the triangulation of data and actions for implementation from the lessons learnt.

2.8 Category of Abuse

2.8.1 Table 4 identifies that reports of Neglect (this include Self-Neglect) as well as incidents of alleged Physical Abuse are the most reported categories of abuse. Neglect reports have increased year on year by 36% and the alleged physical reports have decreased by 7%.

The high number of recorded Physical Abuse cases is a result of the legal requirement to report incidents of alleged physical altercations between patients.

Table 4

Category of Abuse	2019-20	2020-21	Trajectory
Neglect	358	488	↑
Physical	521	482	↓
Emotional	142	140	↓
Financial	97	72	↓
Sexual	59	55	↓
Not Recorded	41	42	↑
Self-Harm	1	5	↑
Total	1219	1284	

* This data is from the actual Adult at Risk Report, not the reported outcome of the LA decision-making process.

2.9 Location of Alleged Abuse

2.9.1 The number of Adult at Risk Reports submitted across the three localities identifies a 29% increase in reports from care homes and an increase of 19% from a person's own home year on year. This is due to the high number of Residential and Nursing Care Home reporting in this area.

2.9.2 Table 5 highlights the specific source of the Adult at Risk Report. In 2019-2020 MHLD Units provided most activity but due to the work undertaken by Corporate Safeguarding to support the MHLD Division directly there has been a 29% reduction in adult at risk reports.

2.9.3 A proportion of the reports received from the wards are associated with unsafe discharges. This has been escalated to the relevant Director and discussed at Safeguarding Forum.

Table 5.

Location Type	2019-20	2020-21	Trajectory
Care Homes	326	419	↑
Own Home	335	399	↑
MH Units	377	266	↓
Wards	97	121	↑
Other/Not Recorded	84	79	↓
Total	1219	1284	

2.10 Adults at Risk – Performance and Activity overarching for MHLD

2.10.1 In 2020-21 there have been 421 adult at risk reports raised from the MHLD division, which equates to a third (33%) of all adult at risk reports in BCUHB. The numbers have reduced by 20% in comparison with the 525 MHLD reports received in 2019-20.

2.10.2 49% (n=205) of the MHLD adults at risk reports were for patients age group 60+ years. However, for 2020-2021 there is an increase in activity from the 40-59 age group. This has been as a result of complex cases within the Hergest Unit.

2.10.3 63% (n=264) of the MHLD reports have occurred within a MH inpatient setting. 47% (n=197) of the MHLD reports have been concerning patient on patient alleged physical abuse. This is a reduction from 62% in 2019-20. This is as a result of the bespoke training and change in practice relating to contact with the Designated Safeguarding Practitioner. Additionally there has been virtual training on patient on patient altercation voice over recorded by a Ward Manager of an OPMH unit that has been cascaded across the Division.

2.10.4 Table 6 provides numerical detail of the activity across localities and regional services. Higher activity in the East is a result of the MHLD's Divisional changes as OPMH services we relocated to the Heddfan Unit. Furthermore, increased training activity and learning from desktop reviews may have supported an increase in awareness and reporting.

Table 6.

Year	West	Central	East	Forensics	Rehab	Learning Disability	Total
2019-20	159	125	154	9	12	66	525
2020-21	125	89	128	7	1	71	421
Year on Year % Increase	↓ 21%	↓ 29%	↓ 17%	↓ 22%	↓ 92%	↑ 8%	↓ 20%

2.11 Learning Disability, Forensics, Rehabilitation and Commissioned Care all form part of the Regional Services within MHLD Division.

2.11.1 **Learning Disability - Adult at Risk**

2.11.2 There has been 71 Learning Disability Adult at Risk Reports reported in 2020-2021. This is an increase of 7.6% from 2019-2020. This is likely to be as a result of Learning Disability being captured separately and not integrated within the MH data.

2.11.3 **Rehabilitation - Adult at Risk**

2.11.4 There has been 1 Adult at Risk Report during 2020-2021. In 2019-2020 the Head of Safeguarding for MHLD/Adults supported the service in their efforts to fully understand the Adult at Risk process and ensure that the staff team work with individuals to make their own choices.

The reduction in the number of Reports received is not an indication of a lack of safeguarding activity as the service explores other safeguarding frameworks and interventions.

2.11.5 Age groups - Adult at Risk.

2.11.6 Reports received in relation to patients aged 60-79 continues to form the majority of the MHLD Adult at Risk reports for 2020-2021 (28% n=118). This relates to the higher vulnerability within this age range. It is noted that the 40-59 age group continues to have an increase in activity year on year (↑ 25%). The main source of reports are from the Hergest Unit, predominantly patient on patient alleged physical abuse cases due to the complexity of some of the patients. Corporate Safeguarding provided support for each case and continued to monitor through attendance of the local Putting Things Right meeting.

2.11.7 Categories of Abuse

2.11.8 Alleged patient on patient physical abuse remains high within the MHLD Division. The introduction of the Adult at Risk Procedures in September 2020 may impact upon this statistic as there is now a requirement under the legislation to complete a Best Interest meeting to determine if an adult should or requires support via the Adult at Risk process prior to submitting an Adult at Risk Report. Previously Adult at Risk Reports for individuals who lacked the capacity to understand the Adult at Risk process were mandatory.

3. Safe Care

3.1 Rationale

3.1.1 All organisations must have a safe recruitment process that takes into account the risks to children and adults at risk.

3.1.2 There should be a system by which safeguarding concerns about employees should be raised and addressed. Departments and professionals delivering services must take full consideration of their safeguarding responsibilities.

3.1.3 Corporate Safeguarding actively engage with and support WOD and HR services to promote compliance with DBS requirements and Section 5 (Allegations against Professionals) legislation.

3.2 Safeguarding People living with Dementia

3.2.1 The Head of Safeguarding for MHLD/Adults has attended the Dementia Clinical Strategy Group and is fully engaged with the implementation of identified key priorities.

3.2.2 The Head of Safeguarding for MHLD/Adults has worked with the Consultant Dementia Nurse to promote the The Dementia Pathway and Community Pathways and Standards.

3.2.3 Corporate Safeguarding introduced the role of the Adult/Dementia Specialist for Safeguarding to strengthen the Dementia strategy and safeguarding structure. The Safeguarding Adult/Dementia Regional Specialist post is at interview stage.

Priority Action 2 (2021-2022)

On recruitment of the Regional Safeguarding Adult/ Dementia Lead, commence mapping and scoping of patients within acute and community services	December 2021

3.3 The Sexual Safety - Task Group

The MHLD Division have co-produced a service user led policy that offers guidance to staff and patients when an individual is admitted onto a Mental Health ward in relation to sexual safety. Consultation sessions took place across North Wales between BCUHB staff, partner agencies, third sector agencies and service users. Safeguarding Team continue to have a presence in the Sexual Safety Task group to support its implementation. Due to the COVID-19 Pandemic, meetings and training have been delayed. However, meetings are reconvening for April 2021.

Priority Action – 7 (2020-2021)

To support on the implementation of a multiagency co-produced MHLD guidance for patients and staff specific to Sexual Safety.	March 2021

Priority Action 3 (2021-2022)

To support the Sexual Safety Group with training and evaluation of the co-produced MHLD guidance for patients and staff	March 2022

3.4 Commissioned Care

3.4.1 Corporate Safeguarding support the BCUHB services with safeguarding concerns raised in commissioned care homes, independent hospitals, and out of area placements.

3.4.2 During 2020-2021 Corporate Safeguarding have supported colleagues by working in partnership with the independent sector, other commissioners, HIW, Police and Local Authorities to ensure residents are safeguarded during the COVID-19 Pandemic, this includes the safety of staff whilst undertaking key duties.

3.4.3 There has been an increase in the number of care homes that have entered the Escalating Concerns (EC) process. The Corporate Safeguarding Team continue to be fully engaged and support the Continuing Health Care Teams. The increase is as a result of the high number of reported positive COVID-19 cases requiring significant support by BCUHB practice development teams and primary care services.

Priority Action – 3 (2020-2021)

Increased engagement with BCUHB contract and commissioning services to review the safeguarding standards, policies and procedures of external care providers	March 2021

Priority Action 4 (2021-2022)

Provide Safeguarding contribution to the development of the Quality Assurance Framework for both residential and nursing homes. Corporate Safeguarding attendance to the CHC CMG meetings.	June 2021

3.5 COVID-19 Response

3.5.1 The Corporate Safeguarding response to the COVID-19 Pandemic has been substantial. A Safeguarding COVID-19 Action Plan was developed to identify and action activity required to mitigate potential risks across the safeguarding agenda.

3.5.2 The plan has demonstrated and been successful in:

- Innovative thinking to include virtual training, group and individual supervisions
- Increased communication and engagement with services internal and externally with partner agencies
- Weekly triangulation of data to identify themes and trends
- Provide specialist support with attendance to meetings to include Home First Bureau, Primary Care and MHLD Division
- Ensuring new staff to include volunteers received safeguarding training.
- Provided Provide face to face safeguarding training to the three field hospital sites.
- Continued working with respective commissioning and CHC teams to review any concerns raised with regard to all current BCUHB supported placements.
- Improvement in quality of reports and associated risk documentation.

3.6 MHLD - Heddfan Unit

3.6.1 The acuity and provision of care of the MHLD Heddfan Unit changed during the COVID-19 Pandemic. The unit became the Older Person's Mental Health Admissions unit for the Mental Health Division. This meant that all Older Person Mental Health admissions for North Wales were directly to the Heddfan Unit. This meant an increase in the number or beds for older people from 27 beds to 54 beds.

3.6.2 The change in function of the unit contributed to an increase in incidents and Adult at Risk Reports being submitted. Key themes were identified in the nature of the reports, to include increase in patient on patient assaults, the quality of adult at risk reports, risk assessments and protection plans.

3.6.3 There have also been an increase in the number of professional allegations reported. Corporate Safeguarding continue to work closely with the Division, Workforce and colleagues from Local Authority and North Wales Police. The potential risks at time of allegations were mitigated immediately.

3.6.4   HIW reported that they had been contacted by members of BCUHB staff to raise their concerns about Heddfan Unit since the change in service delivery to an OPMH Unit.
Corporate Safeguarding worked closely with Heddfan to identify any key themes across concerns raised by Corporate Safeguarding and the reports from HIW.

3.6.5   A Safeguarding Peer Review Report was undertaken commissioned by the Executive Director of Nursing and Midwifery with full support of the Chief Executive and Executive Medical Director, with the objective to attain assurance of patient safety and staff well-being. As a result of the findings, six (6) key domains of improvement were identified:

- Leadership
- Communication
- Quality & Governance
- Compliance with legislation
- Practice Development & Staff Engagement
- Partnership Working

3.6.6 A Heddfan Safeguarding Improvement Action Plan was developed and was independently monitored by colleagues in local authority as the statutory leads for Safeguarding. Local Authority had also identified Heddfan as a Service of Concern.

3.6.7 The focus of the action plan was to obtain assurance against the safeguards and overall quality and safety of both patients and staff at the Heddfan Unit. The Safeguarding preventative agenda included:

- Training and Learning
- Supervision and Support
- Patient on Patient Physical Abuse.

As part of the Safeguarding Action Plan, the corporate Safeguarding Team identified a Single point of Contact (SPoC) for the unit. This commenced on the 15th May 2020 .The purpose was to ensure that staff on the unit had a designated Safeguarding Specialist to support and provide advice on Safeguarding concerns.

This included:
- To have an oversight of all the safeguarding activity on the unit. Ensuring a visible presence on the unit to support staff with any safeguarding concerns.
- Providing both planned and ad hoc supervision for staff who are submitting safeguarding reports and providing advice regards all Safeguarding matters.
- To establish and provide Group and Individual Supervision for all staff on the Heddfan Unit to discuss practice, raise concerns, learn, and reflect on interventions. Coordinate and facilitate Desk Top reviews for those wards with highest levels of Adult at Risk reporting triangulating with number Datix incidences, Falls, HAPU. Medication Errors, Professional Allegations, Safe Staffing, PADR and Mandatory Training compliance.

This is in line with the Corporate Safeguarding Escalating Standard Operating Procedure.

- Quality assure all Safeguarding reports prior to submission to local authority. This was in agreement and support of the Local Authority and in line with the Wales Safeguarding Procedures and the role of the Designated Safeguarding Person (DSP).
- Audit of Adult at Risk Reports, associated documentation and any delay in escalation or reporting within the Divisions Governance framework, Datix Incidents and Police Reporting.
- Provide training for staff on the Adult at Risk Process, Report Writing and the safeguarding Procedures both face-to-face and virtually.
- Provide bespoke training to include Level 3 training for all Band 6 and Band 7 staff on the unit on Quality Assuring the Safeguarding reports prior to submission.
- Train staff to become Safeguarding Ambassadors for the unit.
- Support representatives from the unit as part of the Adult at Risk Processes.
- Engage staff in other learning activities such as Tissue Viability
- Support staff in their review of their own Heddfan Quality Improvement Plan (HQIP). This included recommendations from HIW visits and interventions.
- Corporate Safeguarding to be the single point of contact for the Local Authority for Safeguarding concerns. This ensured that partner agencies are engaged and updated ensuring complete transparency.
- Attending the following meetings on the unit- Risk Meetings, PTR, Falls Meetings, Acute Care meetings, Safety huddles and the HQIP meetings.
- Corporate Safeguarding to attend all strategy and Service of Concern meetings.

3.6.8 There were Professional Allegation Concerns on two of the wards who provide provision for Older Persons with a diagnosis of dementia in Q3. The themes of these reports have been cross-referenced with the original Heddfan Safeguarding Improvement Action Plan. Further actions were identified as an addendum. These actions are near completion for local authorities' consideration.

3.6.9 Further learning has been identified from the Adult at Risk Reports received around Patient Transfers, the completion of Body Maps and Covert Medication. There is a new management within the Unit with agreed plans how to identify key areas from the unit to participate in developing and sharing this learning with colleagues across the Division.

3.7   Outcome of the Heddfan Safeguarding Improvement Action Plan

3.7.1 In response Corporate Safeguarding have provided, at times, 7-day week working to support the mitigation of risks and to gain assurance specific to the agreed actions taken for each individual case. Engagement between services has been challenging and positive. The activity and nature of the safeguarding concerns highlights the need to further strengthen long term safeguarding support plans for the division.

3.7.2 From the six (6) domains and 33 actions within the Heddfan Safeguarding Improvement Action Plan, only one (1) action remains open.

This is result of the recommendation to have three (3) additional Safeguarding Specialists dedicated to each of the geographical areas of the MHLD Division. There remains a discussion as to the allocation of budget for these posts.

3.7.3 The dedicated SPoC and involvement of the remainder of the Safeguarding Team has evidenced significant improvement and achievements. HIW, Local Authority and the North Wales Safeguarding Board have all recognised the work undertaken and have commended Corporate Safeguarding input, engagement, change of practices and allocation of the SPoC as Best Practice.

3.7.4 The practice of Ad hoc, planned Group and Individual Supervision has been welcomed. Face-to-Face sessions have been with 42 staff members. Sessions were undertaken where appropriate in various meetings within the Unit. The Group supervision sessions are still to be fully established on the unit. Further dates are provided and coordinated for the period of 2021-2022.

3.7.5 Responsive Supervision was completed for all Adult at Risk reports submitted during the period where the single point of contact support was in place. This took place either via telephone or face to face for all reports during this period focusing on quality and learning around the adult safeguarding process, risk assessments and protection plans for patients.

3.7.6 The provision of a Single Point of Contact for the Heddfan unit ended on the 16th October 2020. The East Corporate Safeguarding Team continue to have a presence on the unit attending the PTR, Falls, QSE meetings and supporting in the SUI processes where there are safeguarding concerns identified.

3.7.7 The number of the Adult at Risk Reports have reduced. Figure 2 clearly identifies the reduction since the allocation of the Safeguarding Single Point of Contact (SPoC). Local Authority have commented on the improvement of the quality of the submitted reports since this intervention.

Figure 2
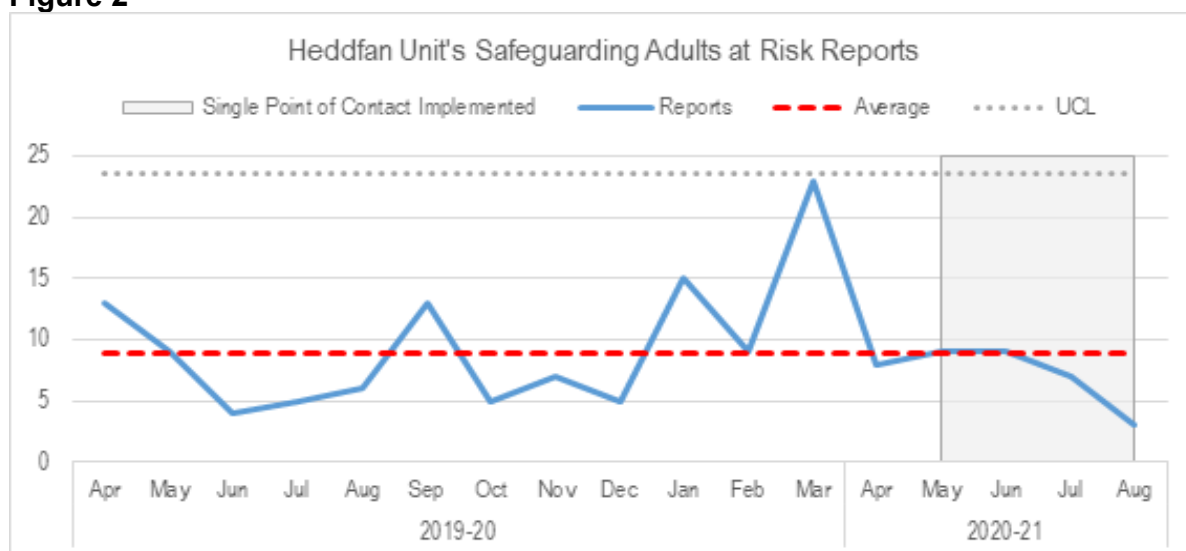
3.7.8 The number of historical Professional Allegations are reducing; those remaining open cases are waiting for internal investigations to be completed. These are managed under Section 5 of the All Wales safeguarding Procedures.
When completed, the outcomes are shared with the Wrexham Local Authority Safeguarding Team for review under Section 5.

3.7.9 The unit returned to its original purpose from January 2021. Both Clywedog and Dyfrdwy Wards are now acute admissions ward for Adult Mental Health Patients. With Tryweryn ward providing a PICU service. The numbers of Adult at Risk Reports have since decreased for those wards.

3.7.10 Heddfan Unit is no longer considered as a service of concern and has been closed under the safeguarding process by the local authority formally on the 9th March 2021.

3.7.11 The Plan Do Study Act model was utilised and considered almost on a monthly basis collaboratively with the Division who were also working to their HQIP with the supportive arm of SPoC and Safeguarding Team. The PDSA cycle approach enabled changes to be made even as simple as attendance of different meetings, changing the delivery of training, merging of meetings, different approach to reporting and escalating . Each change from learning overall resulted in improvement to patient, staff, Division and organisation.

Priority Action 5 (2021-2022)

Consultation with MHLD Services to fund additional 3 x Band 7 Safeguarding Specialists for MHLD across the Region	October 2021

3.8   Audit Quality of Adult Safeguarding Documentation.

3.8.1 Following Desktop Reviews learning with common themes identifying poor quality and standards of Safeguarding Documentation, a randomly selected audit was undertaken across West , Central and East of the MHLD Division (n=65). East reported differently due to the specific work on the Heddfan Unit

3.8.2 Purpose was to examine and evaluate the Quality of the Adult at Risk (AAR) Reports to identify themes in order to inform Corporate Safeguarding what additional learning is required for BCUHB Staff. The learning is to ensure preventative measures of poor quality AAR reporting and the associated documentation such as Safeguarding Risk Assessments and Protection Plans that provides assurance that immediate safeguards are in place

3.8.3 The audited reports had 15 key indicators to include:
- Patient consent
- Extent of information,
- Patient capacity,
- Police involvement,
- Delay in reporting,
- Patient involvement.

Findings from the audit identified the following themes:
- Overall, the information included in the reports have been sufficient to enable the enquiry stage to proceed.

- Improvement required on capturing the patient's capacity on the report. This is consistent across all three areas.
- Individuals consent not well documented.
- The make it safe steps were clearly recorded in reports from across all three areas.
- For those reports linked to patient on patient physical abuse, when applicable, the process to inform the police and family/advocate was followed.

In addition for the Heddfan Unit:
- The quality of the information provided has improved since the SPoC from safeguarding was in situ and then ongoing with empowerment of staffs own quality checks.
- Improvement was noted from Q1 to Q4 with regards to receiving the adult at risk reports, risk assessments and risk reduction strategies (protection plan) in a timely manner.
- There has been a significant improvement in the knowledge and understanding of the adult at risk process.
- The improvements from older persons wards are more evident than working age adult wards but the trend is still a significant improvement across the Unit
- The person with capacity clearly has their wishes documented, considered and where possible actioned.
- There is less evidence of this where the person lacks capacity. For example, there is little evidence of how that person was supported to be involved, nor the speech and language involvement for communication difficulties. Equally evidence that observation charts have been referenced to correlate any change in presentation post incident was also sparse.

3.8.4   From the findings, all three areas created recommendations which include conducting group supervisions, escalating concerns at weekly PTR meetings and ensuring that the quality of adult at risk reports are discussed at safeguarding training sessions.

Priority Action 6 (2021-2022)

Review of Phase 1 of Adult at Risk and Safeguarding Documentation audit tool	June 2021

Priority Action 7 (2021-2022)

Robust monthly audit sampling of Safeguarding Documentation across Acute and Community Services	Quarterly

4. ACE Informed

4.1 Rationale

4.1.1 Adverse Childhood Experiences (ACEs) such as exposure to domestic abuse, substance misuse and mental illness are known to have a direct and immediate effect on a child's health.

The safety of the child and the safety of the vulnerable adult are intrinsically linked; preventing early exposure can reduce the impact on children and future generations.

4.1.2 During all health assessment activities the wider family must be considered to determine risk and harm and the impact this has on others. This is captured and reinforced in training, care planning and risk assessments.

4.2 Agencies Domestic Abuse Perpetrator Tasking (ADAPT)

4.2.1 ADAPT is an initiative that is led by North Wales Police and currently being piloted in Conwy and Denbighshire. The objectives of ADAPT are to safeguard adults and children at risk of domestic abuse by changing or disrupting offender behaviour and to reduce the offending of domestic abuse perpetrators. In order to identify the most harmful perpetrators a process has been developed using an analytical programme namely the Regency, Frequency and Gravity Process (RFG). Data is analysed monthly by the ADAPT coordinator who applies an RFG Matrix to prioritise perpetrators in line with the RFG score of offending.

4.2.2 In addition, the number of victims connected to each perpetrator is also scored as part of the matrix to enable identification of serial perpetrators. The maximum score attributed is 100, this being the most harmful. Consideration of the removal of an individual from the ADAPT process is made when an individual RFG score has been reduced to a level where ADAPT intervention is no longer required. A total of 21 ADAPT nominals have been considered over 16 months. North Wales Police have undertaken a review of the ADAPT with plan to implement the same process across North Wales.

4.2.3 Corporate Safeguarding continue to engage in ADAPT and have achieved a 100% attendance record. Whilst the ADAPT is a perpetrator focused meeting, the risk management plans are designed to benefit adult victims and any children associated with the cases.

