Bundle Quality, Safety & Experience Committee 3 May 2022

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

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Carer Story – Michael's story
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Associate Director of Quality
Awdur yr Adroddiad Report Author:	Matthew Joyes, Associate Director of Quality Carolyn Owen, Assistant Director of Patient and Carer Experience Rachel Wright, Patient and Carer Experience Lead
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Associate Director of Quality
Atodiadau Appendices:	Carer Story https://nhswales365-my.sharepoint.com/:v:/g/personal/zoe_gamble_wales_nhs_uk/Ef-1g2mnBshGufQDIB_S5dwBty23G91ejYrwsawu2iIDrw?e=RUxhha

Argymhelliad / Recommendation:
The committe is asked to receive and reflect upon the carer story.

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

Michael's Story

A video story, told by Michael, will be played at meeting

<u>**Overview of Michael's story**</u>

I am an unpaid carer for my mum suffers who has severe mixed dementia. My mum cannot go anywhere on her own at all so, when she was admitted to Ysbyty Glan Clwyd by ambulance with chest pain and vomiting, I drove to the hospital to accompany her.

Whilst we were at Ysbyty Glan Clwyd Emergency Department, I felt that my mum was ignored for hours and no support was offered to help her, or me as her carer. Staff did not seem to acknowledge her dementia diagnosis and showed no awareness that her being left for many hours with now treatment would escalate her agitation.

I was left to deal with her extremely distressed state alone, with very little support from staff. Although I repeatedly asked for a butterfly to be put above her bed, to indicate to staff that my mum had dementia, this was never done. A very important letter that I have to carry with me to explain my mum's dementia diagnosis was lost whilst my mum was in hospital, and I had to request that another one be sent to me by her Psychiatrist.

I feel that more robust dementia awareness training needs to be put in place to ensure all staff are aware of how to recognise and deal with dementia patients. The Butterfly Scheme needs to be implemented in the Emergency Department and the butterfly symbol should be supplied above the bed and on the notes of all dementia patients as a signifier to staff that they are dealing with a dementia patient.

Key issues identified:

- Long wait in ED for elderly patient with little communication or support offered
- Patient's dementia diagnosis was not taken into account and patient was left for a long time without treatment
- Patient's carer was not acknowledged or supported
- Butterfly scheme was not implemented in the Emergency Department.

Summary of learning and improvement

- The Emergency Department will ensure the Butterfly Scheme is implemented for all patients with dementia.
- The Patient and Carer Experience Team will work with the Dementia Specialist Nursing Team to explore re-launching the Butterfly Scheme across the Health Board.
- Staff will be reminded to be mindful of patient belongings when patients are moved between beds to prevent items being lost.
- Managers will take action to ensure staff complete mandatory ESR training on dementia.
- The Patient and Carer Experience Team are currently working with the Alzheimer's Society to continue to capture the experiences of dementia patients and their carers.

This is a very recent story and further actions will be developed.

The Patient and Carer Experience Team have shared this feedback with services and will seek assurance from departments by way of evidence that changes have been embedded.

The Patient and Carer Experience Team extend their gratitude and appreciation to Michael for sharing his experience.

Quality, Safety and Experience (QSE) Committee
DRAFT Minutes of the Meeting Held in public on 1.3.22 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, North Wales Community Health Council
Gareth Evans   Chair of Healthcare Professional Forum (*part meeting*)
Simon Evans-Evans   Interim Director of Governance
Sue Green   Executive Director of Workforce and Organisational Development (OD)
John Gallanders   Independent Member
Gill Harris   Executive Director of Nursing and Midwifery / Deputy Chief Executive
Matthew Joyes   Acting Associate Director of Quality Assurance
Mandy Jones   Director of Nursing
Nick Lyons   Executive Medical Director
Molly Marcu   Interim Deputy Board Secretary
Teresa Owen   Executive Director of Public Health
Philippa Peake-Jones   Head of Corporate Affairs (minutes)
Mike Smith   Interim Director Of Nursing Mental Health
Chris Stockport   Executive Director Primary Care and Community Services
Joanna Watson   Good Governance Institute
Iain Wilkie   Interim Director of Mental Health

Agenda Item Discussed	Action By
It was noted that the meeting was being recorded in Teams for administrative purposes.	
QS22/36 Patient Story **QS22/36.1** The Acting Associate Director of Quality Assurance introduced the story which was from the parents of baby Hunter and noted that the covering paper highlighted the range of improvements in response to their experience. He thanked the parents for sharing their story. **QS22/36.2 The** Executive Director of Public Health acknowledged that it was a very sad story and that the Woman's team have reflected, that there has been a lot of learning from this experience, and they are working closely with neonatal. **QS22/36.3** The Committee acknowledged the bravery of the parents to have shared their story, concern was raised that the review into the case had been a desk top exercise and that the parents were not given the opportunity to input into the report. The Acting Associate Director of Quality Assurance advised that this had been an error	

and they should have been given the opportunity. It was noted that the parents had since met with a number of staff, their story has been shared in supervision meetings to embed the learning from what happened.