5. Learning Culture

5.1 Rationale

By promoting, a positive culture of multi-agency learning to generate new learning organisations can support continuous improvements in service delivery and practice. Feedback from patients and clients in the NHS must be used to monitor and improve the quality of services.

5.2 Adult Safeguarding Training

5.2.1 Safeguarding training compliance is a key target for Corporate Safeguarding. A reduction in compliance is reported during 2020-2021 (Table 7). Initially there were no face-to-face mandatory training taking place due to COVID-19 restrictions. Corporate safeguarding training continues to be available on e-learning and digital platforms and is supported by a revised virtual program to encourage ongoing training and assessments during the pandemic.

Table 7

Safeguarding Module	May 2020	March 2021	Trajectory
MCA – Level 1	85.3%	76.7%	↓
MCA – Level 2	86.0%	79.2%	↓
Safeguarding Adults – Level 1	78.9%	80.2%	↑
Safeguarding Adults – Level 2	76.7%	79.3%	↑

5.2.2 Safeguarding training compliance is scrutinised via the Practice Development, Learning & Training Task Group, which reports into the Corporate Safeguarding Governance & Performance Group and Area/Divisional Safeguarding Forums.

This reporting framework promotes a collaborative and supportive approach to achieve BCUHB Key Performance Indicator of 85% for all staff.

5.3 Safeguarding Training Sessions

5.3.1 The Corporate Safeguarding Team have embraced the use of technology to mitigate the risks of face-to-face training. Delivery of Safeguarding Training incorporates blended teaching methods via voiceover presentations, skype and small socially distanced groups. Level 1 and 2 safeguarding training is available via the NHS Wales E-learning platforms through ESR. Table 9 illustrates BCUHB Safeguarding Training compliance for 2020-2021. No data was available for April 2020 due to COVID-19.

Table 8.

Safeguarding Module	May 2020	March 2021	Trajectory
MCA – Level 1	85.3%	76.7%	↓
MCA – Level 2	86.0%	79.2%	↓
Safeguarding Adults – Level 1	78.9%	80.2%	↑
Safeguarding Adults – Level 2	76.7%	79.3%	↑
Safeguarding Children – Level 1	79.4%	79.3%	↓
Safeguarding Children – Level 2	77.5%	78.5%	↑
VAWDASV	78.4%	79.9%	↑

5.3.2 MCA Level 1 & 2 has seen the biggest negative trajectory over the year. Low-level compliance in all modules are shared through BCUHB Corporate Safeguarding Reporting Framework. Quarterly training reports are presented at:

- Safeguarding Governance and Performance Group
- Area Safeguarding Forums
- Practice Development, Learning & Training Task Group.
- Senior Leads
- BCUHB Mandatory Training Group.

5.3.3 It is evident that there is improvement in the compliance of nursing staff across the ED department in comparison to 2019-2020 (Table 9). There is some improvement in compliance of medical staff across all three acute sites however; there remains an urgency in engagement to improve this training compliance.

This reporting framework escalates key safeguarding training compliance data to the divisions across the organisation and escalated to the Safeguarding Forums.

Table 9

March 2021	Staff	MCA L1	MCA L2	Adults L1	Adults L2
YG Medical Staff	48	47.9%	45.0%	64.6%	62.0%
YG Nursing Staff	94	92.6%	90.0%	93.6%	91.0%
YGC Medical Staff	42	61.9%	62.0%	59.5%	45.0%
YGC Nursing Staff	84	85.7%	84.0%	78.6%	81.0%
WMH Medical Staff	40	50.0%	48.0%	52.5%	48.0%
WMH Nursing Staff	110	84.6%	83.0%	89.1%	87.0%

5.3.4 There are four (4) divisions with an overall safeguarding compliance over the required 85% target, which include Area Teams East, Area Teams West, Women's and MH/LD divisions. This is an excellent achievement in the current pandemic

5.3.5 The development of the Adult and Child at Risk Workbook and Assessment will assist in supporting those key areas of very poor compliance for 2021-2022.

5.4 MHLD Training Compliance

5.4.1 Table 10 highlights the most up to date training data compliance available. The MHLD Division have achieved the organisational target of 85% across all Adult Safeguarding training.

5.4.2 Corporate Safeguarding have worked collaboratively with the MHLD Division to implement an educational and training package to increase training compliance. Mandatory Level 3 Adult at Risk Bespoke Safeguarding Training has been agreed and delivered across MHLD services.

5.4.3 These training sessions are based upon the findings and learning from Internal, Desktop and Practice Reviews.

Priority Action – 6

Implement the revised Level 3 MHLD training programme to obtain a minimum 85% target; this is to include the ICAN volunteers.	March 2021

Priority Action 8 (2021-2022)

Implement recommendations from Adult & Child Practice Reviews and Domestic Homicide Reviews and embed in safeguarding training	October 2021

Priority Action 9 (2021-2022)

Monitor Emergency Staff medical staff safeguarding compliance across the organisation to obtain the KPI of 85%.	Quarterly

Priority Action 10 (2021-2022)

Monitor BCUHB Managed GP practices safeguarding compliance across the organisation to obtain the KPI of 85% and engage with Clinical Director of Primary Care.	Quarterly

Priority Action 11 (2021-2022)

Monitor ward safeguarding training compliance, which is below 70% in 3 or more safeguarding modules and Divisions to provide position statement at SGPG.	Quarterly

Priority Action 12 (2021-2022)

Monitor BCUHB Estates & Facilities Safeguarding Training compliance to obtain KPI of 85%.	Quarterly

Priority Action 13 (2021-2022)

Corporate Safeguarding to implement an internal process for the approval, review and internal evaluation of all safeguarding programmes.	September 2021

Priority Action 14 (2021-2022)

Evaluate the effectiveness of Safeguarding Bulletins in promoting safeguarding skills, knowledge and competence.	September 2021

5.5 Practice Development & Training Task Group

5.5.1 BCUHB safeguarding training packages are reviewed and updated periodically to reflect and support the health board's policies, procedures, and the wider safeguarding agenda.

5.5.2 Safeguarding training is monitored by this group and compliance is escalated through the Safeguarding Reporting Framework. It facilitates learning from all Adult and Child Practice Reviews and Domestic Homicide Reviews, local, regional and national inquiries, new legislation and evidence-based practice.

5.6 Adult Practice Reviews (APR)

5.6.1 The purpose of Adult Practice and Domestic Homicide reviews is to clearly identify multi-agency learning for preventative and safe future practice.

5.6.2 Table 10 provides a numerical picture of the APRs undertaken since 2018.

Table 10

Year	Number of live APRs	Number signed off	Number Ongoing
2018-2019	3	1	2
2019-2020	2	1	1
2020-2021	0	1	0

5.6.3. In 2018/2019, there were 3 ongoing APR's, one (1) was signed off and two (2) carried forward to 2019- 2020. There were no additional APRs in 2019-2020 however of the two (2) carried forward one (1) was signed off. In 2020/2021 there were no additional APRs however of the one (1) carried forward this has also been signed off therefore at time of report there are no APRs open.
(Delays in APRs completion can be due to ongoing criminal investigations)

5.6.4 The monitoring of the learning is undertaken by the North Wales Safeguarding Adults Board and internally by the BCUHB Safeguarding Forums. Key themes and learning from the APR's and DHR's during 2020-2021 include. Of five (5) Adult Practice Reviews since 2015, there have been 15 recognised common themes identified that includes:

- Poor communication across agencies
- Organisational compliance of training
- The quality of record keeping and documentation
- Revision of current processes and protocols
- Routine Enquiry Domestic Abuse consideration and implementation

5.6.5 Impact for BCUHB will be the requirement to lead on identified actions devolved from the recommendations collaboratively with partner agencies.

Priority Action – 15 (2021-2022)

Corporate Safeguarding to continue to contribute and support as, Chairs, Reviewers and Panel Members as required	March 2022

Priority Action – 16 (2021-2022)

Corporate Safeguarding to continue to support and mentor BCUHB staff who are Reviewers and Panel Members to include sharing key themes from the reviews and producing 7 minute briefings to share for learning across BCUHB Safeguarding Forums and Governance meetings alike.	March 2022

5.7 Desktop Reviews

5.7.1 Corporate Safeguarding works to and implements the Safeguarding Escalating Standard Operating Procedure. This provides clear process where Safeguarding activity falls within Level 3 criteria set a desktop review may be required to establish areas of concern for support and further learning.

5.7.2 From July 2018 to July 2020 there have been six (6) completed Desktop Reviews. These include two (2) that were repurposed as OPMH Wards since COVID-19.

5.7.3 Reviews reflect a setting's practice and provide recommendations that would improve safeguarding measures. With the activity, increasing within higher risk areas of very vulnerable adults a Concise Thematic Review is to be completed. Initial findings between all reports include:

Room for improvement and action:
- Staffing and Skill Mix concern
- Communication
- Voice of the patient not always heard
- Standard of documentation in particular Adult at Risk reporting
- Omissions of pivotal information in adult at risk reports

Good Practice:
- Improvement in advocacy and specialist services
- Transparency of reporting incidents

5.7.4 **Learning and Recommendations:** Staff have embraced the reviews in each area and are engaged in improvement plans. These plans have been monitored within the MHLD Safeguarding Forum ensuring learning is implemented across the Division. Corporate Safeguarding will continue to provide support in quality improvement projects in addition to Safeguarding Supervision sharing themes and trends from quarterly data.

Priority Action 17 (2021-2022)

Undertake Desktop Reviews as required in line with the Safeguarding Escalation SOP. Learning from internal reviews to be shared at Safeguarding Forums both Area and MHLD	March 2022

5.8 Outcome and Learning

5.8.1 All Adult Practice Reviews and Domestic Homicide Reviews are a standing agenda items for monitoring at Area and Divisional Safeguarding Forums reporting to the Safeguarding Governance Performance Group.

5.8.2 To gain additional assurance Corporate Safeguarding have developed an action plan to benchmark recommendations from high profile Regional and National Safeguarding Reviews and investigations. The implementation of this work is a key priority for 2021-2022 and will offer further assurance that lessons learnt have been implemented by the Health Board.

Priority Action – 5 (to continue as Priority 17 for 2021-2022)

Benchmark recommendations from National/Regional Adult Safeguarding Reviews and investigations.	March 2022

5.9 Safeguarding Supervision

5.9.1 For 2020- 2021 Corporate Safeguarding commenced an Adult Group and Individual Supervision Plan to promote the adult safeguarding agenda and support staff to engage in the Adult at Risk process.

The Group Supervision allows staff to discuss cases, reflect and learn in a safe and supportive environment. These sessions are offered to all BCUHB services.

5.9.2   As a Phase 1 approach a total of 46 supervisions sessions were held with 219 in attendance. Staff that attended included; SMS, CMHT, Community OPMH, CHC, practice managers, ANP's, Home Treatment Team, Ward Managers, Matrons and OPMH managers.

5.9.3   The themes discussed on request of the staff included; Safeguarding Procedures, Self-Neglect Procedure, Complex Cases, Datix, Care Homes, Personal Wellbeing & Keeping Safe, Section 5 and Safe Staffing.

5.9.4. Feedback from the attendees have highlighted the positive impact on practice from the supervision sessions. Using the time at the sessions to discuss complex cases and challenges that the staff face has been valuable. The initial feedback has informed Corporate Safeguarding of the Phase 2 implementation of Adult Supervision plan for 2021-2022.

Examples of initial feedback include:

"A positive impact, as the majority of cases we deal with has an element of safeguarding risk assessment.

"Always learning from own and others experience of different situations of a safeguarding nature."

"Yes, working in a busy GP with 16500 patients, 350 nursing/residential home residents, so we have to deal with and consider adult safeguarding issues"

5.9.5 .A Group and Individual Adult Supervision questionnaire has been shared with attendees in Quarter 4, the response will strengthen the feedback thus far. Auditing this process will be key to measure the effectiveness of supervision and impact this has had in practice.

Priority Action 18 (2021-2022)

Corporate Safeguarding to review work plan of Adult Safeguarding Group and Individual Supervision for 2021-2022	June 2021

5.10 Safeguarding Ambassadors

5.10.1 There are 68-trained safeguarding ambassadors across BCUHB. Each ambassador has a named Safeguarding Specialist allocated to him or her to provide individual and group supervision.

5.10.2 Staff from across BCUHB have taken the opportunity to undertake ambassador training. They include Ward Managers, CPN's, Matron's, Dental Health Professionals, Registered Nurses, Social Workers, Medical Secretaries, and a Chaplin.

5.10.3 All three localities have registered safeguarding ambassadors. Primary and Secondary care settings, corporate and community based services, adults and children's services have all engaged positively in the initiative.

5.10.4 The ambassadors are supported by drawing on key improvement recommendations and reinforcing that safeguarding is core business. There is evidence of the improved quality of Adult at Risk Reports and a reduction in inappropriate reporting as a direct result of ambassador intervention and partnership working with the Safeguarding Specialists.

5.10.5 Ambassador Training continues to be delivered using a virtual platform, which ensures that Corporate Safeguarding continue to promote and develop the learning culture within the organization. These training sessions have supported in raising awareness and embedding the new Wales Safeguarding Procedures into practice.

Priority Action 19 2021-2022

Corporate Safeguarding to promote and provide further training to recruit up by 25% further Safeguarding Ambassadors for BCUHB	October 2021

5.11 Safeguarding Bulletin

5.11.1 Corporate Safeguarding have continued to produce the monthly safeguarding bulletin throughout the COVID-19 Pandemic. The bulletin has been capturing relevant, topical and current issues, as well as themes and trends specific to all aspects of the safeguarding agenda. Key messages have been shared to promote the practical and theoretical perspective of safeguarding which can be translated into practice. Items within the bulletin are directly linked to current practices and include live updates and communications to inform staff across BCUHB.

6. Multiagency Partnership Working

6.1 Rationale

6.1.1 The protection and safeguarding of adults and children relies on multi-agency working and effective information sharing to improve services and outcomes for all.

6.2 PREVENT

6.2.1 The Associate Director of Safeguarding attends the CONTEST Board on behalf of BCUHB. Head of Safeguarding MHLD/Adults attend the All Wales PREVENT meetings for regular updates from the Welsh Extremism and Counter Terrorism Unit (WECTU).

6.2.2 Work is being developed with the Vulnerability Support Hubs in the UK; an identified priority for 2020-2021 is for key engagement at the All Wales Group. BCUHB to have 100% attendance. However due to the COVID – 19 pandemic meetings have been paused.

6.2.3 The Home Office, have made amendments to the National PREVENT training standards. PREVENT training within BCUHB has been updated to ensure staff are competent in the management of any patients who may manifest radicalisation thoughts during clinical assessments.

6.3 County Lines and the Harm Agenda

6.3.1 Throughout 2020-2021 Corporate Safeguarding, on behalf of BCUHB, have been engaged with North Wales Police (NWP) to support their work in relation to a North Wales County Lines Needs Assessment. This is an increasing agenda for all agencies and BCUHB are a key partner agency.

6.3.2 The Serious Violence and Organised Crime Board had commissioned a Task and Finish Group to review the multi-agency approach. This activity is paused due to the outbreak of the COVID-19 pandemic.

Priority Action – 2

Benchmark and implement the County Lines Needs Assessment.	March 2021

6.4 Vulnerability and Exploitation Board

6.4.1 The purpose of the Vulnerability and Exploitation Board in North Wales is to provide leadership, governance and strategic direction to meet nationally and regionally driven priorities relating to vulnerability and exploitation.

6.4.2 The Board will ensure the effective delivery of national, regional and local priorities for protecting and preventing vulnerability and exploitation.

6.4.3 The Board will also seek to identify opportunities to align activity with other partnership arrangements across North Wales in order to provide a joint approach to the efficient use of resources and effective delivery of priorities.

6.4.4 Strategic priorities include working together in partnership to support the progress of vulnerability and exploitation priorities, including developing a strategic overview of exploitation, supporting a proactive partnership where those at risk are recognised and offenders are disrupted and prosecuted.

6.4.5 A further priority is the recognition of an efficient and effective response to domestic abuse, sexual violence and serious harm caused by violence against women.

6.4.6 The Associate Director for Safeguarding represents BCUHB at the Board.

6.5 Multi Agency Public Protection Arrangements (MAPPA)

6.5.1 MAPPA are the statutory arrangements for managing sexual and violent offenders. MAPPA is not a statutory body in itself but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a coordinated manner. Agencies at all times retain their full statutory responsibilities and obligations.

6.5.2 The Responsible Authority (RA) consists of the Police, Prison, and Probation Services. They are charged with the duty and responsibility to ensure that MAPPA is established in their area and for the assessment and management of risk of all identified MAPPA offenders.

Corporate Safeguarding representatives and MHLD Divisional colleagues contribute to the identification and assessment of risk and agree a multi-agency risk management plan.

6.5.3 Attendance at MAPPA is mandatory and Corporate Safeguarding have a 100% attendance rate, MHLD have a reported improved attendance and engagement.

6.5.4 Learning from a review of a complex MAPPA case was presented by the MHLD Division in the Safeguarding Governance and Performance Group. This demonstrated positive outcome and notable good practice from BCUHB practitioners in partnership with multiagency colleagues.

6.6 Advocacy

6.6.1 Corporate Safeguarding engage and liaise directly with advocacy services across North Wales to ensure the patients individual rights are upheld. The offer of advocacy is now a legal requirement and is embedded into law.

6.6.2 A priority for 2020-2021 is to engage and support commissioning services to review the contract for the advocacy service.

Priority Action – 24

Engage and support the review of contracts for Advocacy Services.	March 2021

6.7 Partnership Working

6.7.1 In highly complex cases there has been inter-agency working between BCUHB and other key partnership organisations, these include the North Wales Fire Service, North Wales Police, Local Authorities, Third Sector agencies and Independent providers. The ethos of the Safeguarding agenda dictates the need for good partnership working, the importance of information and intelligence sharing at an early stage can support an immediate reduction in abuse or neglect.

6.7.2 It is recognised that the BCUHB Corporate Safeguarding Team, in accordance with the Wales Safeguarding Procedures, are not the lead agency in relation to the Adult at Risk process.

Although by our strengthened internal processes, ability to scrutinise copies of the Adult at Risk reports, which are directly reported to the LA, and identify trends and themes by the data, we are able to target areas in a proactive manner.

6.8 Holden Report

6.8.1 A complaint was received via the North Wales Safeguarding Board in relation to the Holden Report. Corporate Safeguarding have ensured engagement with the Board with the Head of Quality Assurance identified as BCUHB's Single Point of Contact. An agreement that two (2) members of staff will represent BCUHB within the agreed Task and Finish Group to address concerns raised, all members are independent of the Holden report and activity. The Safeguarding Board identified Multi-agency partners and the initial meeting will commence from May 2021.

7. Risk Management and the Corporate Risk Register

7.1 Corporate Safeguarding currently record that there is a risk that the Health Board does not discharge its statutory and moral duties in respect of Safeguarding concerning Safeguarding Adults / Children / Violence against Women, Domestic Abuse, Sexual Violence (VAWDASV), the wider harm agenda and the Deprivation of Liberty Safeguards (DoLS).

7.2 This risk may be caused due to the failure to develop and implement suitable and sufficient safeguarding arrangements, develop an engaged and educated workforce and provide sufficient resource to manage the demand and complexity of safeguarding activity

7.3 The current Corporate Safeguarding risk rating is recorded as 16 with a target risk of 12.

7.4 Safeguarding have added Level 3 compliance reporting to the Corporate Safeguarding Risk Register as it cannot be accurately reported by ESR. Current Risk Score is 6 .Mental Health and Learning Disability Division (MHLD) have mitigated this risk by collating Level 3 training compliance from attendance registers and report compliance into the MHLD Safeguarding Forum.

7.5 The change in the risk reduction has not yet been achieved. This is a direct result of the challenge posed by the COVID-19 Pandemic and following the National Welsh Government guidance relating to social distancing and face-to-face contact. As an immediate response, corporate safeguarding have introduced more flexible working and training methods to support the health board.

8. Conclusion

8.1 This report provides an overview of the ongoing Safeguarding activity 2020-2021. The development and implementation of improvement plans to safeguard the patients, staff and organisation as a whole.

8.2 Following an initial reduction in Adult at Risk Reporting noted at the beginning of the COVID-19 Pandemic Corporate Safeguarding undertook immediate actions to ensure that BCUHB Divisions and Services were reminded of their duty to be vigilant and report any appropriate concerns.

8.3 Trajectory of compliance and the identification of performance data within 2020-2021 has highlighted the challenges faced by the service during the COVID-19 Pandemic. However, the valued support, advice and guidance given by the Corporate Safeguarding team demonstrates the commitment of the staff and the service.

8.4 Bespoke training sessions, awareness raising sessions, individual and group adult supervision, promoting the role of the safeguarding ambassadors, and direct links to safeguarding legislation, documentation, policy and procedures via the BCUHB intranet webpages contributed to the activity taken.

8.5 2020-2021 identified that the business case to the Patient, Quality Safety Group and position update in relation to the HASCAS 8 / Ockenden 6 recommendation is paramount to mitigate risks to patients, staff and organisation. This relates specifically to the Corporate Teams staff resource due to the increased demands, specifically MHLD Divisional Support and the implementation of new legislation to include the Liberty Protection Safeguards (LPS).

8.6 It is envisaged the proposed structure would provide additional assurance against specialist strategic, operational and administrative activities. This is based upon the recognised activity data, and reported risks relating to the Deprivation of Liberty Safeguards and increased high risk and complex activities within the MHLD Division.

8.7 The report highlights updated priority activities for 2021 -2022 to confirm full organisational engagement, ensuring BCUHB continue to strive, to fully implement the changing and challenging face of safeguarding across these priority areas.

**Safeguarding Children at Risk, Safeguarding Midwifery
and Violence Against Women, Domestic Abuse
and Sexual Violence (VAWDASV)**

1. Introduction

1.1   This Annual Report (April 2020 – March 2021) provides an overview of progress made in relation to the activities and priority actions highlighted in the Corporate Safeguarding Annual Report 2019-2020.

1.2   Appendix (ii) is specific to these three areas, Safeguarding Children at Risk, Safeguarding Midwifery and Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV).

1.3   It also sets out additional strategic priorities, for these three areas, strategically driven by the Corporate Safeguarding Team for 2021-2022, demonstrating their commitment to continual improvement.

1.4   The report includes the time period of the current COVID-19 pandemic, including the lockdowns, which has influenced some of the data findings and safeguarding activities.

1.5   The reporting framework is based using the key domains of the National Safeguarding Maturity Matrix – Governance and Rights Based Approach, Safe Care, ACE Informed, Learning Culture and Multi-agency Partnership Working.

2. Governance and Rights Based Approach

Rationale

2.1   There should be a clear line of accountability, without doubt or ambiguity about who is responsible at every level for the well-being and protection of children. The UNCRC states that children should be free from abuse, victimisation and exploitation. The environments where children are treated should be safe, secure and child friendly.

Safeguarding Children at Risk

2.2   Safeguarding Maturity Matrix (SMM)

2.2.1   The Safeguarding Maturity Matrix (SMM) is a quality outcome monitoring tool with the aim of capturing and collating a national SMM providing assurance, shared practice and drive improvements towards a 'Once for Wales' consistent approach to safeguarding.

2.2.2   The SMM is a self-assessment of safeguarding arrangements by each Health Board/Trust. The five standards assessed are Governance and Rights Based Approach, Safe Care, ACE Informed, Learning Culture and Multi Agency Partnership Working. The highest achievable score is 5 for each standard giving a total score of 25.

2.2.3   BCUHB achieved a score of 14 in 2018, a score of 23 in 2019 and a score of 25 in 2020. This demonstrates excellent continued progress and was achieved by evidencing service quality improvements, full engagement in multi-agency arrangements and demonstrating good examples of evidenced based learning.

2.2.4   Contributing to this work BCUHB are able to inform the national picture report through the NHS Safeguarding Network to the Chief Nursing Officer in Welsh Government.

2.2.5   In 2021-2022, an All Wales Task and Finish Group will review the Safeguarding Maturity Matrix to ensure it remains fit for purpose.

2.3   Children at Risk – Performance Reporting

2.3.1   A total of 3116 child at risk reports generated by health professionals in BCUHB, were received in 2020-21.This averages at 260 per month. This is an 11% increase on the total from 2019-2020 (April omitted as start of data collection was in May 2019). Figure 1 identifies the total number of child at risk reports, by month, from May 2019 to end of March 2021. The graph reports a lower and upper control limits and median line to provide an overview of any trends and highlights the period of Wales's lockdowns.

Figure 1 - Number of Child at Risk Reports (May 2019 – March 2021) with Wales's lockdowns highlighted.
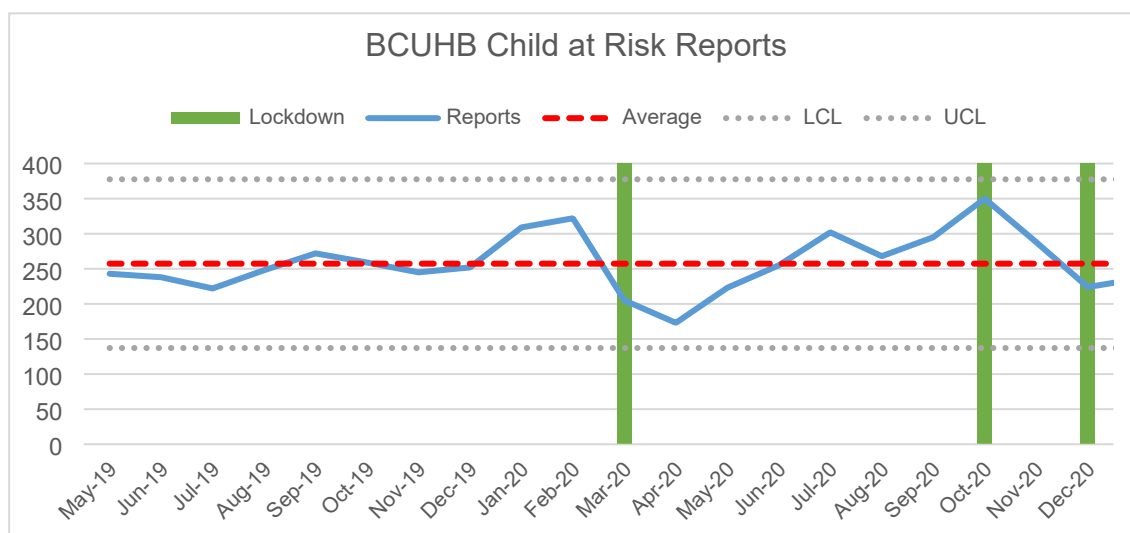
2.3.2   Following the first lockdown on the 23rd of March 2020, there was a reduction in the number of child at risk reports in the West and Central Area. The East area has seen an overall increase in child at risk reports.

The decrease in child at risk reports could be attributed to a reduction in the number of children accessing the Emergency Departments and a change of practice and overall reduction of face-to-face working arrangements, by predominately community staff and the closure of schools.

2.3.3   This local picture also represented a national picture across Wales, with many agencies voicing the impact of COVID-19 being due to social distancing measures, associated issues and families' disengagement with services or the avoidance of services.

2.3.4   During this period, good multi-agency working was adopted between BCUHB Children's Services, Local Authority Children's/Education Services and Corporate Safeguarding to ensure a co-ordinated approach was implemented to continue to safeguard children. Weekly multi-agency meetings were held.

2.3.5   A good example of partnership working, during the pandemic, was the development of Safeguarding Partnership Meetings in the West. These included representation from Local Authority, School Nurse & Health Visitor Managers, CAMHS Manager, Corporate Safeguarding and Substance Misuse Midwife. All agencies provide service updates enhancing collaborative partnership working.

2.3.6   The reporting numbers have since increased from June to October 2020 to a higher than the monthly average. This is since COVID - 19 lockdown restrictions have been eased and children have returned to school. The associated risks of this data is that children might have been harmed during lockdown but only had the opportunity to disclose when services resumed. Health services must be vigilant in accessing children and young people and maintain services at all times recognising their statutory responsibilities.

2.3.7   Following the firebreak in October 2020, there was a reduction in child at risk reports but this reduction was not as noticeable when compared to the first lockdown. In April 2020, the number of child at risk reports had reduced to 175 whereas in December 2020 the numbers were on average 225.

2.4   Reports by Location and Report-Makers Designation

2.4.1   For 2020-2021, the number of reports from the community total to 1539 and those from the acute sites total to 1566. These areas are now comparable compared to Q1&2 2020-21, community made up (44%) and those from the acute sites (56%). This demonstrates the number of reports have increased in the community setting in Q3 &4 2020-2021 which could be due to more children being seen as services resumed.

2.4.2   The highest reports to children's safeguarding in 2020-21 were:

- Emergency Department (ED) – 29%
- Midwives – 17%
- Health Visitors – 16%
- CAMHS – 8%

2.4.3   The highest report-makers in 2020-21 have been ED (29%) even after a reduced number of child at risk reports around April/May 2020. Although in comparison to 2019-2020 this is a reduction from 35%, whereas Midwives, Health Visitors and CAMHS remain much the same.

Co-ordinated approaches have taken place to ensure practitioners are regularly reviewing safeguarding cases and to consider safeguarding children remains a priority in the new virtual world. This includes an increase in safeguarding supervision and educating practitioner to always be vigilant of the associated risks of harm and abuse to children and young people.

2.4.4   Almost half the reports to date are generated from the East area (n=1711, 55%) as demonstrated in Figure 2. In 2020-2021, there has been an overall decrease in the number of child at risk reports from the Central area compared to data in 2019-2020. This reduction is within the under 5's and 5-10 year old age groups.

Figure 2 – Child at Risk Reports by Area
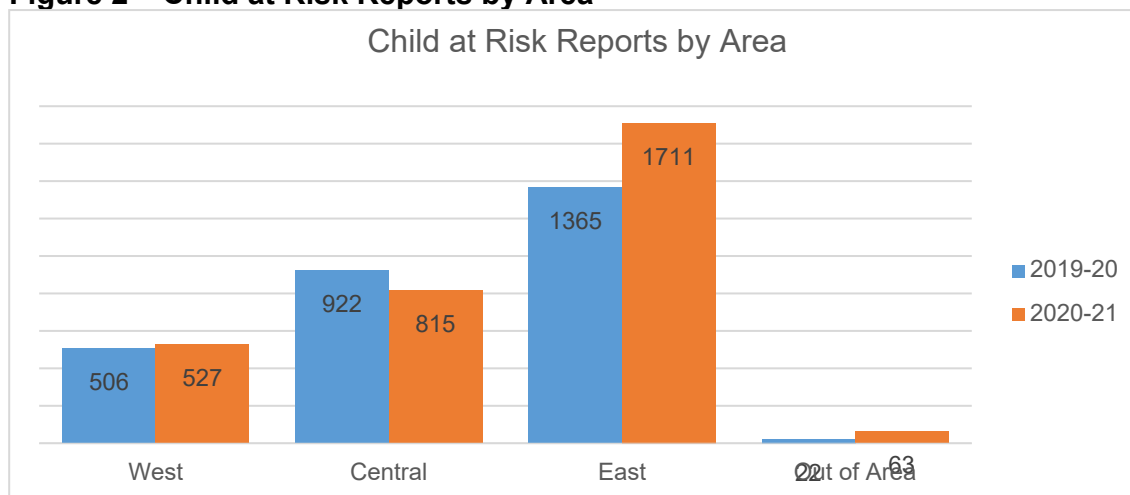
Figure 3 – Child at risk reports per 10,000 under 18 population

2020-21	Under 18 Population	Reports	Reports per 10,000 Under 18
West	36,720	527	143.5
Central	40,728	815	200.1
East	61,380	1711	278.8

2.4.5   When analysing the reports per 10,000 under 18 population the West still has the lowest number of reports with the East having the highest.

2.4.6   The age group with the highest number of reports is the under-five age group where each area saw the most reports relating to this age group. A third of the reporting total are in this age group alone (32%). A breakdown of reports by age groups in 2020-21 is given in Table 1.

Table 1. Child at risk reports by age group

Age Group	Unborn	<5	5-10	11-15	16-18	Not Recorded	Total
2019-20	337	920	463	663	374	58	2815
2020-21	415	1006	494	711	407	83	3116

2.4.7   In 2020-2021, 40% of the unborn reports are from the East, 37% from Central and 21% from the West. More than half of the child at risk reports from the West and Central areas are for children under 5 years old and the unborn (52% and 54% respectively). These findings can conclude that Midwives and the Safeguarding Team in the East and Central are actively involved in supporting safeguarding issues affecting the unborn. Equally, in the West and Central areas safeguarding issues will involve the team supporting Health Visitors and Acute Services. This data allows the safeguarding team to target education and interventions.

2.4.8   Nearly two-thirds (64%) of all the older aged children (11+year olds) child at risk reports are generated from the East alone. These findings can conclude that School Nurses, CAMHS and Acute Services are involved in the majority of safeguarding children activity in the East. This data allows the safeguarding team to target education and interventions.

2.4.9   The West area has seen a spike in reports from children under 5 years old (35% of the areas total) but the numbers across the other age groups are similar.

Figure 4. Child at risk reporting heat map

2.4.10 This graph provides a heat map of the children's residency where child at risk reports have been generated. It clearly highlights the hot spots of Wrexham, Rhyl, Colwyn Bay, Bangor, Caernarfon and Holyhead. This data supports the safeguarding team and wider service areas, in the identification of the exceptionally high levels of safeguarding children activity, in certain areas and to be able to target resources to meet the demand.
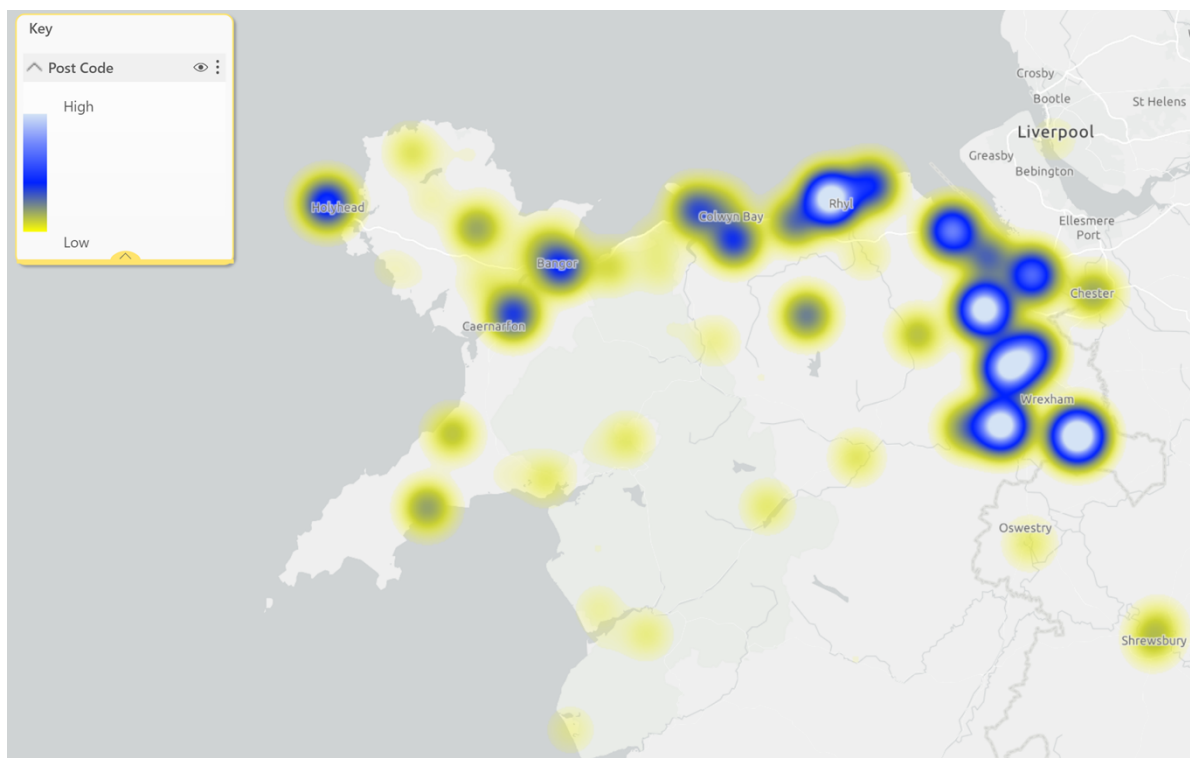
2.5   Themes of Abuse

2.5.1   The main themes that emerge from the child at risk data in 2020-21 is that older children are more susceptible to emotional abuse and younger children to neglect. While it appears to be the case that children and young people are less susceptible to physical illness from COVID-19, there is growing concern about the impact of the pandemic on young people's mental well-being. This data is supported by the "NSPCC Childline Supporting Children and Young People during the Coronavirus Pandemic – April to June 2020" where mental and emotional health was the main concern children spoke about. The second main concern was suicidal thoughts and feelings and the third and fourth were family relationships and self-harm respectively.

2.5.2   This gives BCUHB rich data to be able to develop their safeguarding training plan to include these areas of high concerns that children and young people are experiencing, and ensure staff are appropriately trained to respond.

2.6   Outcomes of Child at Risk Reports

2.6.1   Current outcomes of child at risk reports received are 41% for West, 42% for Central and 19% for East. The percentage of outcomes has increased across all areas but good communication is still required between Areas Safeguarding Managers and Children's Services to monitor the agreed processes.

2.6.2   886 outcomes have been received in 2020-21 of which 604 (68%) required no further action. These findings could conclude that the child at risk report was considered by Children's Services and deemed to require further information due to quality issues, did not meet the threshold for further interventions or the family had adequate support.

2.6.3   Of the remaining 282 (32%) outcomes included: child already open to Children's Services, advice/assistance was given, referred to other agencies, allocated for a Section 47 investigation and referred for a Care and Support assessment. Further work will be completed with the Local Authorities to align the outcomes to the Wales Safeguarding Procedures 2019.

2.6.4   To analyse this further, a retrospective audit has been conducted to review the quality of child at risk reports received from West, Central and East areas. Thirty (30) reports were randomly selected from 173 reports in April 2020.

2.6.5   **Key findings include:**

- ***If Child Protection has been identified is the detail of the risk(s) of abuse, harm or neglect to the child been completed*** –of the 21 'yes' answers, 15 were of good quality, 3 were unsatisfactory and 3 were of poor quality.
- ***Have any Adverse Childhood Experience's (ACE's) been identified*** – 20 reports had no documented evidence of ACE's, 8 were of a good quality and 2 were of a poor quality.

- *Have the views of the child/young person and family been captured* – 21 reports had no documented evidence in this section. All the reports (10) reviewed from the East had no documented evidence.
- *If consent is required, has this been completed* – 18 reports had no documented consent with the East area making up 8 of the reports.
- *Reviewing the report in its entirety, would it be classed as poor/satisfactory or of a good quality (Figure 5)* – 8 reports were of a poor quality, 10 were satisfactory (lacked relevant detail) and 12 were of a good standard.

Figure 5 – Reviewing the report in its entirety, would it be classed as poor, satisfactory or of a good quality

Figure 6 – Breakdown of quality of reports by staff groups
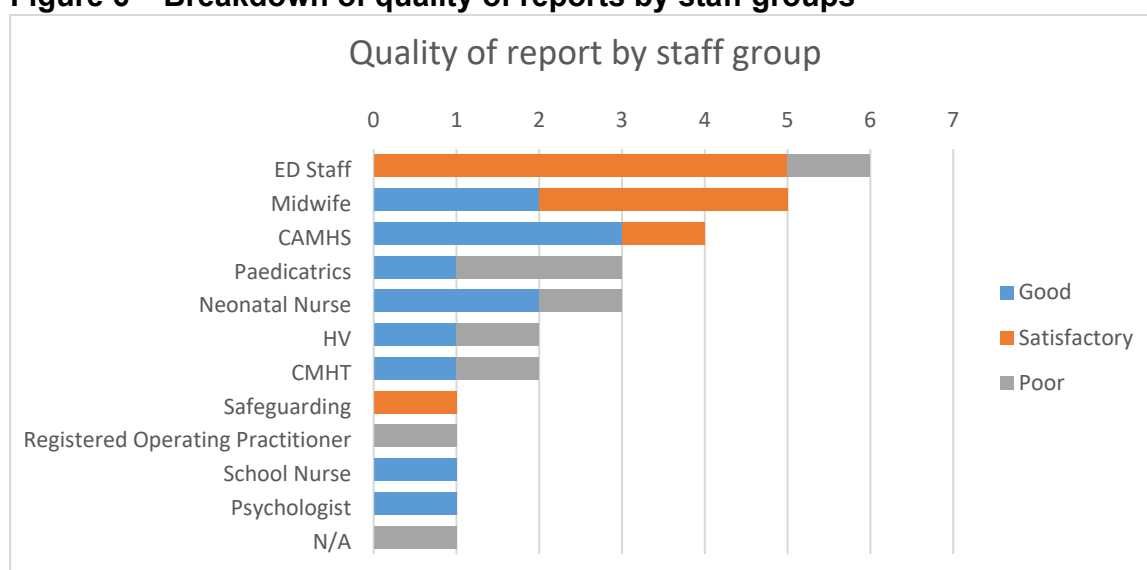
2.6.6   As reported in 2.4.2, the highest number of report makers are ED, Midwives, Health Visitors and CAMHS. All of the reports reviewed by Midwives and CAMHS were either good or satisfactory with the other staff Groups' evidencing some poor quality reports.

2.6.7   The sections consistently not completed were ACE's. Consent if required and the 'what matters' section. ACEs such as exposure to domestic abuse, substance misuse and mental health illness are known to have a direct and immediate effect on a child's health.

Equally gaining the views of the child, parents and carers adds richness and quality to the report and can influence decision making and interventions.

2.6.8   Failure to complete all the relevant sections on a child at risk report could fail to further safeguard children and young people and BCUHB staff will fail in their statutory duty to report under the Wales Safeguarding Procedures 2019. The initial findings will be shared in safeguarding supervision and training sessions and in relevant forums. A larger scale audit of child at risk reports will be completed in 2021-2022.

Priority Action 1a & b - Children at Risk 2021-2022

1a) Implement the initial findings from the retrospective audit of child at risk reports 2020-2021	December 2021
1b) Conduct a larger scale regional retrospective audit of the quality of Child at Risk Reports	March 2022

2.7   Section 47 Child Protection (CP) Medical Examinations

2.7.1   Community paediatricians continue to be available every weekday, on a rota system for Section 47 CP medical examinations at the request of North Wales Police or Social Services. These take place across BCUHB in each of the three areas.

2.7.2   In 2020-21 there have been 227 examinations carried out across BCUHB. This shows a reduction in the number of examinations compared with 2019-2020 (n=277).

Figure 7. Child Protection medical examinations by area
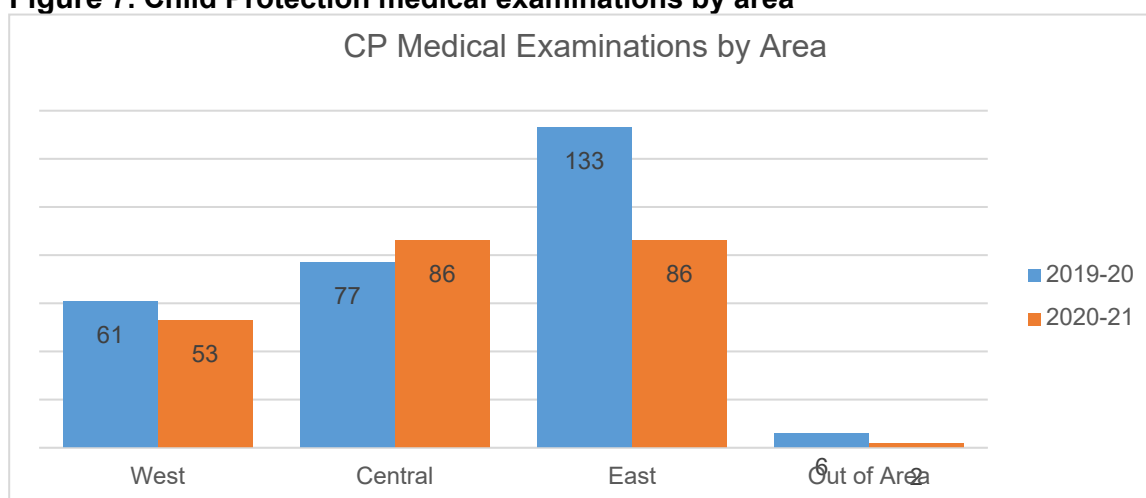
2.7.3   The biggest decrease is demonstrated in the East area of the Health Board. The Local Authority/Police refer for medical examinations as part of the safeguarding process. It is not a BCUHB generated activity.

2.7.4 Examinations for alleged physical abuse in 2020-2021 (n=190) remain the highest as in 2019-20 (n=197). The number of neglect cases has increased with a reduction in the number of sexual abuse cases.

Table 2. Child Protection Medical Examinations

	< 2 yrs.	2 - 4 yrs 11 mths	5 - 12 yrs 11 mths	13 - 15 yrs 11 mths	> 16 yrs	N/A	Total
Physical	48	56	67	13	3	2	189
Sexual In Hours	1	1	9	5	2	0	18
Neglect	1	6	6	1	0	0	14
Sexual Out of Hours	0	0	0	3	2	0	5
Total	50	63	82	22	7	2	226

2.7.5 Nearly all examinations for the under 13 year olds were carried out for alleged physical abuse. A rationale supports visual identification of harm, and a possible limited ability to articulate any other form of abuse.

2.8 Child Protection Peer Review Meetings

2.8.1 Monthly Peer Review meetings continue to take place in each of the three sites, East, Central and West. All paediatricians (Community and Hospital) are invited, cases are reviewed and uploaded onto a shared drive to enable sharing of learning across BCUHB.

2.8.2 Since COVID-19 meetings have been held virtually and attendance has improved. Consideration will be given to continuing this way of holding the meetings once BCUHB reverts back to normal patterns of working.

2.9 Safeguarding Children Supervision Sessions

2.9.1 Priority Activity 2 (2019-2020) has been developed and fully implemented across the Corporate Safeguarding Team in 2020-21, providing consistency of reporting and monitoring.

2.9.2 Safeguarding Supervision has continued during the COVID-19 pandemic with group sessions being delivered virtually or safely face to face. This blended approach of delivery has ensured consistency of attendance, which tends to include Health Visitors, School Nurses, Looked After Children (LAC) Nurses, CAMHS practitioners and Midwives.

Table 3 – Summary of safeguarding supervision compliance 2020-2021

Area	Individual Supervision -% compliant	Group Supervision – number of sessions	Group Supervision – number of attendees
Ynys Mon	89%	12 (West)	114
Gwynedd	90.7%		
Conwy	90.23%	11 (Central)	137
Denbighshire	92%		
Flintshire	81%	29 (East)	180
Wrexham	80.5%		

2.9.3   100% compliance was not achieved during 2020-2021 due to staff being redeployed to other service areas, sickness and those who were shielding due to COVID-19.