QS22/36.4 The Committee noted that the visiting guidance between England and Wales had been different at the time which had meant that the experience that the parents had was different between hospitals. The Executive Director of Nursing and Midwifery / Deputy Chief Executive advised that the policy on visiting and wider guidance is being reviewed by Welsh Government and should any changes occur the policy will change. It was noted that individual cases should be assessed with regards to visiting.

QS22/36.5 It was resolved that the Committee receive and reflect upon the story.

QS22/37 Apologies for Absence

QS22/37.1 Apologies had been received for Adrian Thomas and Louise Brereton – welcome to John Gallanders, new Independent Member

QS22/38 Declarations of Interest

QS22/38.1 There were no declarations noted.

QS22/39 Minutes of Previous Meeting Held in Public on 11.1.21 for Accuracy

QS22/39.1 The minutes were agreed as an accurate record subject to Jo Whitehead being in attendance for the meeting and the change in the date from February to January 2022.

QS22/40 Matters Arising and Table of Actions

QS22/40.1 Updates were provided to the summary action log and actions were agreed as closed where highlighted.

QS22/41 Report of the Chair

QS22/41 The Chair's Assurance report was received and agreed.

QS22/42 Report of the Lead Executive

QS22/42.1 The report of the Lead Executive was received, the Executive Director of Nursing and Midwifery / Deputy Chief Executive highlighted the areas of concern addressed in the report in particular noting the failure to escalate in a timely way and that a piece of work being led by Mandy Jones about having a coordinated approach has commenced.

QS22/42.2 It was resolved that the Committee received the report.

QS22/43 Recommend Quality Aspects of the Integrated Medium Term Plan (IMTP) **QS22/43** The Executive Director Primary Care and Community Services presented the paper thanking John Darlington and Matt Joyes for producing the report. It was noted that the Quality Act, yet to be passed, has been used as a tool to pull together the quality aspects of the IMPT report. An Independent Member noted that Public Health does feature but that this could be an area to highlight further. Another Independent Member queried how the issues around eye care will be evaluated and how all carer's issues are being included. The Executive Director Primary Care and Community Services clarified that with regards to eye care, the specification for follow up is clearly laid out in terms of clinical expectations and that patient outcomes and experience would be collected during the pathways with a view that this will improve the pathway. It was noted that the carer's perspective is being brought through the IMTP and will be clear in the wider document which will be reviewed at Board Meetings. **QS22/43.2** A discussion took place around Cancer Pathways it was noted that a strategic cancer group buddying with the Greater Manchester Board is being set up where a number of issues will be taken forward including MDT working and access. It was agreed that the Executive Director of Nursing and Midwifery / Deputy Chief Executive and Cheryl Carlisle would pick up this discussion offline. **QS22/43.3 It was resolved that** the Committee received the report.	 GH/CC
QS22/44 Quality Priorities **QS22/44.1** The Executive Director of Nursing and Midwifery / Deputy Chief Executive presented the paper highlighting that during Covid the Quality Strategy had been put on pause but that it is now being re-started and stakeholder engagement would be key. It was noted that there would be other priorities but these are the ones being highlighted for the Committee. **QS22/44.2** The Interim Deputy Board Secretary suggested that the priorities be aligned to the Board Assurance Framework and agreed to pick this up outside of the meeting. The Executive Medical Director welcomed the document, clarification was sought with regards to terminology and the phrase "patients" mainly being aligned with secondary care. Attendees discussed the Speak Out Safely facility and the other ways available to raise concerns, how they will be addressed. It was noted that the Vice Chair and the CEO have monthly meetings with the Speak Out Safely guardians. **QS22/44.3** Acting Associate Director of Quality Assurance reiterated that the priorities shared are interim, that Public Health will be addressed as part of the Quality Strategy that engagement would be with patients, carers and language would be reviewed but noted that there has never been an overarching word for patient that has been unanimously agreed. **QS22/44.4** The Executive Director of Nursing and Midwifery / Deputy Chief Executive advised that if a complaint had been received then the Health Board had already failed. The Chair suggested that the strategy be a live ongoing one that is continuously reviewed.	 MM

QS22/44.5 The Acting Associate Director of Quality Assurance thanked the Committee for the feedback and noted that it would be a multifaceted approach with the Health and Safety team and other areas being fully involved. A focus on moving away from compassion towards kindness was fully supported.

QS22/44.6 It was resolved that the Committee endorsed the priorities noting that they would likely change as the strategy progressed.