2.9.4   Themes for discussion have included: responses to COVID-19, Health Pre Birth Assessments and audit findings, Wales Safeguarding Procedures, neglect, Non-Accidental Injury (NAI's) and implications for practice and identified learning from reviews.

2.9.5   Examples of new initiatives include the development of monthly joint supervision with ED and Paediatric staff in YGC. In the East the Flintshire CAMHS Team have been supported with highly complex cases and in the West targeted safeguarding supervision sessions have been delivered to the Children's Unit, Special Care Baby Unit and ED. The sharing of learning and targeted support has been hugely beneficial in the improvement of better outcomes for children and families.

2.9.6   A regional evaluation audit of safeguarding group supervision sessions was conducted across all three areas. This audit was to inform supervisors of supervisees expectations, barriers to attendance, usefulness or not and use of outside speakers to improve session delivery. 332 questionnaires were sent to Health Visitors, LAC nurses, School Nurses and Midwives, with a return rate of 63 (21.2%).

2.9.7   Overall audit findings included: opportunity for reflection, opportunity to share good practice, aided communication, gained insight into other services from guest speakers and an opportunity to discuss cases.

2.9.8   Barriers to attending included: general workload, other meetings or on annual leave, not being aware of the session and information technology availability.

2.9.9   Recommendations include the development of a Task and Finish Group to review the delivery of current supervision sessions as restrictions are lifted following the lockdowns. The content and structure of the sessions will also be reviewed with a responsibility on staff to present cases to the group. This will enhance engagement and participation.

Priority Action 2 – Findings from the Regional Audit of Safeguarding Children Supervision (2021-2022)

Develop a Task and Finish Group to implement the findings of the Regional Audit of Safeguarding Children Supervision	June 2021

2.10   Safeguarding Supervision for School Nurses in Ruthin School

2.10.1 Due to high level safeguarding multi-agency concerns regarding Ruthin School, it was agreed for BCUHB to support the delivery of safeguarding supervision, to the three school nurses employed by the school.

2.10.2 A Service Level Agreement was developed between BCUHB and Ruthin School and this agreement was implemented on the 1st April 2020.

2.10.3   During the lockdown, which commenced in March 2020, all schools were closed, so no supervision sessions were required. In September, on the opening of schools, a safeguarding supervision session was delivered to the school nurses and further sessions have been arranged.

2.11   Wales Safeguarding Procedures 2019

2.11.1   The Wales Safeguarding Procedures were implemented in September 2020. In preparation, the Corporate Safeguarding Team developed an Implementation Plan with clear actions and timescales.

2.11.2   This included the preparation of BCUHB staff and contractors in having easy access to the Procedures, training around the implications to clinical practice, the review of all Procedures/Guidance/Documents and a review of the Safeguarding Homepage.

2.11.3   A BCUHB Child at Risk Procedure has been developed and ratified in November 2020. This is fully operational across BCUHB.

2.12   Children (Abolition of Defence of Reasonable Punishment (Wales) (Act) 2020

2.12.1   The legislation gained Royal Assent and became an Act on the 20th March 2020. The Act will be implemented on the 21st March 2022. This Act removes the defence of reasonable punishment if cases reach court.

2.12.2   The Head of Safeguarding Children attends the National Operation, Guidance and Training Group, looking at reviewing processes and updating guidance/training within organisations.

Priority Action 3 – Implementation of the Act across BCUHB (2021-2022)

To develop a Strategic Implementation Group with supporting working groups, to drive this agenda forward, ensuring BCUHB will be compliant with their statutory duties	February 2022

2.13   Ward Accreditations

2.13.1   Following a review of a Ward Accreditation Award, it was identified additional Safeguarding information was required to support the Reviewers in their assessment.

2.13.2   An agreed template capturing the relevant safeguarding activity and suggested questions is now provided prior to the review, providing consistency across all areas.

2.13.3   Corporate Safeguarding have completed the template in five Ward Accreditations relevant to Children/Women's in 2020-21.

2.13.4   In October 2020, a Guidance was developed to support the process of sharing safeguarding information supporting the Ward Accreditation Reviewers in their assessment.

2.14   Procedure for the Safeguarding of Children and Young People Admitted to Adult-Based Wards and Environments

2.14.1   Across BCUHB children and young people are admitted to adult-based wards and environments for various medical and surgical assessments/interventions. In 2020, a review highlighted a total of 600 children and young people were admitted.

2.14.2   The procedure ensures the health and well-being of children and young people, up to the age of 18 years, is promoted and safeguarded when they are cared for within what is traditionally viewed as adult-based wards and environments, across BCUHB.

2.14.3   The aim of the procedure is to gain assurance all health practitioners understand their role and responsibilities and provide guidance on identifying and escalating risks relating to children and young people on adult-based wards and environments.

3. ACE Informed

Rationale

3.1   Adverse Childhood Experiences (ACEs) such as exposure to domestic abuse, substance misuse and mental health illness are known to have a direct and immediate effect on a child's health.

3.2   The safety of the child and safety of the vulnerable adult are intrinsically linked; preventing early exposure can reduce the impact on children and future generations

3.3   Looked After Children (LAC)

3.3.1   The accountability and portfolio for the LAC Service sits within the Children's Division and outside of the Corporate Safeguarding Team. The Head of Safeguarding Children attends the quarterly LAC Team meetings to share up to date knowledge/good practice and learning regarding safeguarding. This ensure good two-way communication between both services.

3.4   Safeguarding Supervision data

3.4.1   The standard agreed for LAC Nurses is that they attend six monthly safeguarding supervision and have access to all group supervision sessions. Supervision Compliance Data 100%.

3.5   Exploitation

3.5.1   There are no current Child Sexual Exploitation (CSE) Operations being operated across North Wales.

3.5.2   In light of Section 6, Wales Safeguarding Procedures, the All Wales Practice Guidance on Child Sexual Exploitation (CSE), a Regional Safeguarding Children Board (RSCB) Task and Finish Group has been developed, to consider the implementation of a regional CSE Screening Tool.

This will provide consistency across all partner agencies in the identification of CSE in children and young people.

3.5.3   The National CSE Action Plan and the Tackling Child Sexual Abuse Strategy (2021) remains a priority action of the RSCB will full engagement from BCUHB.

3.5.4   Conwy Local Authority have piloted a Multi-agency Child Sexual Abuse (CSA) Practice Leads Programme. BCUHB have fully engaged with five health professionals attending. The Programme consisted of 10 days held over 10 months with sessions included: CSA in different contexts, working with children and young people who display harmful sexual behaviour, women who sexually abuse children and working with survivors.

3.5.5   The programme has enhanced participant's knowledge and skills, thereby improving their own practice and enabling them to develop their ability and confidence to disseminate learning across the team and organisation, and to support colleagues with CSA cases in order to influence change at a wider level.

3.5.6   A Multi-Agency Regional Action Plan will be developed hosted by the RSCB and a full evaluation will take place by the Centre of Expertise on CSA with commitment and engagement from BCUHB and their partners.

3.6   Child Sexual Abuse Round Table

3.6.1   This is chaired by the Children's Commissioner and attended by the Head of Safeguarding Children. Recent meetings has focussed on the impact of COVID – 19 on children and young people who are at risk of or have been sexually abused, with a particular focus on CSE and the services that support them and routine or longer term developments.

4. Learning Culture

Rationale

By promoting a positive culture of multi-agency learning to generate new learning organisations can support continuous improvements in service delivery and practice. Feedback in the NHS must be used to monitor and improve the quality of services.

4.1   Training

4.1.1   Due to the cancellation of face to face safeguarding training, the Corporate Safeguarding Team have embraced the use of technology to ensure the availability of training remains a priority during the COVID -19 pandemic.

4.1.2 Delivery of training incorporates blended teaching methods via voiceover presentations, skype and small social distanced groups. Level 1 and 2 Child at Risk sessions are available via NHS Wales E-Learning platforms through ESR.

4.1.3 As a result of COVID-19 face to face training modules are now accessible to the Safeguarding Team on Oracle Learning Management (OLM) system allowing the team to input training registers of those attending any virtual sessions. This has enabled the team to create classes and update staff compliance in a timely manner.

4.1.4 Level 3 training compliance is reported within Level 2 and this process is managed by the training team within Workforce and Organisational Development. As Level 3 cannot be accurately reported Corporate Safeguarding have added this to the risk register.

4.1.5 During May and June 2020, Child at Risk training sessions were delivered in the field hospitals to new or returning staff employed in a direct response to COVID-19.

4.2 Training Activity

Table 4 – Training Data for Safeguarding Children Level 1 and 2 – 2020-2021

Safeguarding Module	May-20	March - 2021	Trajectory
Safeguarding Children – Level 1	79.4%	79.3%	↓
Safeguarding Children – Level 2	77.5%	78.5%	↑

4.2.1 The overall compliance for Child at Risk Level 1 has seen a slight reduction in trajectory (0.1%) however; Child at Risk Level 2 compliance has seen an increase of 1%.

4.2.2 In the West the Safeguarding Children Level 1 has increased from 82% (May 2020) to 82.4% in March 2021. Central saw an increase from 77% to 79.4% with the East seeing a reduction in compliance from 79.7% to 78%.

4.2.3 In the West the Safeguarding Children Level 2 has increased from 77.9% (May 2020) to 80.3% in March 2021. Central saw an increase from 77% 79.3% with the East seeing a reduction in compliance from 78.8% to 77.2%.

4.2.4 There has been considerable COVID -19 pressures in the East which has had an effect on the areas safeguarding children's training compliance. Table 5

Division (March 2021)	Staff	Children L1	Children L2
Area Teams Central	2758	87.4% ↑	85.7% ↑
Area Teams East	2556	86.3% ↑	85.7% ↑
Area Teams West	1835	86.9% ↑	85.9% ↑
Corporate Services	8487	67.8% ↑	62.0% ↑
Estates and Facilities	1987	43.1% ↑	32.8% ↑
MHLD Services	2059	87.4% ↑	85.3% ↑
NW Managed Clinical Services	1468	83.2% ↑	80.9% ↑
Women's	835	91.9% ↑	92.2% ↓

Ysbyty Glan Clwyd	2130	79.0% ↑	74.9% ↑
Ysbyty Gwynedd	1900	82.5% ↑	80.2% ↑
Ysbyty Wrexham	1870	80.3% ↑	74.6% ↑
Average Compliance	27885	79.6% ↑	76.4% ↑

4.2.5   There are five (5) divisions over the required compliance of 85%, which are Area Teams Central, West and East, Women's and MH/LD. This is an excellent achievement in the current pandemic.

4.2.6   When comparing compliance data from October 2020, all areas have demonstrated an increase. Although Estates and Facilities and Corporate Services have improved their compliance is still well below the 85% target compliance. Workbooks have been developed to support staff who do not have access to IT.

4.2.7   YG Medical Staff working in ED compliance data has increased considerable from October 2020 to reach the target of 85% (Table 6). YGC and WMH Medical staff still requires improvement.

Table 6 illustrates compliance across the three BCUHB Emergency Departments that includes medical staff in 2020-2021.

ED Medical Staff March 2021	Staff	Childrens L1	Childrens L2
YG Medical Staff	48	85.4% ↑	85.0% ↑
YGC Medical Staff	42	64.3% ↓	60.0% ↓
WMH Medical Staff	40	52.5% same	48.0% ↑

4.2.8   Four (4) out of thirteen (13) GP Managed Practices have achieved the 85% target compliance with an overall compliance of 69.2% (Level 1) and 67% (Level 2). This is an area where improvements are required due to the level of contact GP's have with children and young people. All training information is shared via the safeguarding bulletin, GP's have access to the BCUHB Webpage and information is shared with the Primary Care Communications Team.

4.3   Child at Risk Level 3 Programme of Learning

4.3.1   Safeguarding Children at Risk Level 3 is co-ordinated via a 3-year training plan incorporating specific safeguarding topics identified from recommendations of child practice reviews and national reviews.

4.3.2   In 2020-21, there were 34 Level 3 Child at Risk training sessions delivered with 569 attendees. Topics included, Non-Accidental Injuries, Fabricated Illness, Neglect, Mental Health and Parenting and Lessons Learnt.

4.4   Deprivation of Liberty (DoL) 16/17 year old

4.4.1   In 2019, new case law was introduced which stated that, "parental responsibility for a child aged 16 to 17yrs of age does not extend to authorising confinement of a child in circumstances which would otherwise amount to a deprivation of liberty."

4.4.2   In essence, a parent cannot consent to the young person being deprived of their liberty if a young person lacks capacity. If DoL applies, an application to the Court of Protection takes place.

4.4.3   To ensure clinical staff have full understanding of this case law, a YouTube voiceover, training package has been developed and two power point training sessions have been delivered to Children's Services Managers.

4.4.4   Following feedback from staff in Children's Services a DoL 16/17 year old virtual workshop to discuss complex was delivered in November 2020 with good attendance and engagement from Children's Services.

4.5   Safeguarding Ambassadors

4.5.1   Staff have received training to equip them to be Safeguarding Ambassadors in their respective areas. This role importantly ensures all aspects of safeguarding is embedded into clinical areas and practice, by the dissemination of up to date procedures, legislation and knowledge.

4.5.2   In East 42, West 44 and in Central 25 staff received training in 2020-2021. This supports them to implementation role and responsibilities.

4.6   Child Practice Reviews (CPR)

4.6.1   During the period of this report there have been three (3) new cases commissioned by the Child Practice Review Sub Group – Flintshire, Conwy and Wrexham. The incidents include two child hangings and a death of a baby by drowning.

4.6.2   A Conwy CCPR was published in April 2021 with key learning/themes identified including disguised compliance/professional curiosity, coping with crying, parental substance use and its impact on parenting capacity and documentation. BCUHB will fully engage in the Action Plan.

4.6.3   A Wrexham CCPR was published in June 2020.There are no specific actions identified for BCUHB but key themes identified include working with families who display disguised compliance, hoarding and the need for professional curiosity. These themes are being discussed in group safeguarding supervision sessions to ensure learning is captured widely.

4.6.4   A Flintshire CCPR is awaiting publication. Key learning identified is the requirement of safety information regarding bathing of babies, parental substance misuse and impact on parenting capacity and relapse prevention during pregnancy for previous substance users. BCUHB have commenced the implementation of the recommendations.

4.7   Learning from Child Practice Reviews (CPR's)

4.7.1   Cardiff and Vale Child Practice Review
4.7.1.1 The Cardiff and Vale Safeguarding Board commissioned and published an Extended Child Practice Review (CPR) in 2016, following a death of a child. The CPR highlighted that there was a number of health contacts that could have provided an opportunity to safeguard this child.

4.7.1.2 As part of the CPR, an action plan was developed, and recommendation 3 of the action plan, requires that the Emergency Department (ED) hold a weekly safeguarding meeting, to consider head injuries and burns in children aged under one. This was extended to include fractures in children aged under two years old.

4.7.1.3 Following a pilot in the Emergency Department (ED) in YGC from February – April 2019 this activity was implemented in the ED's in Ysbyty Gwynedd and Ysbyty Maelor in January 2020.

4.7.1.4 Activity has been audited by reviewing 371 sets of notes from 1st January – 31ST December 2020:

- 270 (73%) of the cases were children presenting with head injury
- 68 (18%) of the cases were children presenting following a fracture
- 33 (9%) of the cases were children presenting with a burn

4.7.1.5 Wrexham Maelor Hospital made up the highest number of head injury cases (39%, n=105), Ysbyty Gwynedd saw the highest number of fractures (51%, n=35) and Ysbyty Glan Clwyd saw the highest number of burn cases (39%, n=13).

4.7.1.6 July 2020 saw the highest number of attendances in relation to this audit, 44 children presented across BCUHB – 18 at YG, 18 at YGC and 8 at WMH.

4.7.1.7 27% (n=48) of the audited notes had no evidence of safeguarding considerations documented between July and December 2020. This is an improvement from the 41% (n=78) of notes audited between January and June 2020.

Table 7 Breakdown of Cases with No Safeguarding Consideration by Hospital with Presenting Complaint – July to December 2020

Hospital	Head Injury	Fracture	Burn	Total
YG	7	4	0	11
YGC	3	0	0	3
WMH	27	4	3	34
Total	37	8	3	48

4.7.1.8 If a comparison is made from the above findings to the compliance training in Level 1 & 2 Child at Risk training, WMH medical staff have poor compliance – 52.5% and 48% respectively requiring urgent improvement to safeguard children.

4.7.2 Trauma Risk Management (TRiM)

4.7.2.1 Trauma Risk Management (TRiM) is a peer-led process that seeks to identify and assess the psychological risk to individuals who have experienced trauma in the course of their work.

4.7.2.2 Early identification of staff exposed to trauma, aids to promote a healthy workforce, by supporting the welfare needs of staff, and contributes towards reducing staff absence.

4.7.2.3 Following the introduction of the TRiM process, from the 4th May 2020 to end of March 2021 (11 months), there have been a total of 28 incidents referred.

4.7.2.4 The breakdown of the referrals per area is:

- Central – 14
- East – 6
- West – 8

4.7.2.5 The Divisions where the referrals have been generated are:

- Emergency Departments/Secondary Care Services –9
- GP Services – 1
- Community Services including Community Hospital/District Nurses -5
- General Medicine – 9
- Paediatricians – 2
- Pharmacy - 1

4.7.2.6 Eighty seven (87) staff have attended for a Trauma Incident Briefing (TIB) with a further thirteen (13) staff requiring a group/individual TRiM assessment.

4.7.2.7 A full quantitative and qualitative evaluation has taken place in 2020-21, to include feedback from staff, who have experienced the TRiM process. 76 evaluation questionnaires were disseminated with a return of 10 (13%). Although this is a poor response rate invaluable information was extracted.

4.7.2.8 Findings included:

- 80% attended Trauma Incident Briefing (TIB) and all found it beneficial
- 60% attended further assessment and all found it beneficial
- 90% had the support of their managers to attend
- 100% would recommend or signpost the TRiM service to a colleague

4.7.2.9 Qualitative findings - Examples are:

- *I was able to speak to the TRiM assessor and be truthful with how I was feeling and how I have been affected.*
  The assessor was then able to listen to me and I felt comfortable with talking and being honest.
- *I was also given an opportunity to be referred to occupational health and also complete the emotional resilience training.*
- *Good opportunity for people from multiple teams to come together to discuss difficult cases, and to explore how they might be feeling. Good explanation of different feelings, and that it is ok to find things hard.*
- *It felt comforting to know that I wasn't on my own grieving for our colleague. Sharing the same pain.*

- *I think I am the first radiographer to have attended one of these meetings and I found it very beneficial as I felt part of a team. I would like the invitation to be extended to my Colleagues in radiology as we are present for all trauma patients who come to ED and participate in their care.*
- *I feel that myself and other members of the team may have gone off sick if we had not had this valuable support. The team, once contacted were professional, understanding and supportive.*
  They should be given a higher profile within the health board.

4.7.2.10 Suggestions to improve the service included, the service should be promoted more, difficult to signpost to Occupational Health as there are long waiting lists to be seen and would prefer face to face assessment rather than on a virtual platform.

4.7.2.11 Eight staff from Corporate Safeguarding will complete the TRiM Practitioners training in May 2021 giving additional resources to the process

4.7.3 Mid and West Wales Safeguarding Children Board Concise Child Practice Review

4.7.3.1 This report was published in early 2020. The Head of Safeguarding Children and the Specialist Safeguarding Midwives are leading on this activity and have developed a BCUHB Action Plan.

4.7.3.2 A Task and Finish Group was developed. Membership included: Health Visitors, Learning Disability Team, Complex Need Team, Speech and Language Therapists and Safeguarding. The purpose was to develop a training package for Midwives and Health Visitors to raise awareness and training on the subject of learning disabilities/difficulties and the potential effect on parenting capacity.

4.7.3.3 In April 2021, the training package, following consultation, has been agreed and will form part of the Safeguarding Children Level 3 programme.

4.8 A Guide to Responding to a Single or a Cluster of Suicides in Children and Young People

4.8.1 This Guidance was developed by the Steering Group of the North Wales Suicide and Self-harm Prevention Group and was finalised in June 2020. It sits within the governance processes of the Child Death Overview Process, the North Wales Safeguarding Children Board Policies and Procedures and the North Wales Suicide and Self-Harm Prevention Plan.

4.8.2 The document brings together useful resources to respond to suspected death by suicide. It also provides information on identifying and responding to suicide clusters in children and young people.

4.9 Datix Incidents

4.9.1 The new Datix Safeguarding section was launched on the system in June 2020.

4.9.2   This guides the practitioner, in closely considering if the incident is linked to safeguarding, by asking specific questions ensuring an appropriate response.

4.10   Single Unified Safeguarding Reviews (SUSR)

4.10.1 This is a National activity being driven by the Welsh Government with the aim of bringing Domestic Homicide Reviews, Adult and Child Practice Reviews and Mental Health Homicides Reviews into one single safeguarding review.

4.10.2 The aim is for a more centralised, proactive and structured approach to facilitate learning from reviews. This approach will support families who previously might have been involved in more than one review.

4.10.3 Four Task and Finish Groups have been established: Policy/Process, Legal/Governance, Learning/Training and a Central Repository/National Library. The Corporate Safeguarding Team are fully engaged.

5. Multi Agency Partnership

Rationale

The protection and safeguarding of vulnerable adults relies on multi-agency working and effective information sharing; working together to improve services and outcomes for all.

5.1   Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

5.1.1   The North Wales Safeguarding Children's Board provides the governance arrangements around the PRUDiC process within North Wales. All cases are monitored through the Regional Child Practice Review Sub Group.

5.1.2   The PRUDiC Standard Operating Procedure (SOP) has recently been reviewed, and strengthens communication and process with out of area hospitals, for those children who unexpectedly die outside of North Wales.

5.1.3   On looking at the themes: four babies were found unresponsive in their cots, another baby suffered a cardiac arrest, a 13 year old, a 10 year old committed suicide by hanging, a child aged 14 years suffered a cardiac arrest, and a 17 year old died following a Road Traffic Accident (RTA).

Table 8 – PRUDiC Cases – Annually 2018-2021

Year	West	Central	East	Total	
2018-19	2	4	8	14	⇩
2019-20	3	7	4	14	
2020-21	2	4	3	9	

5.1.4   There is a considerable reduction in the number of unexpected deaths in children during 2020-2021. It is difficult to make any correlation to COVID-19.

5.2   Child Death Overview Panels (CDOPs)

5.2.1   The CDOPs continue to take place across North Wales in each of the three areas. They are well attended by senior management from all agencies responsible for safeguarding children.

5.3   North Wales Protocol for the Management of: Complaints Relating to Child Protection Conferences

5.3.1   Stage 2 – Formal Complaint of this protocol was instigated in September 2020. The Head of Safeguarding Children BCUHB was a member of the Inter-Agency Conference Complaints Panel demonstrating good engagement from BCUHB. The learning outcome identified for BCUHB was to remind all Health Visitors/School Nurses to discuss their Conference Reports with parents prior to the Conference.

5.4   Mothers and newborn babies requiring 24-hour supervision on Maternity Units when safeguarding concerns have been identified.

5.4.1   When an unborn is deemed to be at risk of harm, Local Authorities cannot apply for an Interim Care Order until the baby is born. The consequence of this is a delayed discharge and subsequent financial costs to BCUHB.

5.4.2   Discussions have taken place between Welsh Legal and Risk and the legal representative for the Regional Safeguarding Children Board. A solution to this has yet to be agreed.