QS22/45 Workshop Feedback Update

QS22/45.1 The Executive Director of Nursing and Midwifery / Deputy Chief Executive advised that following a recent meeting it was agreed to pilot a revised Committee coversheet for Committee papers to enable the papers to give more assurance, reflect risk, identify why the paper was being received at the committee and reduce the size of papers to focus down on answering the question. That each patient story, wherever possible, should link to an agenda item and reflect what difference has been made. It was reflected that the Committee needed to continuously ask the "so what?" question to ensure that it doesn't become transactional and the agenda should be flexible.

QS22/45.2 The Interim Deputy Board Secretary advised that authors should be asked to gage the level of assurance they are giving with their papers and that the annual report had previously been a retrospective assessment but that a holistic process is being developed which will include an annual survey to feed in to ensure that the Committee terms of reference are being discharged in a dynamic smarter way.

QS22/46 Vascular Steering Group Update

[Joanna Watson joined the meeting]

QS22/46.1 The Executive Medical Director advised that the update had been recently reviewed at the Extraordinary Board meeting. It was noted that Susan Akenhead had been appointed as Chair of the Vascular Quality Panel. There is process ongoing to appoint a lead who has been working nationally with the Royal College of Surgeons, to work one day per week to move some of the softer sides of the agenda forward. It was noted that a Memorandum of Understanding with Liverpool has been written and is currently being finessed.

QS22/46.2 An Independent Member advised that she felt more assured than she had in previous years but asked whether it would be possible to tell if a "good day" had been had within the service as a result of the actions. The Executive Medical Director advised that in his opinion the vascular improvement plan is right, that the next step would be to produce a vascular quality dashboard so that it would be possible to understand at a glance what was happening. It was noted that the number of patients actually treated is very small, the vascular society have produced some guidance and the national guidance is welcomed. Welsh Government are now working with the Health Board to produce a quality dashboard.

QS22/46.3 An Independent Member queried that with regard to the contract in place with Liverpool, who would have the responsibility for the patients and that the paper

highlights additional workforce requirements and if it would be possible to understand what was required.

QS22/46.4 The Executive Medical Director advised that there are some patients that would be transferred to Liverpool but the Memorandum of Understanding is around the multidisciplinary discussions and that the majority of patients would stay with the Health Board. With regards to recruitment it was clarified that this included the diabetic foot pathway that are not necessarily part of the vascular service.

QS22/46.5 The Chair of the Committee queried what the delay was on some of the improvement actions included the helpline. The Executive Medical Director advised that he had made the decision not to set up a helpline until the Vascular Steering Group had been set up, however, he acknowledged this had been the wrong decision to make and the helpline is now in place. The Acting Associate Director of Quality Assurance advised that the line was operating within 48 hours of the decision being made to open and actively promoted from the Monday thereafter. It was noted that there had not been much activity on the helpline but there was a dedicated complaints team enabled to specifically deal with vascular concerns and that this would be reported through the vascular quality panel.

QS22/46.6 The Chair of the Committee advised that there was had a meeting scheduled to discuss regular reporting to the Minister and that the Chair had already met the Minister about the service. It was noted that all reports that go to the Minister will also be reported to the QSE Committee and that it was essential that the Health Board is able to provide evidence based progress.

QS22/46.7 It was resolved that the Committee received the update from the Vascular Steering Group.

QS22/47 Urology Service Review of Terms of Service

QS22/47.1 The Executive Director of Nursing and Midwifery / Deputy Chief Executive informed the committee that an external review by the Royal College had been requested by the Board on the Urology Service. It will link in with the ongoing Vascular work. It was noted that the Terms of Reference for this review had been discussed and agreed in collaboration with the Royal College and the Committee are being asked to approve subject to some very minor amendments.

QS22/47.2 The Executive Medical Director advised that he supported the terms of reference and that the delay in these being brought for approval was due to him wanting to take personal responsibility for them being correct as it was essential that the change in Urology needed to start immediately. The Executive Director of Nursing and Midwifery / Deputy Chief Executive advised that this meant that the work would be across the Health Board and that it would be drilled down through the Network manager to ensure there is one version of the truth, that the MDT are supported with the advantages of buddying up with Manchester to understand best practice and getting things right first time.

QS22/47.3 The Committee discussed the learning from the Vascular review to ensure that lessons had been learned with regards to providing the Royal College with the

correct information and files and that the Urology team understood why the review was taking place and that they were fully engaged. The Executive Medical Director advised that they were, that he has met with the Urology Consultants and the Urology Improvement Group would be included in the process.

QS22/47.4 The Committee discussed patients being included in the review and that a workforce model defines what clinical staffing means that the whole of the workforce is identified not just those with clinical positions. It was noted that when staff enter the conversations they understand what any implications may be.

QS22/47.1 It was resolved that the Committee approved and endorsed the draft terms of reference.