5.4.3   This issue has been identified as a risk and has been added to the Women's Division and Corporate Safeguarding's Risk Register.

5.5   Multi- Agency Working with Partners

5.5.1   Multi-agency engagement is a statutory requirement of BCUHB. The Corporate Safeguarding Team have achieved 100% attendance at statutory Safeguarding Boards and Sub Groups. The level of required engagement is high with the requirement of full participation and contribution to the Work Plan.

5.6   Under 18s assessed for Section 136 Assessments

5.6.1   In 2020-21 there have been thirty four (34) under 18's assessed under Section 136 of the MHA. This is a reduction from 38 in 2019-2020. The ages ranged from 14-17 years.

5.6.2   Table 9 highlights the outcomes – 9 children were admitted to hospital in 2019-2020 compared to 13 children in 2020-2021, demonstrating a higher number of children presenting with a serious mental illness.

Table 9 – Under 18's assessed under Section 136 April 2020 – November 2020

Area	Number	Age Range	Outcome
East	12	14-17 years	
Central	6	14-17 years	
West	16	14-17 years	
Total BCUHB	34		**1** Discharged – no mental disorder **3** Discharged – referred to services **16** Discharged – follow up services **13** Admitted **1** Section Lapsed

5.6.2 Due to a number of incidents not reported to safeguarding, the S136 Clinical Pathway and the Notification Form was updated, with the addition of sections relevant to safeguarding, to be completed by staff in MHLD. This has improved communication/information sharing between the MHLD Division and Corporate Safeguarding.

5.7 Liberty Protection Safeguards (LPS) 16/17 year olds

5.7.1 DoLS authorisations only authorise the actual deprivation of liberty, whereas LPS authorisations authorise the arrangements for care that give rise to the deprivation of liberty. This is an important distinction, since the new process focuses more on the support and care of the child.

5.7.2 The Head of Safeguarding Children attends the National LPS 16/17 year olds meetings. The key areas discussed include: promoting an understanding of roles and responsibilities, communications, information and supporting materials, training and data monitoring/reporting and mapping of the Articles of the UNCRC particularly relevant to LPS.

Safeguarding Midwifery

6. Learning Culture

6.1 Health Pre Birth Assessment (HPBA) Audit

6.1.1 Following on from the 2019-20 HPBA Audit a follow up audit for 2020-2021 took place to compare performance.

Table 10 – Findings from the HPBA Audit 2020-2021 comparing with findings in 2019-2020

BCUHB	HPBA completed between 12-30 weeks of pregnancy	Good quality HPBA	Written consent for completion and information sharing	HPBA populated with name and ID number	Signed by both MW & HV	Evidence of Review	Evidence of HPBA shared with LA
Q1 2019-20	100%	74%	41%	37%	70%	19%	56%
Q2 2019-20	89%	78%	44%	33%	94%	7%	56%
Q3 2019-20	85%	85%	89%	52%	85%	41%	52%
Q4 2019-20	67%	96%	93%	74%	81%	52%	74%
Q1 2020-21	70%	89%	89%	37%	67%	48%	52%
Q2 2020-21	78%	85%	89%	59%	67%	41%	30%
Q3 2020-21	85%	96%	100%	56%	96%	41%	52%
Q4 2020-21	85%	89%	93%	52%	81%	52%	59%

6.1.2   Targeted compliance requires 85% of HPBA's to be completed between 12-30 weeks of pregnancy.

6.1.3   The quality of the assessments are better in the West and Central than in the East. This has been highlighted to Team Leaders to quality assure prior to sending to Local Authority.

6.1.4   Written consent for completion and information sharing has improved significantly in 2020-21 to 93% compared to 41% in Q1 2019-20.

6.1.5   The West area documented 100% of their notes signed by both the midwife and health visitor in 2020-202.

6.1.6   Improvements are still required in evidencing a review but there has been significant improvement from 19% in Q1 2019-2020 to 52% in Q4 2020-2021.

6.1.7   Improvements are still required in evidencing of sharing HPBA with Local Authority - 59% in Q4 2020-2021.

6.1.8   The HPBA and the accompanying Guidance has been reviewed and amended to support midwives/health visitors.

6.1.9   The HPBA audit findings are shared on a quarterly basis at the Women's Divisional Group and Children's Services Group to ensure learning and improvements can be made following each quarter. The findings are also discussed in team leader meetings, safeguarding supervision sessions and shared via the Safeguarding Bulletin.

6.2   Female Genital Mutilation (FGM)

6.2.1   Female Genital Mutilation (FGM) is a criminal offence as set out in the FGM (2003) in England, Wales and Northern Ireland. It is child abuse and a form of violence against women and girls, and therefore must be treated as such.

6.2.2   All health staff have a safeguarding obligation to identify the potential for and cases of FGM, in addition to the mandatory duty to report for regulated professionals in line with the Serious Crime Act (2015).

6.2.3   BCUHB provide quarterly reporting FGM data to Welsh Government.

Table 11 – FGM reports annual comparison 2017 – 2021

Year	Cases	
2017-18	6	⬇
2018-19	5	
2019-20	5	
2020-21	1	

6.2.4   There has been one (1) case of FGM reported in 2020-21.

6.2.5   The FGM Action Plan has been updated but targeted training in high-risk areas has been paused due to COVID – 19. Women's Division have identified two Consultant Obstetricians/Gynaecology to lead on FGM and In April 2021 a Safeguarding Midwifery Lead commenced in post with FGM accountability within her portfolio.

6.3   Coping with Crying Guidance

6.3.1   Non-accidental Head Injury (NAHI) remains the most common cause of fatal maltreatment in infants. At least half of the infant survivors will have significant neurological impairment. Crying is considered as being a key trigger for NAHI.

6.3.2   The Coping with Crying Guidance has been ratified and now includes external and internal links to the NSPCC Film, providing wider access for parents, carers and professionals.

6.3.3   A recommendation from a recent Child Practice Review highlights the need for the auditing/assurance of compliance with the Coping with Crying Guidance. This will be led by the Women's Division with support from the Safeguarding Midwifery Lead.

Priority Action 4 – Audit of the Compliance with the Coping with Crying Guidance (2021-2022)

Women's Division to lead, with support/engagement from the Safeguarding Midwifery Lead, on an audit of compliance with the Coping with Crying Guidance	December 2021

6.4   Safeguarding Supervision

6.4.1   As part of the Safeguarding Maturity Matrix Improvement Plan 2019-2020 the Corporate Safeguarding Team agreed to extend the provision of formal safeguarding supervision to midwives and other health practitioners across the Health Board. In July 2019, it was agreed to offer the Women's Division group supervision sessions similar to the ones offered to Health Visitors and School Nurses.

6.4.2   The uptake of safeguarding supervision by midwives was poor in Q1&2 (2020-21) instigating a review by Corporate Safeguarding and the Women's Division. New key performance indicators (KPI'S) have been agreed and incorporated into an improvement plan.

6.4.3   By Q4 2020-2021, the uptake of safeguarding supervision has seen an improving picture but this still requires commitment/engagement to provide sufficient assurance that the agreed KPI's are being met.

Priority Action 5 – Midwifery Safeguarding Supervision (2021-2022)

To review the safeguarding supervision database, monitor and demonstrate an improvement in safeguarding supervision compliance for midwives	March 2022

6.5   Midwifery Safeguarding Children Level 3 Training.

6.5.1   Due to the first part of the COVID-19 pandemic, all face-to-face midwifery mandatory training was cancelled. Corporate Safeguarding mitigated against this risk by producing an Interim COVID 19 Safeguarding Children Level 3 Midwifery training, by filming a power point presentation with voiceover and completion of an assessment.

6.5.2   Since January 2021, the Safeguarding Specialist Midwives have delivered a 4 hour Level 3 training via Microsoft Teams. The theme is Exploitation and Child Sexual Exploitation. A total of eleven (11) sessions have been delivered in 3 months. Evaluations remain positive.

6.6   Pre-Birth Pathways

6.6.1   The Wales Safeguarding Procedures 2019, made changes to the registration of the unborn in that they cannot be placed on the Child Protection Register until birth.

6.6.2   Corporate Safeguarding have engaged with Conwy, Denbighshire and Wrexham in developing a Pre-Birth Pathway.

6.6.3   Full engagement with the Regional Safeguarding Children Board has taken place to review the North Wales Multi-agency Pre Birth Pathway Procedure.

6.7   Information Sharing with Shrewsbury and Telford Hospital NHS Trust

6.7.1   A high proportion of women (on average 80) from Shropshire choose to deliver their babies in Wrexham Maelor Hospital. The Safeguarding Specialist Midwife East identified, information sharing, especially safeguarding information between the two organisations, required improvement.

6.7.2   In September 2020, meetings commenced between BCUHB Corporate Safeguarding, the Named Midwife and Community Team Leader's in Shropshire to commence the development of a Standard Operating Procedure, communication pathway and to establish regular meetings to discuss safeguarding cases.

6.7.3   This activity will improve patient safety and provide a mechanism for good communication.

6.8   Thematic Review of Stillbirths in BCUHB 2019

6.8.1   In 2019, there was a sudden and unexpected rise in stillbirths in BCUHB which instigated a Thematic Review.

Table 12 – Shows the rates of Stillbirths since 2015.

Year	England And Wales Stillbirth Rate	Wales Stillbirth Rate	BCUHB Total Births	BCUHB Number Of Stillbirths	BCUHB Stillbirth Rate
2015	4.5	4.7	6727	21	3.12
2016	4.4	4.44	6650	26	3.90
2017	4.2	3.99	6594	13	1.97
2018	4.1	Not available	6602	22	3.3
2019	Not available	Not available	6322	28	4.4

6.8.2   The Head of Safeguarding Children and the Named Doctor Safeguarding Children participated in the review, focussing on the safeguarding issues identified.

6.8.3   There is strong evidence in research to suggest a link to domestic abuse in pregnancy and stillbirths and thus it is imperative Routine Enquiry Domestic Abuse (RE DA) is completed. For eight mothers RE DA was not undertaken.

6.8.4   One of the nine recommendations of this review stated that RE DA must be fully embedded within midwifery practice and there should be clear documentation as to why RE DA cannot be carried out.

6.8.5   The Audit of RE DA during Pregnancy 2020-21 (7.7.1, p 28) will fully support this recommendation.

6.8.6   The audit findings were presented to the Regional Safeguarding Children's Board in February 2021 providing assurance.

6.9.   Child at Risk Reports

6.9.1   Table 13 shows the number of Child at Risk Reports generated by midwives in the antenatal and postnatal period.

Table 13

Midwives Reports	Unborn	<28 days	Total
West	83	9	92
Central	147	22	169
East	135	39	174
Out of Area	4	2	6
Total	**369**	**72**	**441**

6.9.2   East and Central midwives generate the majority of Child at Risk Reports, which demonstrates the greater additional resources required by the safeguarding specialist midwives in those areas.

6.9.3   Due to the consistent year on disparity in safeguarding activity across the region, the Safeguarding Midwifery Lead will commence a service review of the Safeguarding Midwifery Service. Terms of Reference were agreed. Staff engagement from Corporate Safeguarding and the Women's Division will inform the review.

Priority Action 6 – Corporate Safeguarding Midwifery Service Review (2021-2022)

To review the safeguarding midwifery service with full staff engagement	March 2022

Violence Against Women Domestic Abuse and Sexual Violence   (VAWDASV)

7. ACE Informed

7.1   Routine Enquiry Domestic Abuse during Pregnancy

7.1.1   Audit of Routine Enquiry Domestic Abuse during Pregnancy 2020-21

7.1.2   A further audit to obtain assurance took place due to recognised areas of poor compliance by the audit during 2019-20.

Table 14 – Audit of Routine Enquiry Domestic Abuse during Pregnancy 2019-2021

BCUHB	Audited Notes	Asked Once	Asked Twice	Not Asked At All	Mitigation – Accompanied	Mitigation – No Reason Given
Q1 2019-20	135	70%	41%	30%	15%	15%
Q2 2019-20	135	62%	41%	38%	19%	19%
Q3 2019-20	135	79%	50%	21%	14%	7%
Q4 2019-20	135	77%	57%	23%	14%	9%
Q1 2020-21	135	80%	67%	20%	12%	8%
Q2 2020-21	135	91%	73%	9%	1%	7%
Q3 2020-21	135	82%	73%	18%	1%	17%
Q4 2020-21	135	89%	80%	11%	1%	10%

7.1.3   The audit findings demonstrate that the proportion of pregnant women being asked the routine enquiry questions at least once at their antenatal appointment is improving; 70% in Q1 (2019-2020) and 89% in Q4 (2020-2021).

7.1.4   The proportion of women being asked twice or more is also improving; 41% in Q1 (2019-2020) and 80% in Q4 (2020-2021).

7.1.5   In Q1 (2019-2020) 30% of women were not asked at all with 15% mitigation given and 15% no reason given.

7.1.6   In Q4 (2020-2021) significant improvements had been made: 11% of women were not asked at all with 1% mitigation given and 10% no reason given.

7.1.7   The overall improvements may have been attributed to the restrictions in visiting within the Women's Division during the COVID-19 pandemic, which has allowed more women to be seen on their own.

Priority Action 7 – Audit of Routine Enquiry Domestic Abuse during Pregnancy 2021-2022

To undertake the Routine Enquiry Domestic Abuse Audit for 2021-2022 to provide continued assurance of improvement and compliance	March 2022

7.2   Review of the All Wales Antenatal Routine Enquiry into Domestic Abuse within NHS Wales

7.2.1   As part of the NHS Wales Safeguarding Network Work Plan, the Head of Safeguarding Children BCUHB and a Designated Nurse National Safeguarding Team PHW, agreed to conduct a review of the All Wales Antenatal Routine Enquiry into Domestic Abuse within NHS Wales.

7.2.2   Two of the recommendations are being actioned with full engagement from BCUHB. These include:

- Health Boards need to ensure that Health Visitors and Midwives have robust communication and sharing information protocols to ensure relevant information related to routine enquiry is shared appropriately between them – BCUHB engage in a questionnaire regarding information sharing. Evaluations have been shared at the NHS Wales Safeguarding Network.

- The NHS Wales Safeguarding Network to revise the All Wales Minimum Standards in order to support the development of a consistent universal audit process of the routine enquiry – A National Task and Finish Group was developed chaired by WG with a Working Group chaired by BCUHB Head of Safeguarding Children. Welsh Women's Aid Survivor Group provided invaluable engagement of the Draft Minimum Standards. This work should be completed by May 2021.

7.3   VAWDASV Training

Table 15 – BCUHB Overall Compliance

Safeguarding Module	May 2020	March 2021	Trajectory
VAWDASV	78.4%	79.9%	↑

7.3.1   The overall BCUHB compliance has increased in 2020-2021.

7.3.2   The high performing divisions are, Area Team Central, East and West, Women's Division and the MHLD Division.

7.3.3   The lowest performing divisions are Corporate Services and Estates/Facilities.

7.3.4   Each Division is required to review the compliance data and provide assurance in the Safeguarding Forums of improvements.

7.4   Multi Agency Risk Assessment Conferences (MARAC)

7.4.1   MARAC Referrals

7.4.1.1   High-risk victims of domestic abuse, identified by health professionals, are referred for discussion at a MARAC. These meetings are held in the six Local Authority Areas with key representation from BCUHB.

Table 16 – Number of MARAC Referrals Annual data 2018-2021

Year	West	Central	East	Total	
2018-19	46	57	68	171	⬇
2019-20	66	53	61	180	
2020-21	46	68	63	177	

7.4.1.2 There have been 177 MARAC Referrals from health in 2020-2021. This is a reduction from the previous year with the majority of reductions in the West. the Central and East area have both seen an increase. This could be related to patients being seen alone due to restrictions in visiting during the COVID-19 pandemic giving staff opportunities to ask routine enquiry questions. Equally it could be due to an increase in domestic abuse due to the challenges of the COVID-19 pandemic and lockdown periods.

7.4.1.3 95% of these referrals was in relation to female victims; 45% of which were in the 25-39 age group.

7.4.1.4 69% of the victims had children. Between March and May 2020, the NSPCC helpline received 1,500 contacts from adults worried about the impact of domestic abuse on children, and Childline delivered over 500 counselling sessions to children and young people who were worried about domestic abuse.

7.4.1.5 23% of those referred were pregnant at the time of referral. This data could be related to the advice pregnant women were given during the COVID- 19 pandemic, to 'shield', increasing their risks to domestic abuse situations. However, identification is reassuring, due to the restrictions on birth partners attending antenatal appointments and births.

7.4.1.6 When analysing the relationship of perpetrator to victim, 45% stated that it was an ex-partner/ex-husband/ex-wife and 44% stated that it was a partner/husband/wife.

7.4.1.7 In 2020-21, the two highest service areas where MARAC referrals are generated from: Emergency Department (n=48) and Midwives (n=41).

7.4.2 MARAC Virtual Meetings

7.4.2.1 Due to the success of the Flintshire pilot, North Wales Police has implemented this process across North Wales. From the 1st April 2020 Wrexham commenced, Gwynedd and Ynys Mon from the 21st April 2020 with Conwy following in May and Denbighshire in June 2020.

7.4.2.2 The MARAC weekly virtual meetings now gives opportunities for cases to be reviewed promptly (within a week of the incident rather than waiting up to a month). Practitioners are receiving the information in a timelier manner, which enable them to assess risk prior to home visits and allows for earlier intervention and support.

7.4.2.3 The volume of cases discussed in the monthly MARAC's has reduced considerably with only those very high-risk cases being discussed there.

7.5   Regional and National VAWDASV Groups

7.5.1   North Wales Vulnerability and Exploitation Board

7.5.1.1 The Regional VAWDASV Board was stood down in Q1 2020-2021 and has been replaced by the North Wales Vulnerability and Exploitation Board. Terms of Reference and a North Wales Safeguarding Partnerships Vulnerability and Exploitation Strategy 2020-23 has been developed.

7.5.1.2 The Associate Director of Safeguarding is a member of this Board.

7.5.2   The Regional VAWDASV Commissioning and Training Sub Groups

7.5.2.1 The Commissioning and Training Sub Groups are well attended by BCUHB with full engagement and participation.

7.5.3   Regional MARAC Steering Group

7.5.3.1 This Group has recently been developed to monitor and oversee the activities of the MARAC. Terms of Reference will be developed with the Group reporting to the North Wales Vulnerability and Exploitation Board. BCUHB will provide full engagement and participation.

7.5.4   National VAWDASV Steering Group

7.5.4.1 The National VAWDASV Steering Group is a Sub Group of the All Wales Safeguarding Network. The Group have continued to meet quarterly during 2020-21 with 100% engagement from BCUHB. The focus of the group has been around Routine Enquiry Domestic Abuse and the G2 NHS Wales Package for VAWDASV.

7.5.5   Identification and Referral to Improve Safety (IRIS)

7.5.5.1 IRIS is a specialist domestic violence and abuse (DVA) training, support and referral programme for general practices. It is a partnership between health and the specialist DVA sector.

7.5.5.2 Corporate Safeguarding, Regional VAWDASV Co-Ordinator and Primary Care have met to look at implementing a pilot in North Wales. The model will look at being implemented in Conwy and Denbighshire with one full-time advocate Educator working in partnership with a local Clinical Lead.

7.5.5.3 The practices will receive in house training for the practice teams, a named contact for patient referrals, ongoing support and consultancy. This will improve General Practice's response to DVA and essentially improve the safety, quality of life and wellbeing of survivors of DVA.

7.5.5.4 In 2020-2021, there are only 3 out of 13 BCUHB managed practices who are compliant with VAWDASV training.

Priority Action 8 – Corporate Safeguarding to support of the IRIS Pilot 2021-2022

Corporate Safeguarding to continue with their support to the implementation of the IRIS Pilot	March 2022

7.6 Domestic Homicide Reviews (DHR)

7.6.1 A DHR is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.

Table 17 - Number of DHR's 2018 - 2021

Year	Number of live DHRs	Number signed off	Number Ongoing
2018-2019	6	3	3
2019-2020	3	0	3
2020-21	4	2	4

7.6.2 A Gwynedd DHR is currently ongoing with the completion of BCUHB Internal Management Reviews and is awaiting approval from the Home Office. A Flintshire DHR is awaiting sign off by the Flintshire Community Safety Partnership. Two new DHR's have been commissioned: one in Wrexham and one in Gwynedd.

7.6.3 BCUHB are fully engaged with all the DHR's across North Wales. An overview of current DHR's across North Wales was discussed at the Patient Safety and Quality Group in March 2021.

7.6.4 Main themes and trends identified: Mental health and substance misuse featured in three out of four reviews, one couple were over 70 years of age, lack of compliance with Routine Enquiry Domestic Abuse, perpetrator male and victim female and relationship of the perpetrator to victim was husband/partner and wife/partner. These latter two themes mirror the profiles within MARAC referrals – 7.4.1.3 & 4.

7.6.5 Risks identified:
- o The omission in Routine Enquiry Domestic Abuse remove the opportunity for victims, to safely disclose domestic abuse and increase the risk of them experiencing escalating domestic abuse,
- o A lack of referral to specialist services and in some cases a homicide.
- o It is also a risk for BCUHB, if staff are non-compliant with mandatory VAWDASV training.

7.6.6 Recommendations include:
- o Full implementation of all learning from DHR's,
- o Quality assurance of all BCUHB Internal Management Reviews, DHR Reports and Action Plans,
- o Development of a business case to include a Safeguarding Specialist post for Domestic Abuse
- o Ensure high risk areas, such as, MHLD and Emergency Departments are accountable for monitoring and auditing compliance with Routine Enquiry Domestic Abuse.

7.7   Agencies Domestic Abuse Perpetrator Tasking (ADAPT)

7.7.1   ADAPT is a multi-agency approach of working with repeat perpetrators of abuse. The key objectives are to: reduce re-offending of domestic abuse perpetrators, safeguard adults and children at risk of domestic abuse and break the cycle of abuse of the perpetrator. This approach has been developed in Conwy and Denbighshire.

7.7.2   Since 2019 twenty one (21) cases have been discussed. Corporate Safeguarding have achieved 100% compliance at all meetings.

7.7.3   North Wales Police have undertaken a review of ADAPT with a recommendation to roll out the initiative across North Wales in 2021.

7.8   The Ask for ANI Scheme

7.8.1   In January 2021, the Government teamed up with Independent Pharmacies and Boots to launch a domestic abuse Ask for ANI code word scheme.

7.8.2   The scheme allows those at risk or suffering from abuse to discreetly signal that they need help and access support. By asking for ANI a trained pharmacy worker will offer a private space where they can understand if the victim needs to speak to the police or would like help to access support services such as national or local domestic abuse helplines.

7.8.3   BCUHB have engaged in the promotional activities of the scheme.

7.9   Sexual Assault Referral Centre (SARC)

7.9.1   Amethyst is a Sexual Assault Referral Centre (SARC) for North Wales, where a range of specially trained professionals give help, support and information to individuals who have been raped or sexually assaulted, whether recently or in the past. This service has been developed in partnership with the police, health and voluntary services to ensure that victims of crime get the best possible care.

7.9.2   During 2020-2021, the number of clients accessing the SARC and its services has been affected by the pandemic and associated lock down measures. Referrals into the service were reduced by 32%: 448 in 2019- 2020 and 33 in 2020-2021.

         Forensic medical examinations associated with acute cases of sexual violence were reduced in the year by just over one third from 158 in 2019/20 to 98 in 2020/21.

7.9.3   Despite the lower number of forensic medical examinations and overall referrals, the workloads of the Independent Sexual Violence Adviser (ISVA) and Children and Young Person's Sexual Violence Adviser (CYPSVA) significantly increased from the onset of the lockdown, due to the complexity and vulnerabilities of the service user group.

COVID has had a significant impact on the mental health and wellbeing of many of the service users, struggling with increased anxiety and mental health issues, and further impacted by the temporary cessation of criminal trials and delays in the Criminal Justice System.

7.9.4   The ISVA/CYPSVA service has developed its telephone support service as an alternative to in-person support, along with increased use of Teams where this can be utilised in a safe and confidential manner. One benefit of this way of working has been a significant reduction in travel time, enabling the service to support an increased number of clients. At the same time, this alternative has not been suitable or helpful for all clients, especially for children and young people. The CYPSVAs have introduced a 'walk and talk' service. This involves meeting with clients at suitable outdoor locations for social distancing and which are safe and confidential so that there can be in- person contact. An evaluation of this form of client contact for its benefits with all clients even after COVID-19 measures have been relaxed.

7.9.5   The department has appointed and is developing the role of the Forensic Nurse Examiner to provide day-time cover for adults requiring forensic medical examination. This new member of staff has enrolled onto the Forensic Medical Examination in Rape and Sexual Assault (FMERSA) course, which is on-going and is being supported by the out of hours Forensic Medical Examiners.

7.9.2   The Complex Trauma Group

7.9.2.1 This 3-year project has involved the service working collaboratively with colleagues from Adult Psychological Therapies services and external partners (RASASC NW and Stepping Stones NW) to develop a group therapy for adult survivors of childhood sexual abuse. The project was funded by the UK Tampon Tax Fund and the Welsh Government and in-kind support provided by BCUHB. The project was concluded before the end of the financial period 2020/21. Associated research activities demonstrated the benefits of the group and plans are in place to implement post-project groups when the COVID-19 restrictions are eased.

7.9.3   Lime Culture ISVA/CYPSVA service accreditation

7.9.3.1 This accreditation is part of a national quality standard for ISVA and CYPSVA services to ensure that every victim/survivor should be able to access a high quality, well managed ISVA/CYPSVA service across the UK, regardless of their age, gender, race, sexuality or beliefs. It will also reflect and support the professional status and quality of the service provided both to other professional organisations.
The accreditation process was initiated in Q3 by one ISVA and one CYPSVA and is anticipated to be completed within 12 months following multiple assessments conducted by Lime Culture. The direct benefits of undertaking the accreditation work are that it will align the services working practices, including administrative process.

7.9.4   Birth Trauma Project

7.9.4.1 The CYPSVA is currently undertaking a research project to investigate how survivors of sexual violence experience pregnancy and consider the links between childhood sexual abuse and birth trauma. The work is ongoing and part of a Masters in Trauma, a request for ethical approval for the research has been submitted to the Ethics Committee.

8. Conclusion

8.1   Throughout the Annual Report, it is clearly reported that the level of safeguarding activity has continued, in relation to safeguarding children and those affected by VAWDASV, despite the COVID-19 pandemic. These unprecedented times have brought complexities and challenges to the Corporate Safeguarding Team, in ensuring the safeguarding agenda is fully implemented.

8.2   The Report highlights the adaptability of the Corporate Safeguarding Team in their approach to the delivery of safeguarding training, safeguarding supervision sessions and multi-agency working, in meeting the mandatory requirements of BCUHB employees.

8.3   The identified improvements from 2019-20, include the availability of Child at Risk Performance data, the improvements made within the Safeguarding Maturity Matrix in regards to the assurances in relation to BCUHB's safeguarding arrangements, audit activities and in the learning activities captured to embed learning and improve practice.

8.4   Within the VAWDASV agenda, significant activities are demonstrated on a local, regional and national picture, which required continued multi-agency working and engagement.

Appendix (iii)

1. Introduction

1.1 This Deprivation of Liberty Safeguards (DoLS) Annual Report provides an overview of the DoLS activity undertaken by BCUHB during 2020-2021.

1.2 The activity recorded provides oversight and organisational assurance in relation to BCUHB's statutory duty under DoLS and the Mental Capacity Act (MCA).

1.3 The activity includes key actions and activities taken in response to the COVID-19 pandemic to ensure that DoLS/MCA, as part of the wider Corporate Safeguarding agenda, remains paramount to services delivered across BCUHB.

1.4 From March 2020 there has been a significant change in service delivery as a response to the global COVID-19 pandemic. The DoLS/MCA Team has offered full engagement and support to all services across BCUHB.

1.5 The report is presented within the key domains of the National Safeguarding Maturity Matrix (SMM). The Safeguarding Maturity Matrix (SMM) is a quality outcome monitoring tool with the aim of capturing and collating a national SMM providing assurance, share practice and drive improvements towards a 'Once for Wales' consistent approach to safeguarding across Wales.

2 Governance and Rights Based Approach

2.1 The HASCAS Investigation and Donna Ockenden Review

2.1.1 The HASCAS Improvement Group monitors the implementation and progress of all recommendations (see Table 1 below) across BCUHB. The Associate Director of Safeguarding was a standing member of this group and reported on progress, and compliance.

Table 1.

Reference	Recommendation	Recommendation Position
HASCAS 4	Safeguarding Training	Implemented
HASCAS 5	Informatics, and Documentation	Implemented
HASCAS 6	Policies and Procedures	Implemented
HASCAS 7	Tracking Adult at Risk across North Wales	Implemented
HASCAS 8 / Ockenden 6	Review and implementation of the Corporate Safeguarding Team Structure	Implemented
HASCAS 12 / Ockenden 9	Review of the Deprivation of Liberty Safeguards (DoLS) work plan identified in 2017-18 for implementation in 2018-19 into 2019-2020	Implemented

2.1.2 HASCAS 8 / Ockenden 6 recommendation was completed and a further four Best interest Assessor's (BIAs) were appointed. Due to the increase in safeguarding activity, complexity and new legislation a further of the Safeguarding Team Structure review has taken place. This has resulted in the development of a Corporate Safeguarding Business Plan, which includes additional posts within the structure to strengthen BCUHB's safeguarding commitments and implement the new Mental Capacity (Amendment) Act 2019 and Code of Practice for the Liberty Protection Safeguards.

2.1.3 The Business Case is to be discussed with the Executive Team for consideration during Q1 of 2021-2022.

2.2 Safeguarding Governance and Reporting

2.2.1 DoLS were introduced in April 2009 as safeguards set out in Schedule A1 and are an amendment to the Mental Capacity Act 2005. DoLS is supported by the Mental Capacity Act Code of Practice 2005. The safeguards were introduced to ensure that any deprivation of liberty to a person who may lack capacity complies with the European Convention on Human Rights (ECHR) (Article 5(1)) and the Human Rights Act (HRA) 1998 (Article 5).   The HRA states that; "Everyone has the right to liberty and security of person. No one should be deprived of their liberty save in accordance with a procedure prescribed by law" (i.e. a Deprivation of Liberty Safeguards or a Court Order). This means that if a person is deprived of their liberty without an authorisation in law to do so, then it will be an unlawful deprivation.

2.2.2 The DoLS framework sets out that it is the Health Board's responsibility in its role as a Supervisory Body to grant an authorisation for a DoLS. This authorisation provides a legal framework and protection when a deprivation of liberty is considered unavoidable and it is in the person's best interests for the person to be detained when in a hospital setting, or a hospice registered as a hospital or an independent hospital. This would apply where detention under the Mental Health Act 1983 is not appropriate for the person at that time.

2.2.3 The Health Board has a dual role when discharging its duties by following the DoLS legislation and guidance. There are two key frameworks, the Supervisory Body, which is the DoLS/MCA Team (part of the wider Corporate Safeguarding Team and BCUHB) and the Managing Authority, which is the Ward or Service responsible for the and ultimately the Executive Director, who has accountability for the delivery of the service responsible for the care of patients on the ward or unit.

2.2.4 DoLS legislation requires clear separation from the two different frameworks and BCUHB has a dual function, as both the Commissioner and Provider of services. The Supervisory Body function (Corporate Safeguarding Team) operates independently of those staff who are responsible for managing and providing the care and treatment for patients and service users.

2.2.5 The Supervisory Body's function also provides a strategic role for those approved to be 'Authorisers' formerly known as 'Signatories' within the Division to grant a deprivation of liberty safeguards.

Currently there are 55 approved authorisers within BCUHB. This is following a training programme and offers assurance with regard to the authorisation of applications in a timely manner.

2.3 DoLS Internal Audit (March 2020)

2.3.1 Positive feedback was received regarding the improvements and the strategic direction of the service since 2018. However, the outcome was reported as <u>Limited Assurance.</u>

This was directed to areas of improvement required by the wards (Managing Authority) and all recommendations have been implemented to support this improvement. The Corporate Safeguarding Team (Supervisory Body) have actioned the following;

- Appointment to the vacant position of a Best Interest Assessor (BIA).
- Standard Operating Procedure (SoP) has been developed and implemented to reinforce the DoLS Code of Practice for front line practitioners.
- Safeguarding Ambassadors are identified throughout the organisation.
- A governance and supervision framework supports their activity, which is to focus upon the continued implementation of the safeguarding recommendations of the HASCAS/DO reviews and key learning from audits.
- Increased number of DoLS Authorisers, a significant piece of work took place to increase the number of DoLS Authorisers who are supported by a governance and training framework. There are total of 55 DoLS Authorisers, seven (7) are from the MHLD Division. A further training programme is planned for 2021-2022.
- Bespoke MHLD MCA/DoLS Level 3 training continues to be delivered to focus upon the key omissions in the DoLS process by the wards (Managing Authority). The training was created in Q1 using a variety of IT platforms. During Q3 and Q4 this training was offered to all staff across BCUHB.
- Corporate Safeguarding Level 3 mandatory training also emphasises the DoLS agenda. A lay member was engaged as a critical friend when the training material was developed and has provided constructive feedback which, influences future training packages.

2.4 Quality and Assurance activities and findings

2.4.1 To gain assurance, audit activities and learning from data and the review of individual cases and incidents has influenced the strategic agenda. The Corporate Safeguarding Team (Supervisory Body) have developed;

- A process of scrutiny to cross-reference incidents with Datix to target trends, provide individual supervision, and ensure reporting compliance.
- Developed and implemented a DoLS COVID flowchart to ensure practice continued during the pandemic. This was reviewed and updated in September 2020; this activity is compliant with guidance published by the Department of Health & Social Care for Hospitals, Care Homes and Supervisory Bodies in England and Wales (2020).

2.5 Data Analysis - Deprivation of Liberty Safeguards (DoLS)

2.5.1 In 2020-2021, the DoLS team received a total of 1162 applications, see Table 2 below. This is the largest number of applications received since the DoLS framework was implemented. Over the last 4 years' DoLS applications have increased annually. The introduction to the Liberty Protection Safeguards (LPS) will see the number of applications double to in excess of 3000 per year. This is a direct result of changes in the legislation.

2.5.2 The increasing number of DoLS applications is in accordance with the legal framework, which offers the patient protection for 7 days, or a further 7 days if an extension is granted by the Supervisory Body for an urgent application. There are significant pressures, challenges and risks associated with the responsibility of the Supervisory Body to allocate and assess all patients within the statutory 7 day timeframe. The only time that the legal frame for a DoLS extends beyond 14 days is when a standard authorisation alone would allow for 21 days before completion. The number of standard requests are minimal, for 2020-2021 this stands at just 11 applications (less than 1%).

Table 2.

Year	West	Central	East	England	Other	Applications	
2018-19	89	257	343	55	0	743	⬆
2019-20	177	282	483	72	0	1014	
2020-21	208	322	550	82	0	1162	

2.5.3 Prioritisation of all applications for a DoLS is according to the risks and urgency identified within the application and accompanying documentation (Capacity Assessment, Care Plan or Specialist Nursing Assessment) which will be determined at the scrutiny stage when first received by the Corporate Safeguarding Team (Supervisory Body).

2.5.4 Out of the 1162 DoLS applications submitted in 2020-2021, 325 (40%) of them contained some issues or concerns that resulted in their returned.

2.5.5 Applications are returned due to the following themes;
- No formal Mental Capacity assessment form included
- Mental Capacity assessment completed incorrectly
- Missing details regarding communication (language, format) and medical information
- Questions 10 and12 not completed correctly, not signed, not dated, not dated correctly, completed by a Doctor and not the Managing Authority

2.5.6 Poor quality applications, resulting in legally deficient documentation provides the basis for a legal challenge.

2.5.7 The DoLS forms present the evidence necessitated by the statutory qualifying requirements in order to ensure a person's detention is lawful.

The errors in completing the DoLS application could lead to a delay in the authorisation of a DoLS, which may result in the patient been detained unlawfully for longer than necessary.

2.5.8 The Supervisory Body spending unnecessary time pursuing further information to support the application. The internal Audit Review in March 2020 determined the key issues relate to non-compliance by the Managing Authority (wards).

2.5.9 To mitigate risk additional training programmes have been undertaken with bespoke training provided to wards who have a high rate of late and/or incomplete applications.

3. Safe Care

3.1 DoLS applications

3.1.1 DoLS applications are prioritised according to the risks and urgency identified within the application and the accompanying documentation (Capacity Assessment, Care Plan or Specialist Nursing Assessment) which will be determined at the scrutiny stage when first received by the DoLS Team by;

- Whether the patient objects to the restrictions in place
- What level of restrictions are in place including 1:1 nursing, sedating medication, physical restraint etc.
- Whether the patient is in an acute or psychiatric hospital and the level of supervision needs to be greater.
- Whether the patient is already subject to an existing DoLS authorisation which is going to expire.
- Whether there is a Court of Protection appeal or an existing Court Order in place.
- Applications submitted appeared to have included a copy of the care plan.

    1.1.2 The increased demand of applications and the availability to meet that demand within existing DoLS services remains a challenge. The figures alone do not reflect the level of complexity and demand upon the DoLS service. The trend for DoLS applications is an upward trajectory. An increase in the number of BIA's (now 6) has little impact upon the applications waiting list. The Safeguarding Business Case has identified the need for additional clinical and administrative support.

4. ACE Informed

4.1 Rationale

4.1.1 Adverse Childhood Experiences (ACEs) such as exposure to domestic abuse, substance misuse and mental illness are recognised to have a direct and immediate effect on a child's health. The safety of the child and the safety of the vulnerable adult are intrinsically linked; preventing early exposure can reduce the impact on children and future generations.

4.1.2 Safeguarding Training reinforces the requirement for all health assessment to consider the wider family to determine risk and harm and the impact on others. This expectation is also reinforced within care planning and risk assessments.

5. Learning Culture

5.1 Training

5.1.1 Safeguarding training compliance is a key target for Corporate Safeguarding. A reduction in compliance is reported during 2020-21, see Table 3 below. It is recognised that no face-to-face training is taking place due to COVID-19 restrictions; however, safeguarding training continues to be available on e-learning and digital platforms and is supported by a revised virtual program to encourage ongoing training during this period.

Table 3

Safeguarding Module	May 2020	October 2020	Trajectory
MCA – Level 1	85.3%	76.7%	↓
MCA – Level 2	86.0%	79.2%	↓

5.1.2 In 2020-21 a YouTube 'voice-over' presentation was devised to deliver the training and staff can access via the safeguarding web-page. This included learning-sets assessments which can be accessed by managers of staff using the e-learning to ensure learning objectives are being met.
Though this did meet mandatory requirements for training it was not possible to link directly through the BCUHB ESR data collection. This training was developed during Q2 to provide this mandatory training which is linked directly to ESR through Microsoft Teams presentations. These commenced in Q3 and a small increase in compliance was recorded between Q1-Q2 and Q3-Q4. This may be the reason the compliance rate has a downward trajectory and is not currently reporting an accurate picture.

6 Multiagency Partnership Working

6.1 Court of Protection

6.1.1 Additional responsibilities of the DoLS Corporate Safeguarding Team include responding to cases that are to be referred to the Court of Protection. These cases are referred through Legal and Risk Services for the following reasons:

- **Section 21A MCA (2005) Appeal**: is when a patient is subject to a DoLS granted by the Health Board and the patient is objecting to their detention. They have a right in law to appeal against that detention 5(4) ECHR). This often is taken forward by the patient's advocate or their appointed representative (RPR) under DoLS.

In addition to the human right to appeal, current case law supports the right to appeal under *AJ v A Local Authority* [2015] which states that a person appointed as their representative (RPR) must appeal on the patient's behalf if they are objecting to being accommodated in hospital. The MCA (2005) states that unreasonableness of that objection is not to be taken into account.

- **Section 4 and Section16, MCA (2005):** sets out that if there is a need to have a welfare decision relating to the patient, who lacks capacity to agree to their care in hospital or discharge elsewhere; the action proposed is in their best interests but the patient cannot consent because they lack capacity to do so, then the matter must be referred to the Court of Protection.

6.1.2   In most cases where a DoLS is in place, then a Section 21A and Section 4 and Section 16 are combined in the proceedings.

6.1.3   The number of cases referred by the DoLS service through BCUHB Legal and Risk Services has increased significantly from one (1) case in 2018-19 to sixteen (16) cases in 2019-20. Cases may take months for the Court to conclude due to the amount of evidence and complexity with each case resulting in a number of hearings.

6.1.4   During 2020-2021 there were eight (8) new cases subject to court hearings. Projected outcomes in relation to Court of Protection cases is entirely dependent upon a number of variables which include, patient circumstances, litigation by Appointed Legal Representatives (Independent Solicitors) and delays in placement by a Local Authority resulting in a patient unable to be discharged until the matter has been referred through the Court of Protection.

6.1.5   All DoLS cases referred to the Court of Protection are significant as they all incur legal costs for which there is no current indicative Safeguarding/DoLS budget. This has resulted in additional cost pressures. Legal and Risk only submit invoices when cases are fully completed and terminated by the court, therefore costs are often retrospectively incurred.

6.1.6   The Supervisory Body and the Managing Authority also incur cost pressures. The courts will explore if the health board has acted in the best interest of the patient. The real impact is upon the patient and if there is evidence that, the Supervisory Body or Managing Authority has not acted in a person's best interest it also impacts financially upon the organisation.   National cases show that not meeting the statutory requirements i.e. not assessing within a timeframe; breaching Mental Capacity Act principles; or not following case law, can result in substantial reputational damages and financial costs.

6.1.7   The Internal Audit report highlighted that there was a risk to the Health Board and exposure to financial penalties from non-compliance by Managing Authorities within the requirements of DoLS legislation and that this could significantly exceed the costs of supporting improved service delivery and accountability.

6.2 Liberty Protection Safeguards (LPS)

6.2.1 The law relating to the Mental Capacity Act 2005 changed in May 2019 and is now referred to as the Mental Capacity (Amendment) Act 2019. This new Act will change the Mental Capacity Act Code of Practice and DoLS to create new statutory regulations known as Liberty Protection Safeguards (LPS). A new Code of Practice and regulations to accompany the Act were due to be in place by October 2020; however, this implementation in now delayed with the date to fully implement the changes set for April 2022.

6.2.2 It is known that the legislative changes will have significant implications in terms of demand, capacity, training, financial resources and challenges for the Health Board, these include:

- Unlike the current DoLS arrangements where external practitioners known as Best Interest Assessors and S12 (2) Doctors generally undertake the assessments, under LPS these assessments will be done by those already involved in the person's care, for example where someone is deprived of liberty in hospital, it will be hospital ward staff that are responsible for the assessments. This will require substantial education and training requirements.

- The Health Board will be responsible for granting arrangements for LPS in any setting in which it is responsible for commissioning care such as CHC funding for Nursing Homes, Domiciliary Care Packages, 16 or 17 year olds in any setting.

- It will also continue to be responsible for granting arrangements for any BCUHB patients in any registered NHS hospital, Independent hospital and hospice. Any patient objecting to LPS arrangements will have the right to be assessed by an Approved Mental Capacity Practitioner or AMCP (this is a new role replacing the BIA) and will be referred for judgement to the Court of Protection.

6.2.3 National led work-stream task groups are in place to develop a strategic impact risk assessment and actions to mitigating against the risks associated with LPS implementation.

7 Risk Management and the Corporate Risk Register

7.1 Mitigation of Risk

7.1.1 Work has commenced to prepare the organisation and key stakeholders for the intended challenges to ensure implementation of the new LPS procedures and legislation. It is proposed BCUHB will have an additional 1700 applications based upon the current data bringing the total number of assessments up to around 3000, this will also have an impact upon community settings.

7.1.2 Corporate Safeguarding currently attend National working groups in relation to LPS to ensure that we are fully updated and informed of any developments. We have received draft LPS assessment forms from Welsh Government, as well as a summary of the proposed regulations specific to the roles and responsibilities of individuals and organisations under the LPS framework. A review of these documents is underway with further planned during 2021. DoLS and MCA updates are reported through the MHA Committee for consultation, discussion, and agreement before wider circulation within BCUHB.

7.2 Financial Implications

7.2.1 There are recognised financial implications for the Deprivation of Liberty Safeguards (DoLS) service provision due to the demand, complexity and the implementation of the revised legislation in 2021-22, which are noted within the Corporate Safeguarding Business Case.

8 Conclusion

8.1 This report provides an overview of the ongoing DoLS activity during 2020-21. The development and implementation of improvement plans to safeguard the patients, staff and organisation as a whole.

8.2 Trajectory of compliance and the identification of performance data has highlighted the challenges faced by the service during the COVID-19 Pandemic. However, the valued support, advice and guidance given by the DoLS team demonstrates the commitment of the staff and the service.

8.3 In 2021-22 Corporate Safeguarding will present a business case to the Quality Safety Group and position update in relation to the HASCAS 8 / Ockenden 6 recommendation relating to the Corporate Teams staff resource due to the increased demands, specifically the implementation of new legislation to include the Liberty Protection Safeguards (LPS).

8.4 It is envisaged the proposed structure would provide additional assurance against specialist strategic, operational and administrative activities. This is based upon the recognised activity data, and reported risks relating to the Deprivation of Liberty Safeguards.

8.5 All actions are monitored by the Safeguarding Quality and Performance Group and the MHA Committee.

8.6 The actions identified are on target and have the full engagement of the Safeguarding Quality and Performance Group membership.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 6th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Planned Care Recovery Update
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Executive Director of Nursing and Midwifery, Deputy Chief Executive Officer
Awdur yr Adroddiad **Report Author:**	Gary Francis, Interim Secondary Care Medical Director
Craffu blaenorol: **Prior Scrutiny:**	Chief Executive
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:							
The Committee is asked to note the actions and mitigations being taken to recover the Planned Care waiting lists which have increased during the Covid-19 pandemic as a result of panned care activities having been curtailed to address the surge of admissions.							
Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**	**x**	**Ar gyfer Trafodaeth** **For Discussion**	**x**	**Ar gyfer sicrwydd** **For Assurance**	**x**	**Er gwybodaeth** **For Information**	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**						**N**	

Sefyllfa / Situation:
This paper sets out the background, actions taken, mitigations and assurances provided in tackling the accumulating backlog of patients waiting for diagnosis and treatment which has arisen during the Covid-19 pandemic.

Cefndir / Background:
During the Covid-19 pandemic elective activity has been curtailed in order to redirect clinical staff to manage the increased number of patients admitted to BCUHB as emergencies with Covid-19 related disorders. This has meant clinical staff have been re-allocated to areas not familiar to them, with routine activities, including out-patients and operating theatre activity, being paused. As a consequence, the numbers of patients waiting for routine appointments to be seen in a range of clinical specialties has seen an increase. The range of patients obliged to wait for assessment, diagnosis and treatment varies from those who have chronic cosmetic disorders (such as orthodontic patients), through to those with chronic pain arising from arthritic conditions (joint replacement patients) to those whose conditions are more likely to require more urgent attention (vascular, cardiac and cancer). Cancer patents have as far as

possible been dealt with as they arise (taking a pan-North Wales approach with patients, when necessary, being transferred to other sites across BCUHB). The approach taken by each specialty reflects these variations, however each follows the principles outlined in the six point planned care recovery plan which has been shared previously with the Health Board.

As we anticipate emergence from the pandemic, the intention of the Health Board is to recover the delayed planned care activity in the most timely risk-based manner possible. Given the large numbers of patients affected (the total number is in excess of 40,000), the recovery plan will need to be delivered over a period of years; current estimates suggest this could be 4-5 years, which is broadly in line with other Health Boards in Wales.

The rest of this paper describes the actions being taken by the clincal and operational teams to address the backlog and provide assurances that these actions are having the desired impact.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

Delivery of the Planned Care waiting lists will ensure the Health Board achieves its obligation to provide timely healthcare to the population of North Wales.

Opsiynau a ystyriwyd / Options considered

Each service is addressing the management of their waiting lists according to the volume of patients waiting and their clinical priority. This has been developed through a risk-based approach. The manner in which waiting lists have been identified, validated and managed is similar, but with different emphases to take account of variations in the differences in the types of patients and their clinical need. An example of how each site and specialty is dealing with these waiting lists is provided for members in Appendix 1.

The initial phase involves validation of the current waiting lists. Those patients considered to require retention on the waiting list are then subject to a (table-top) clinical review. Please note, other Health Boards have chosen not to include this clinical review however, this additional clinical step affords an additional level of protection for patients thereby reducing the potential to cause harm. Appendix 2 (provided for members) is a flowchart which outlines the process used to validate waiting lists.

Once established as a valid patient for ongoing management each patient on the list is directly contacted by letter (copy provided for members at Appendix 3) and telephone/text to seek confirmation they wish to remain on the waiting list. Non-responders are sent a 'nudge' text and contact is made with the patient's GP in case the patient has changed address since being added to the waiting list. This is seen as a last resort in an attempt to reduce the workload on general practices, who are also busy through the pandemic and struggling to cope with the workload. Appendix 4 (provided for members) is an example of how non-responders are being tracked.

Once the validation has been confirmed, this elective activity will be delivered through a number of mechanisms depending upon the capacity within the system, availability of clinical workforce (through temporary changes to job plans and waiting list initiatives), innovation to deal with these cases that can be managed in a 'virtual' manner and utilisation of external resources either through In-sourcing, or Out-sourcing. Longer term plans (6 months-3 years) include adding additional (modular and static) ward and theatre capacity.

Each directorate and department reviews its own lists. These are considered jointly at Hospital Management Team level and further scrutiny is added through monitoring by the Planned Care operational group, which in turn feeds into the Executive Group.

Once the validation has taken place the options for dealing with the backlog is discussed. In general a three phase approach has been taken to address the backlog:

- Immediate actions (restarting elective lists, waiting list initiatives, temporary job plan changes)
- Medium term options (adding modular ward and theatre capacity, together with In-sourcing and Out-sourcing; and
- Long term options with consideration given to permanent capacity provision (Diagnostic and Treatment Centres, and site redevelopment).

Appendix 1 (provided for members) provides an in-depth analysis of the work undertaken at site level together with the current (as at the date of compiling this report) situation.

Goblygiadau Ariannol / Financial Implications

Welsh Government has already committed circa £100m to help address the additional funding that will be required to address the backlog. Further funding is expected as the recovery plan is developed.

Enabling works to facilitate location modular theatres and wards will be required and are factored in to capital spending budgets.

'Virtual' solutions to manage waiting lists are also factored in to the planned care recovery plan.

Business cases are being written to support Pre-Operative Assessment Clinics (POAC) and Pre-habilitation to ensure patients placed on surgical lists are in the optimum condition.

Dadansoddiad Risk / Risk Analysis

There are clinical risks and patient experience risks associated with the outstanding waiting lists. Clinical risks relate largely to cancer-related diagnosis (although these cases have continued to be managed throughout the pandemic, adopting the 'Once For North Wales' approach). For those patients suffering pain, discomfort and disability active steps have been adopted to provide symptomatic relief and 'pre-habilitation' to optimise patients' conditions prior to surgery with the intention of improving clinical outcomes (a business case is currently being considered by the Executive Team to provide this support).

The Suspected (previously Single) Cancer Pathway (SCP) is closely monitored. The national target is for 75% of patients to be treated within 62 days of referral. Currently BCUHB sees 70% of such patients. This number has improved steadily since the beginning of the year (from 65% in January 2021). Whilst this is below the national target, BCUHB is the best performing Health Board in Wales (national average currently 60%).

The best performing cancer sites in BCUHB are Breast and Skin. The worst performing sites are Urology and Head and Neck. Issues of complexity and lack of capacity to deal with the throughput of cases have been identified as the prime reasons for the performance seen in Urology and Head and Neck.

GP referrals for the SCP has begun to increase again, with referrals up in the last quarter, but still approximately 10% below the pre-Covid referral rate.

'Harm Review' meetings are held for each case which breach the SCP target. It has been noted that the proportion of patients presenting with more advanced disease (Stages 3 and 4) has increased during the pandemic.

The actual number of patients treated on the SCP has increased in the last month (from 350 to 450) but remains at 50% of the activity pre-Covid. The Secondary Care Patient Safety and Quality Group monitor the performance of the Harm Meetings (Appendix 5 – provided for members).

Planned Care risks have been logged as separate risks on the Secondary Care Risk register, scored at between 10 and 20, and mitigated down to 8-10 with the above described measures. These risks align with the Health Board Corporate risks; Planned Care access; and potential to compromise patient safety through the large backlog and lack of sufficient follow up capacity.

The delivery of these recovery plans are dependent upon the assumption that clinical activity will be allowed to return to more normal levels of clinical activity, therefore, any increase in hospital admissions consequent to a subsequent surge in Covid-19 will result in delay. Likewise, recovery of activity will also be hampered by ongoing spacing requirements in ward areas and operating theatres/endoscopy suites.

Although planned care activity has been restarted, currently ward space is constrained following the pandemic, with fewer beds (up to 50% in some specialties) available for this activity across the whole Health Board than was available pre-pandemic. As more beds become available activity will be stepped up. In the meantime, clinically urgent cases are being managed on a risk-based manner with patients invited to travel to other sites in the Health Board where capacity exists.

A number of other factors could place the recovery plans in jeopardy to a varying extent:
- Further Covid-19 surges, particularly variants
- The impact that the pandemic has had on staff in terms of well-being and resilience
- Endoscopy capacity
- Ability of current staff numbers to absorb increased activity, particularly those in support services
- IT reliability (with regard to providing 'virtual' clinics)
- Strict adherence to Infection and Prevention requirements across the Health Board
- Approaching winter pressures

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Asesiad Effaith / Impact Assessment

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 6th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Suspected Cancer Pathway (SCP) Update
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Adrian Thomas, Executive Director of Therapies and Health Science
Awdur yr Adroddiad **Report Author:**	Caroline Williams, Performance Lead, Cancer
Craffu blaenorol: **Prior Scrutiny:**	Chief Executive
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:
The Committee is asked to note the contents of this paper.

Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth **For Decision/** **Approval**		**Ar gyfer Trafodaeth** **For** **Discussion**		**Ar gyfer sicrwydd** **For** **Assurance**		**Er gwybodaeth** **For** **Information**	√
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**						**N**	

Sefyllfa / Situation:
This paper updates the Committee on the Health Board's performance against Welsh Government's Suspected Cancer Pathway (SCP) waiting times target, introduced in December 2020, and actions currently being taken to improve performance. It also provides the latest information on the impact of the COVID-19 pandemic on cancer referral and diagnoses rates in the Health Board.

Cefndir / Background:

The Suspected Cancer Pathway (SCP) target, previously known as the *Single* Cancer Pathway target, was formally introduced by Welsh Government in December 2020. It requires Health Boards to diagnose and treat at least 75% of cancer patients within 62 days of the first suspicion of cancer. This target applies to newly diagnosed cancers only (not recurrences). It is likely that the 75% target will increase to 80% next year; confirmation is awaited from Welsh Government.

The SCP target replaces the two previous targets (the 62 day Urgent Suspected Cancer (USC) referral to treatment target and 31 day non-Urgent Suspected Cancer (non-USC) decision to treat to treatment target) which set different waiting times targets dependent on whether a patient was referred via their GP or diagnosed via another source. The SCP has been introduced to ensure that the same waiting times target applies to all cancer patients, regardless of where the first suspicion of cancer arises e.g. in primary care, screening, during routine follow-up or following an emergency presentation etc.

The move to the new single target has been introduced by Welsh Government as the previous 31 day non-USC target only started from the date of decision to treat. Concern was raised that patients not on a USC pathway experienced significant waits between initial clinical suspicion of cancer and the date of decision to treat and that these waits were not recognised under the old targets. Cancer services teams across the Health Board track all patients on a suspected cancer pathway and the change in the targets has led to a 66% increase in the number of patients tracked and a significant increase in the number of patients escalated to diagnostic services as needing an earlier test. The ultimate aim of the target is to ensure earlier diagnosis for all patients.

Other changes include the fact that suspensions are no longer applied for patient unavailability e.g. if a patient is on holiday for two weeks the clock does not stop for this period. In addition, patients referred by secondary care for treatment in England are now included within the target; for BCUHB this includes patients referred to England for thoracic, plastics and some urology cancer surgery.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications
In an average year, BCUHB treats 350-400 newly diagnosed cancer patients each month. The Health Board's performance to date against the SCP target is shown in the bar chart below; the All Wales position is also shown as a comparator. Whilst the Health Board has not yet achieved the 75% target, it has consistently remained above the All Wales position:

SCP target performance (% patients treated in target)

Month	BCUHB	All Wales
Dec-20	71.7	65.6
Jan-21	64.8	61.2
Feb-21	66.7	59.5
Mar-21	70	67
Apr-21	67	65.8
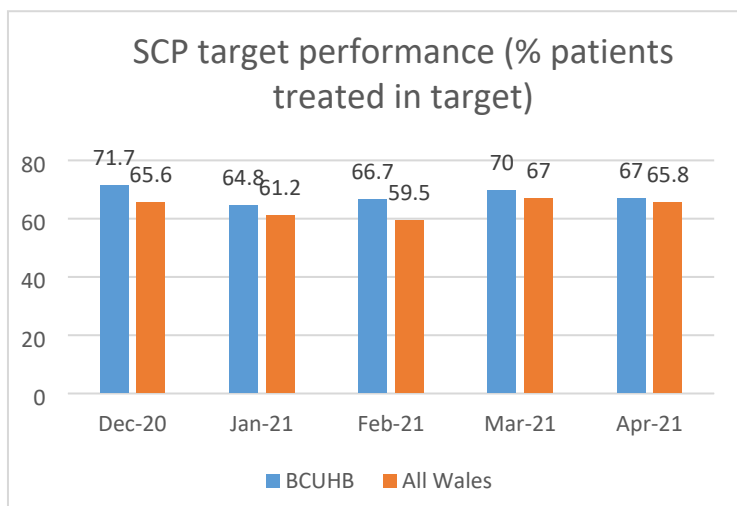
The bar chart below shows the tumour sites with the most pressures are urology and colorectal, principally due to delays to endoscopy and multifactorial issues on the urology pathway including insufficient major urology surgery capacity.

Total cancers treated Dec 20-April 21
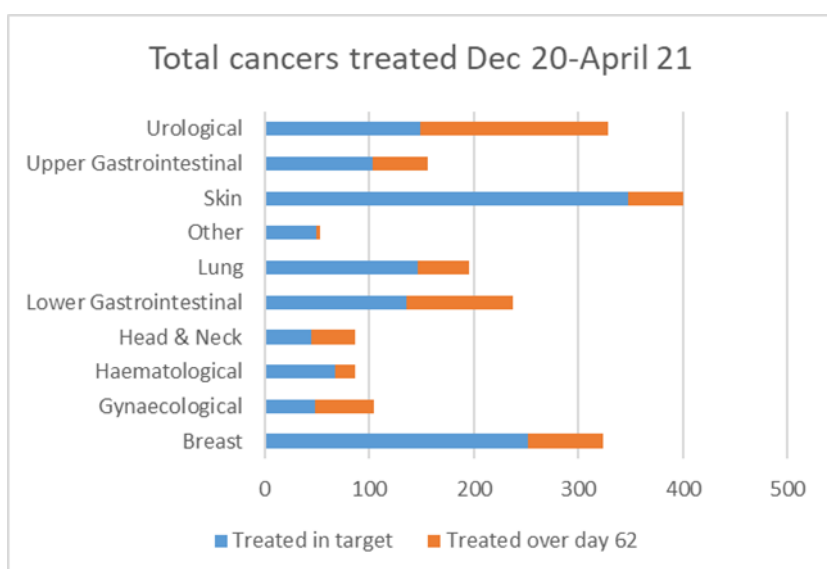
It should be noted that whilst May's performance has yet to be confirmed (to be published mid-July) the Health Board's draft performance has increased to 72.7% with urology in particular showing an improvement from 45% to 54%.

This data, together with a further breakdown by age and gender and analysis of median waits to date first seen and diagnosis is published by Welsh Government at https://gov.wales/suspected-cancer-pathway-waiting-times-interactive-dashboard and will be available internally on the BCUHB Cancer Dashboard within IRIS

Opsiynau a ystyriwyd / Options considered

In preparation for the introduction of the SCP target, a number of service improvements were introduced during 2019 and 2020, including straight to test endoscopy, Faecal Immunochemistry Testing (FIT) for symptomatic bowel patients, in order to better establish risk of cancer, enhanced patient tracking and an early diagnosis lung cancer pathway.

In order to improve performance further, £2million has been identified from the Welsh Government Performance Fund for SCP implementation. The following service improvements have been identified as priorities for this funding:

1. Increased rapid access breast cancer clinic capacity across the Health Board – business case approved by Executive Team June 2021; these clinics have been provided on an ad hoc basis since November 2020 and can now be established as part of core activity once new posts are recruited to
2. Continuation of the early diagnosis lung cancer pathway which ensures patients with a suspicious chest X ray are directed straight to CT – funded in 2021/22 with a business case for ongoing funding being developed
3. Development of one stop neck lump clinics – project team established and pathway agreed; business case to be submitted this month
4. One stop rapid diagnosis clinic for patients with vague but concerning symptoms – project manager in post, project team established and pathway agreed; business case to be submitted this month
5. Increase in Clinical Nurse Specialist and support roles to support patients with their diagnosis and provide direct clinical care as appropriate – business case submitted and to be considered by Health Board business case review team in July
6. Patient navigators to track pathways and escalate delays – funded in 2021/22 with a business case for ongoing funding submitted and awaiting approval.
7. Pathway improvement posts to work with clinical teams to introduce the National Optimal Pathways for cancer ensuring pathways are as streamlined, efficient and effective as possible – business case submitted, awaiting approval (NB one post already funded by Wales Cancer Network and going through recruitment process)

In addition, separate business cases have been submitted to the Health Board and/or Welsh Government in order to significantly increase endoscopy capacity in North Wales and to introduce robotic surgery to the region. Both of these developments will provide more sustainable capacity to reduce diagnostic and treatment waiting times for cancer patients. The outcome of these business cases is awaited.

The robotic surgery development is particularly important for urology which is the tumour site under most pressure as seen in the table in the previous section. A robot will assist with recruitment to urology posts within North Wales allowing the Health Board to increase local capacity. At present a significant proportion of urology cancer patients are referred to London (University College London Hospital and Royal Free Hospital) or Arrowe Park Hospital on the Wirral for robotic surgery. A robot in North Wales will allow the Health Board to recruit specialists to North Wales increasing both diagnostic and treatment capacity and improving performance against the SCP target.

The aim of the above proposed developments is to reduce diagnostic and treatment delays for patients on cancer pathways and to ensure the Health Board achieves the SCP target.

Goblygiadau Ariannol / Financial Implications

The financial implications of the above proposed developments are all set out in the individual business cases which will be considered separately by the Health Board in line with its financial governance mechanisms

Dadansoddiad Risk / Risk Analysis

Each of the above proposed developments has an individual risk analysis contained within its business case with mitigation as appropriate. The main risks relate to funding or recruitment delays.

In addition, the COVID-19 pandemic has affected cancer service delivery and does present risks to the delivery of the SCP target. Cancer services were maintained throughout the pandemic as an essential service; at the start of the pandemic some changes to pathways were introduced due to some services being temporarily suspended in line with national guidance; these included endoscopy, some biopsies and screening services. These services were resumed within three months of the start of the pandemic but the suspensions have led to delays. All patients treated after day 104 on their cancer pathway are reviewed in order to assess whether a delay has caused harm; the outcome of these harm reviews are presented via the Central site's quality structure to the Health Board with no harm identified to date.

The pandemic has led to a significant reduction in the number of patients presenting to their GP with suspicious symptoms. The change in the number of GP USC (urgent suspected cancer) referrals received over the last two years can be seen in the chart below:

GP Urgent Suspected Cancer Referrals 2019-2021
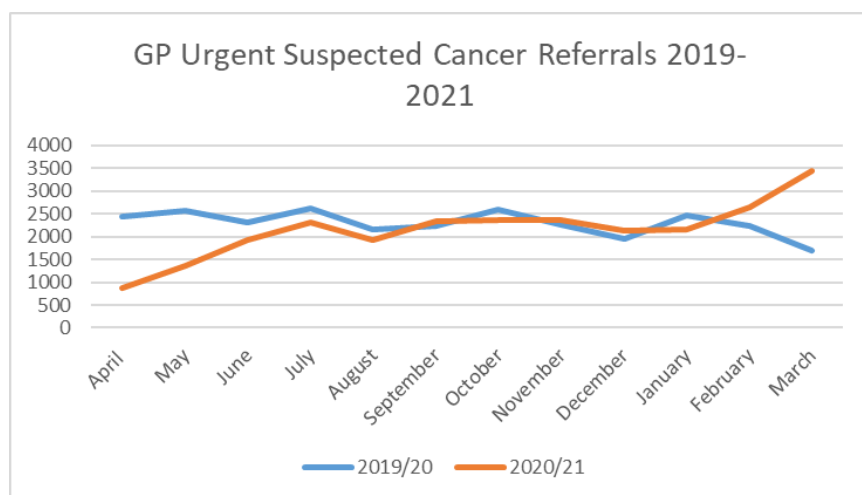
Referrals dropped to just 37% of average numbers in April 2020 but as the pandemic eased they increased to 141% of average numbers by March 2021. Cumulatively the Health Board has received approximately 2,500 less GP USC referrals than expected although the current high level of referrals means the gap is closing.

The table below shows how diagnoses fell at the start of the pandemic but have increased back to expected levels in more recent months. Cumulatively the Health Board diagnosed 327 fewer cancers in 2020/21 compared to the year prior to the pandemic. This is a 7% reduction.

BCUHB Cancers diagnosed by quarter
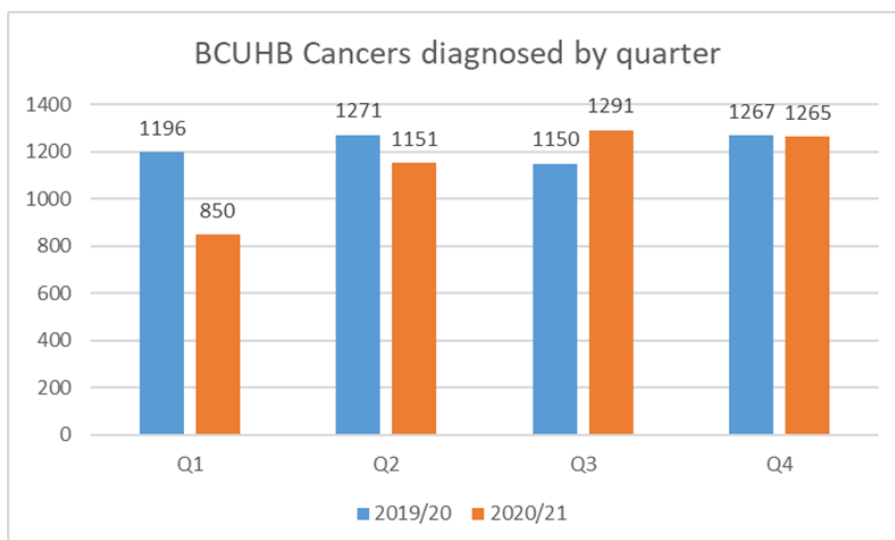
The risk of this pattern is that services may not cope with the new level of demand and some patients may be presenting with a later stage cancer.

In order to mitigate this risk, we continue to monitor GP USC referral numbers weekly with operational managers reallocating capacity as required. We do also review patient's stage at diagnosis quarterly; the current data is showing a reduction in early stage cancers but no significant increase in late stage cancers yet, although it is anticipated this will be seen in the subsequent quarters. In anticipation of this £1.25 million has been secured for additional oncology capacity as later stage cancers require additional oncology input.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

The Health Board will continue to submit data monthly to Welsh Government re:
- the number of suspected cancer referrals received
- the number of cancers diagnosed and treated
- the timeliness of this diagnosis and treatment
- the outcome of harm reviews for patients treated after day 104

In addition, we will continue to monitor stage at diagnosis to assess any potential impact of the COVID-19 pandemic on presentations.

Asesiad Effaith / Impact Assessment

Each of the above proposed developments has an individual impact assessment contained within its business case

Chair's Report

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting or area reporting in	Patient Safety and Quality Group
Chair of meeting or lead for report	Debra Hickman (on behalf of Gill Harris)
Date of meeting	15 June 2021
Version number	V1.0
Appendices	N/A

Reporting To	
Name of meeting	Quality Safety and Experience Committee
Date of meeting	06 July 3021
Presented by	Matthew Joyes, Acting Associate Director of Quality Assurance and Assistant Director of Patient Safety and Experience

1. Alert – include all critical issues and issues for escalation

- **Complaints and incident performance** was noted as an area where improvements had been seen, but further work was needed. Divisions updated on their plans and it was advised that the Deputy Chief Executive will be holding accountability meetings with Divisions in regards to this area.

2. Assurance – include a summary of all activity of the group for assurance

- **Safeguarding Group**: A detailed Chair's Report was received. The group was updated on the position regarding Deprivation of Liberty Safeguards (DOLS) (a separate paper is being submitted to the Mental Health Act Committee), the review of the PRUDIC (unexpected deaths in childhood) process and recruitment to the role of Named Doctor. The group was also updated on the number of complex cases in Child Adolescent & Mental Health Services (CAMHS) and the impact on the Safeguarding Team of supporting these cases.

- **Personal Protective Equipment (PPE) Group:** The group is reviewing the recent revision of Welsh Government (WG) guidance and will work through any changes identified. PPE Hubs have now been decommission as agreed with no reported

concerns. A very detailed legacy document for donated visors has gone through Executive Incident Management Team (EIMT). The ID fit test badge pilot has early positive feedback. Concern was noted about sustainability of the fit testing programme – a business case has gone to the Executive Director of Workforce & Organisational Development (OD) for escalation in regards to a permanent team as it was noted highlighted a lot of testers have been asked to go back to substantive posts.

- **Safe Medications Group:** A detailed update was received including work to develop a new dashboard, the development of an SBAR highlighting improvement actions regarding insulin (which has been tabled at Clinical Avisory Group - CAG) and that Patient Group Directives (PGDs) remain in a good overall position.

- **Medical Gasses Group**: A report was received which included an update on the concerns regarding the design of oxygen cylinders, which has been raised nationally with the supplier.

- **Medical Devices Group**: An issue was highlighted with increased COVID surge equipment and storage, some equipment is now not needed resulting in clutter in some clinical areas. Storage is being provided in shipping containers in car parks, which raises issues with batteries, temperature control and access.

- **Quality Systems Group:** An update was received on the new concerns system, real time feedback system and quality dashboard.

- **Divisional Reports:** Each division submitted and presented a report. Of note, Secondary Care is taking forward a revised improvement plan with regards to fall prevention and management. West Area reported pressures in CAMHS and noted work to secure a private provider to provide increased assessment capacity. A peer review into neonatal services was received and an action plan submitted. Central Area reported challenges with ventilation in primary care impacting on the ability to re-start services. Women's Services provided an update on the changed to visiting guidelines. Mental Health and Learning Disability Services provided an update on ligature risk management and a recent Regulation 28 Notice.

- An update was received on the **external review into a never event investigation** in Urology. It was identified that two areas required further work – staffing and safety culture. This is detailed in the Serious Incident (SI) Report to the Committee.

- MHLD updated on the work to review **ligature risk assessments** in light of the serious incident at the Hergest Unit. It was noted that the Chief Executive Officer (CEO), Deputy CEO/Executive Director of Nursing and Midwifery and Executive Director of Workforce and OD has met and commissioned an external investigation into the serious incident and additional work around reviewing ligature risk.

- Pharmacy updated on a **thematic review of methotrexate incidents**. Electronic prescribing was noted a significant improvement opportunity and systematic barrier to preventing future incidents. A national stakeholder group has been established with

Welsh Government and a timescale of up to 3 years was indicated. Local awareness and improvement work continues including strengthening training.

- A number of **procedural documents** were approved:

  - o Basic Life Support requirements for community pharmacy vaccinators
  - o Intravenous Morphine
  - o Clinical Guideline for the Prescribing and Administration of Intravenous Morphine in Adults with Acute Severe Pain or Acute Cardiac Pain
  - o Various Pharmacy Clinical Trials
  - o Protocol for loading dose vitamin D3 for patients over 50 years age with fragility hip fracture
  - o Care Decisions Guidance

3. Achievement – include any significant achievements and outcomes

- **Realtime feedback**: The CIVICA System is being rolled out during Q1 with a "soft launch" planned for 05 July 2021.

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting or Division/Area reporting in	**Strategic Occupational Health & Safety Group**
Chair of meeting or lead for report	**Sue Green - Executive Director Workforce and Organisational Development** **Peter Bohan – Director of Health Safety and Equality** **Sue Morgan – Head of Health & Safety**
Date of meeting; only if a Sub-group reporting, otherwise 'Not Applicable' (N/A)	**25th May 2021**
Version number	**1.0**
List Appendices, if applicable	**N/A**

Reporting To	
Name of meeting	**Quality, Safety & Experience Committee (QSE)**
Date of meeting	**6th July 2021**
Presented by	**Sue Green – Executive Director of Workforce and Organisational Development**

1. Alert

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) incidents reported April 2020 to March 2021

For 2020/21 there have been 820 reports made to the Health & Safety Executive (HSE) under RIDDOR, compared to the same period in 2019-2020, when 105 reports were made to the HSE. The significant increase is predominantly due to the numbers reported as Occupational Diseases following the requirement to report a person at work who has been diagnosed as having COVID-19 attributed to an occupational exposure to coronavirus.

Report breakdown	2020/21 Total	2019/20 Total
COVID-19 related	745	0
Staff Injuries	57	88
Patient Injuries	18	17
	820	105

COVID-19 Staff Cases reported to the Health and Safety Executive

In the period 1st April 2020 to 31st March 2021, there have been 732 COVID-19 staff diagnosis reported as occupational diseases to the HSE under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

These break down into 86 identified COVID-19 staff clusters:

- 32 in East involving 235 staff,
- 31 in Central involving 243 staff and
- 23 in West involving 254 staff.

There were a 13 further COVID-19 related RIDDOR reportable incidents reported under the category of Dangerous Occurrences. Dangerous occurrences are unintended specified events that have the potential to cause harm and with COVID-19 the incident must or could have resulted in the release or escape of coronavirus leading to a possible or actual exposure to it. As an example all early staff COVID-19 clusters were reported as a Dangerous Occurrence under advice from the HSE and were later reported individually as Occupational Diseases when the guidance changed.

Health and Safety (H&S) Self Assessments

A report was provided to the Strategic Occupational Health and Safety group giving details of the areas that have submitted their H&S self-assessments and gaps where assessments have not been completed. The H&S self-assessment is required to be completed every March and September as per the H&S policy with the H&S Leads to develop escalation procedures within their areas of responsibility in preparation for the September returns. The September returns will then be considered by the Strategic Occupational Health and Safety group

Fire Safety Report

The fire safety report was verbally presented to the Strategic Occupational Health and Safety Group and included the number of fires and unwanted fire signals that the Health Board had had in 2020/21. The report set out that the Risk assessments require review and safety systems implemented as a result. This is particularly relevant with increased oxygen demand and compartmentation issues identified in Ysbyty Gwynedd (YG) for which the business case has been presented to the Executive Team, Finance and Performance and the Board and is now with Welsh Government for consideration.

Risk Register

The following risks were escalated :

Risk ID3187- Inability to deliver a fit testing programme to meet demand

Current score is 5x2= 10H

There is a risk that staff and patients may be exposed to COVID-19 caused by the inability of the Health Board to provide sufficient fit testing capacity and capability to staff and the inability to react quickly and consistently to changes in make/model of FFP3 masks available to the Health Board. This could lead to not all staff being appropriately fit tested or trained in donning and doffing in a timely manner, leaving staff and patients being potentially exposed to COVID-19 without appropriate protection.

This risk was submitted to the meeting to provide an update as the risk is likely to increase due to fit testers returning to substantive roles. The Executive Team has agreed for an escalation process to be implemented. A process for escalation document has been sent to the Area Directors and Hospital Management Teams to notify when fit testers are required to be released to support fit testing in the fit testing hubs.

Risk ID3893- Manual Handling Training and lack of dedicated facilities

There is a significant risk that BCUHB is non-compliant with the Manual Handling Operation Regulations 1992 (amended 2002), due to no dedicated training rooms in East or West and only one dedicated training room in Central. Whilst training is unable to take place there is a risk of staff and patient injury, lost work time, HSE enforcement action and reputational damage

This is a new risk on the risk register and submitted for information and a discussion on the scoring. Subsequent to the meeting, the Executive Team has agreed a set of mitigating actions. A further case for resource to manage the backlog and implement a sustainable provision is being considered by the Executive Team.

HSE Investigations

The annual Corporate H&S report sets out details of the HSE investigations in 2020/21. On the 24th of August 2020 BCUHB received an Improvement Notice and accompanying Notification of Contravention letter relating to the provision of fit testing and competency of fit testers which has been complied with following actions undertaken formulated by a Task and Finish Group. The outstanding actions include the implementation of a Fit Testing Program Team and a business case has been developed for consideration by the Executive Team in June 2021.

On the 23rd of February 2021, following investigation into a specific incident ,BCUHB received a Notification of Contravention (NOC) for not having a monitoring system in place to ensure staff have had a fit test to the respirator they are using and for inadequate completion of the COVID-19 Workforce risk assessment tool. A trial of a fit testing identification badge has been undertaken and a task and finish group established to work through an action plan to comply with the requirements of the NOC.

The HSE are also investigating a suicide in MHLD, two patient falls and have requested information on three COVID-19 staff clusters.

Subsequent to the meeting, HSE has issued an Improvement notice in relation to the Health Boards Management of prevention of harm from falling. Completion of the actions is required by September 2021. Deputy Chief Executive, Director of Nursing is lead Executive for this improvement.

2. Assurance

Health and Safety Leads Group

Overview of items discussed:

- RIDDORs
- Lack of suitable venues for Manual Handling training
- Inconsistent returns of the H&S Self-Assessment Tool
- Return of Shielding Staff

- Quality of fit testing
- Management of oxygen in paediatrics

The focus of the alert for escalation was the lack of returns of the H&S Self-Assessment Tool which is required under the BCUHB H&S Policy to be completed by department manager's in March and September. It was agreed for the H&S Leads group to discuss the escalation within their Divisions for the September submission

Estates Triple A report

A report was received from the Director of Estates and Facilities to give an update on the review of the Board Assurance framework and risk register along with updates from the meetings. The report described progress on key areas of risk including, fire safety, water safety, electrical safety and asbestos.

Divisional Triple A Reports

This was a new requirement for reports to be submitted from Hospital Management Teams (HMTs), Area Directors and MHLD. Report received from all except Area East who will provide reports going forward.

Corporate H&S 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. With changes in restrictions of movement since this date the H&S team primarily focused on supporting the Hospital Management Teams and department managers with site visits to support with the 'social distancing and staying safe' program and later with undertaking risk assessments for staff returning from shielding. In total 431 visits were made in 2020/21. All visits in Q4 were within this timescale. The team also reintroduced on a small scale the formal Corporate Health and Safety reviews in Q3 as part of the BCUHB auditing process. A total of 85 Corporate Health and Safety reviews were undertaken in 2020/21.

3. Achievements

- The updated Prevention of Violence and Aggression Guidance was approved by the Strategic Occupational Health and Safety Group 25.05.21
- The updated Fit Testing Protocol was approved by the Strategic Occupational Health and Safety Group 25.05.21
- Risk ID3853- Failure to comply with the HSE Notification of Contravention update. The trial of the Fit Testing Identification Card has been completed, this was generally well received by departments and progress will now be made to implement a permanent monitoring system to comply with the Notification of Contravention requirements. Funding for this will be required and an SBAR will be submitted to the Executive Director by the end of June 2021 with costs.
- Significant progress is being made to complete the gap analysis following the Corporate Health and Safety Compliance Audit undertaken in 2019/20. Specific H&S reports have now been completed for Water Safety management and Electrical Safety. Action plans have been completed and these will be updated via the specific Estates management group with responsibility for these areas. An in-depth H&S check of

Asbestos Management has now also commenced with an expected completion date of the report by the end of June 2021.

CEG Chair's Report to QSE

Alert Assurance Achievement (AAA) report

Reporting Group	
Name of Reporting Group	**Clinical Effectiveness Group**
Responsible Director	**Prof Arpan Guha, Acting Executive Medical Director**
Date of meetings	**27th April 2021**
Version number	**1**
Appendices	**N /A**

Reporting To	
Name of meeting	**Quality, Safety and Experience (QSE) Committee**
Date of meeting	**6th July 2021**
Presented by	**Prof Arpan Guha, Acting Executive Medical Director**

1. Alert – include all critical issues and issues for escalation

Reducing Avoidable Mortality Steering Group

Issue:

- Attendance remains poor.

Explanation:

- Actions taken to date include review of Terms of Reference, membership and format.

Action:

- Consensus that meetings should continue with close monitoring of attendance and outputs
- Recruitment to Mortality Review lead for inpatient deaths.
- Further work required to establish mortality review process across Primary Care.

Date of completion:

- Update to next CEG meeting, with formal review in 3 months.

A number of Chair's Reports were received from sub-groups and specific agenda items, which are summarised below:

Reporting group: Clinical Law & Ethics Sub-Group

Issue:
- Confirmation of Clinical Executive responsible for End of Life decision making

Explanation:
- End of Life Care and Palliative Care could have different Clinical Executive oversight. New Strategic Delivery Group for palliative and end of life care advocate that all aspects of end of life care decision making should fall within their remit.

Action:
- Seek confirmation from Executives to support this recommendation

Date of Completion:
- Next Strategic Delivery Group meeting

Reporting group: Medical Education HEIW (Health Education & Improvement Wales)

Issue:
- Post Graduate HEIW risk report

Explanation:
- A number of departments remain at high risk through failing to meet General Medical Council (GMC) standards for medical education. Reasons for this include high work load, inconsistent access to education opportunities, access to theatre training lists, high proportion of senior medical locum workforce and access to clinics.
- Covid related impact on training with redeployment and reduced elective activity.
- Staff health and wellbeing – stress related sick leave and early retirements have meant reduced resource to support education.
- Ability for Medical Education to contribute to service business meetings.

Action:
- Completion of individual service improvement plans.
- Review of Kendal Bluck recommendations to progress workforce business cases (Emergency Departments as priority).
- Education requirements included in clinical pathway template, further focus required to ensure full compliance.
- Request for Medical Education to be standard agenda item within all specialty business meetings.

Date of Completion:

- Monthly review at Strategic Medical & Dental Education Board.

Standard Agenda Items

Clinical Audit Annual Plan

- Reviewed and supported.

Clinical Effectiveness Strategy

Feedback suggested further work on the following areas:

- Implementing NICE guidance linked to Health Board quality and aims
- Link to population health to be added
- Annual Reports
- Tier 2 audit – process identified and agreed
- Progress Tier 3 work
- Reporting compliance – need to assure compliance and bring into Cycle of Business
- Culture of audits to be reviewed

Clinical Effectiveness Organogram

- Queries raised relating to primary care and medical education reporting.

NICE Implementation Policy

- Request for author to review policy following feedback received regarding Clinical Effectiveness Strategy to link to the Health Board's quality and aims.

Quarterly Mortality Report

- Inpatients crude death rate (2.25) is lower than Welsh peer (4.6) with no significant change in the last two years until Covid pandemic.
- National Bowel Cancer Audit highlighted BCU as outlier for 2 year survival, no systematic issues identified. Noted failure to record palliative procedures accurately and inaccurate recording of staging.
- National Lung Cancer Audit noted. A low rate of referral for chemotherapy - this was a missing data field entry now resolved.

Healthcare Associated Infection (HCAI) Covid Death Review Process

- Nationally directed review of all healthcare associated deaths.
- Additional resource required.
- Process for identification, completion of Stage 2s and reporting was agreed.

3. **Achievement** – include any significant achievements and outcomes

Reporting group: ***Clinical Law & Ethics Sub-Group***

Positive feedback received relating to the support offered from this Group in relation to difficult ethical questions particularly during the Covid19 pandemic.

Reporting group: Medical Education HEIW

The Royal College of Obstetrics & Gynaecology have named Mr Fernando (Consultant, Wrexham) as the national trainer of the year.

Mortality Report

Good and excellent examples of End of Life care and multidisciplinary team working between Mental Health & Learning Disabilities, Palliative Care and Care of the Elderly.

CEG Chair's Report to QSE

Alert Assurance Achievement (AAA) report

Reporting Group	
Name of Reporting Group	**Clinical Effectiveness Group (CEG)**
Responsible Director	**Prof Arpan Guha, Acting Executive Medical Director**
Date of meeting	**17th June 2021**
Version number	**1**
Appendices	**N /A**

Reporting To	
Name of meeting	**Quality, Safety and Experience (QSE) Committee**
Date of meeting	**6th July 2021**
Presented by	**Prof Arpan Guha, Acting Executive Medical Director**

4. Alert – include all critical issues and issues for escalation

NICE Assurance Group:

Issue:
- Primary Care Compliance

Explanation:
- Problems remain in receiving compliance status from primary care as there is nothing contractually that requires them to report

Action:
- Continue to explore with Area Medical Directors the professional obligation of GPs to report on this and report back at next CEG

Drugs & Therapeutics Group (D&TG):

Issue:
- Evaluation of effectiveness of treatment modalities that have been approved

Explanation:
- Once treatments have been approved, D&TG have struggled to receive feedback from clinical teams on whether the treatments have been effective.

Action:
- In April 2021, a new form was approved and clinicians will be required to submit an outcome data capture form 4-6 weeks prior to the end of the approved treatment period

Palliative Care and End of Life Strategic Delivery Group

Issue:
- Chair of the group is Executive Director of Primary & Community Care who has not been able to chair due to diary issues.

Explanation:
- The group is not currently chaired by an Executive and often items that require escalation to executive level for decision making do not progress

Action:
- Prof Guha to write to Dr Stockport on behalf of CEG pointing out that we need to see how we can help progress this issue.

Reducing Avoidable Mortality Steering Group

Issue:
- Early warning of potential increase in mortality rates in some areas

Explanation:
- Two of the CHKS mortality indicators indicating that there could be a problem over the last 12 months for fractured neck of femur and older people with organic mental health issues.

Action:
- Further analysis will take place to identify if this is an underlying issue.

Mortality reports:

Issue:
- Mortality Reporting

Explanation:
- Difficulty in getting information back from secondary care, primary care and community sites for reporting.

Action:
- Members of the group to disseminate the request for return of information required for mortality reporting within the next few days.

Clinical Audit Annual Plan:

Issue:

- Clinical audit plan format and presentation

Explanation:

- The plan was reviewed and supported, however a wider discussion ensued around the importance of marrying items on the risk register to the Tier 2 plan and the role of a dedicated group to discuss clinical audit across the health board.

Action:

- AG to convene a meeting to discuss establishing an audit meeting to resolve. Invitation extended to anyone interesting in attending.

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5. Assurance – include a summary of all activity of the group for assurance

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A number of Chair's Reports received from sub-groups and standing agenda items, which are summarised below:

Reporting group: NICE Assurance Group

- Twenty-four new medicines were approved: 16 NICE/AWMSG, 1 treatment prior to market authorisation for early access medicines scheme, and 7 within an appropriate treatment pathway were approved.
- Thirty-four applications for Individual Patient Funding Request (IPFR) in 2021: 4 met the criteria to go to the IPFR panel; the other applications were for low cost treatments for off licence drugs or non-formulary drugs. 31 of the 34 applications were supported.

Reporting group: Strategic Deliver Group for Palliative Care & End of Life Care

- DNACPR (do not attempt cardio pulmonary resuscitation) audit ongoing, which will inform discussions around senior responsible clinician definition and wider aspects of end of life care decision-making.
- Swan model will be implemented, this framework integrates end of life and bereavement care which raises the profile in a visible but compassionate way.
- Dr Chris Stockport has been identified as Executive Lead for Bereavement Care; this aligns with Dr Stockport's role of Executive Lead for Palliative and End of Life Care.
- Engagement plan going live this week comprising of online survey for public and carers to capture views and experiences of end of life care. Focus groups for minority groups and staff. This feedback will inform an outline strategy and deliver plan.
- National Audit for Care at the End of Life opening on 1st June and closes for data collection in October.
- A metrics dashboard is being developed for Palliative and End of Life Care.
- All Wales end of life care Board will be publishing a stock take of a review of Palliative Care across Wales.

Policies received for consideration

Clinical Guidelines for the Management of Osteoporosis
- The group endorsed the guideline

Standard Agenda Items

Clinical Effectiveness Strategy
- The Group endorsed the Clinical Effectiveness Strategy.

NICE Implementation Policy
- Deferred until August 2021.

6. **Achievement** – include any significant achievements and outcomes

Patient Story: Andrew's Story (April 2021)
The group heard Andrew's story, which detailed the compassionate care Andrew's mother received during the last days of her life. Andrew praised the staff for their kind, compassionate, and friendly attitude, which provided his mother with dignity and respect. The quality of care of was excellent and the staff did exceptionally well communicating with family.

Reducing Avoidable Mortality Steering Group
Pan BCU Mortality Lead will be advertised in the coming weeks.

Reporting group: NICE Assurance Group

- Compliance for secondary has improved.
- Audit Management and Tracking (AMaT) system will piloting the NICE guideline element in July 2021 to support the monitoring of compliance with guidance.
- Liz Bowen will be the new Chair of NICE Assurance Group after Geeta Kumar steps down at end of June.

Chair's Report

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting or area reporting in	Patient and Carer Experience Group
Chair of meeting or lead for report	Debra Hickman
Date of meeting	29th April 2021
Version number	V1.1
Appendices	N/A

Reporting To	
Name of meeting	Quality Safety and Experience Committee
Date of meeting	6th July 2021
Presented by	Matthew Joyes, Acting Associate Director of Quality Assurance and Assistant Director of Patient Safety and Experience

1. Alert – include all critical issues and issues for escalation

- **Patient Communication and Readers Panels Sub-group**: Future work plan develop a central library of all of these resources for staff to access.

- **Complaints performance** was noted as an area requiring improvement. Divisions updated on their plans.

- **Terms of reference and membership will be reviewed** to ensure the right divisional representation is consistently achieved at the meeting.

- A **key theme from feedback and complaints is the difficulty relatives are having in contacting wards** to get updated on their loved ones – all inpatient services were asked to provide an update on work being done to improve this and the pilot of a Matrons' Helpline at Wrexham Maelor Hospital was noted.

- **Bereavement sub Group**:

  - The group is confirming the lead executive in respect of the Bereavement Quality work
  - Partnership working is progressing well with a number of stakeholders and Patient Advice and Liaison Service (PALS) service and linking with Community Health Council.
  - Fiona Murphy, who pioneered the SWAN model for end of life and bereavement care has been invited to the Group on 27th May 2021, the group are keen to extend invites to BCUHB colleagues.

- **Triple A reports from Divisions:**

  - Divisions welcome the new roll out of the new complaints procedure.
  - Divisions are working hard to reduce overdue complaints and achieve the compliance target. Positive practice is seen in the Mental Health and Learning Disability Division.

- **Engagement Team:** The team are continuing with positive Engagement work to support service improvement, strengthen partnership and networking.

- **Community Health Council:** Safe space events held, talking to service providers and service users on Mental Health, and the report has been sent to the Health Board and lessons learned will be taken forward.

- **Healthcare Inspectorate Wales (HIW)**: As of 1st July 2021 HIW will resume on-site inspections. Assurance work also continuing through the virtual quality checks. HIW updated the group on the programme of work and some of the future reviews and noted positive engagement with the Health Board.

- **Bi monthly Patient and Carer Experience Report Oct-Nov 2020:** The report provides the Quality, Safety and Experience Committee with assurance on the Health Board's work to improve patient experience. Excellent progress made on acknowledgement of complaints, (within 2 days) response rate plus 100% in March 2021. Response rate for complaints remains struggling to improve. The positive work of the Patient Advice & Liaison Support Service (PALS) Bereavement Support, Letters to loves Ones and Digital Visiting were noted.

- **ISU2 Patient Written Information Procedure : Approved**
  The procedure was approved. Future work plan to include a review of all patient information to ensure a high standard and to develop a central library.

- **Patient Stories Framework : Approved**
  The procedure was approved. Exciting developments were noted around the videoing of patient stories, procuring a video camera for each site, which will make a huge difference in capturing visual stories, and is important for patients and families to tell their own story.

- **Accessible Communication and Information Healthcare Report : Approved**
  The report was approved for submission to Welsh Government. Robust report that highlights the need to drive forward how important the awareness of the Sensory Loss Toolkits that are situated in the clinical ward areas are to obtain interpretation and the British Sign Language (BSL) services.

3. Achievement – include any significant achievements and outcomes

- **Realtime feedback**: The CIVICA All-Wales System is being rolled out during Q1.

- The group highlighted excellent proactive work and engagement by all staff and positive feedback from Stakeholders eg HIW and Community Health Council (CHC).

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 6th July 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Kate Dunn, Head of Corporate Affairs
Craffu blaenorol: Prior Scrutiny:	None
Atodiadau Appendices:	None

Argymhelliad / Recommendation:
The Committee is asked to note the report

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	✓

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 4.5.21
- Executive briefings on urgent matters
- Vascular update from task and finish group