QS22/48 Harms Report

QS22/48.1 The Executive Director of Nursing and Midwifery / Deputy Chief Executive presented the paper, the purpose of which was to highlight to the Committee all of the risks that are being managed as part of the current challenges presented because of outbreaks, beds spaces and workforce gaps. The paper focussed predominantly on falls and pressure ulcers and that close work was ongoing with the Workforce team. It was noted that the national pressure ulcers review is taking place over the next 12 months. The Committee discussed duty of candour and how patients were being communicated with.

QS22/48.2 The Chair queried the differences highlighted in the report with Ysbyty Gwynedd compared to the other sites and the Acting Associate Director of Quality Assurance clarified that this was because they have had both falls and pressure ulcer issues. The environment was discussed, the learning from the falls group has been shared to allow good practice to be shared.

QS22/48.3 The Executive Director of Workforce and Organisational Development provided an update on Health and Safety Executive feedback noting that there is a good element of control and templates are right, that there is high compliance on training but low compliance on risk assessment as a result of this not being seen as part of the clinical notes. It was noted that the focus was now on making sure people are doing what they need to do and at the right time and queried how some of this has not been identified through our own processes.

QS22/48.5 It was resolved that the Committee noted the report   MJ

QS22/55 NU06 – The Prevention and Management of Adult In-Patient Falls
[taken out of agenda sequence]

QS22/55.1 The Committee went on to discuss the Falls Policy in conjunction with the Harms Report. There was a discussion about the monitoring and compliance against the Falls Policy. It was agreed that section 7.4 be updated to include weekly group meetings, how the learning would be shared, how the accountability framework and weekly groups would be included and how all falls would be reported and reviewed.

QS22/55.2 It was resolved that the Committe reviewed the policy and agreed to ratify via chairs action subject to the changes discussed on section 7.4 in agenda item QS22/48 (for launch pan BCUHB March 2022).	
QS22/49 Corporate Risk Register Exception Report relating to Quality Risks **QS22/49.1** The Committee noted the ongoing challenge between corporate and clinical risk and were informed that a really useful discussion at the last Risk Management Group had taken place and that the risk team are also looking at patient feedback and having conversations with the teams alongside ongoing work with the work aligning the Risk Register to the BAF. The target dates were discussed and the Interim Director of Governance agreed to review. **QS22/49.2** The Committee noted the timely access to care homes risk with the Executive Director of Nursing and Midwifery / Deputy Chief Executive highlighting that looking across the Health Board, the longer someone stays under the care of the Health Board, the longer they are likely to develop a pressure ulcer and fall. It was noted that work is ongoing with Local Authorities. **QS22/49.3** The Interim Deputy Board Secretary advised that the paper should say in future when there is a clear misalignment between the risk appetite and where we are. **QS22/49.4** An Independent Member raised the two years wait for an urgent outpatient appointments on site is the highest risk. The Executive Director of Nursing and Midwifery / Deputy Chief Executive advised that a risk assessment for each site is being undertaken to assess which can be brought on line, it was noted that much of outpatient capacity is taken up by follow ups and patient initiated follow ups are being considered to create capacity. **QS22/49.5** The Chair requested that the process of risk management and governance is reviewed outside of the meeting to ensure that the Committee are clear what is being asked of them.	SEE SEE/ MM/NL
QS22/50 Patient Safety Report **QS22/50.1** The Chair noted that she had provided the Acting Associate Director of Quality Assurance with some feedback noting that these would be addressed outside of the meeting and attached to the minutes. It was noted that fundamentally, concern was that there was no assurance over the learning from incidents, that the report was informing about the incidents and the immediate learning, but not what has happened to previous incidents. This learning should feed into the clinical audit plan where reoccurring themes are identified and what learning and changes have taken place because of this. The Never Event action plan that was sent back to the service had not returned to Committee, it was requested that this be done. **QS22/50.2** The Chair highlighted that this agenda item was supposed to provide a deep dive of Never Events and that she was disappointed with the lack of detail within the report. The Acting Associate Director of Quality Assurance apologised for missing the expectation with the report, he noted that there had been 9 Never Events in the current financial year with 5 in the previous year. The recurring theme that is that the majority	PPJ MJ

are surgical and in particular with regard to the use of the surgical checklist. It was agreed that further work would be done outside of the meeting and that when deep dives are undertaken clarity about what is being asked is defined. It was noted that Internal Audit would be able to support this work. **QS22/50.3** The Acting Associate Director of Quality Assurance advised that the Coroner was reviewing a number of cases at the moment involving delays with ambulances, not just associated with the BCUHB, he was looking at other Health Boards in the round. **QS22/50.3** The Chair noted that a robust clinically focussed audit plan is required and that this should be reviewed at the next meeting. She also requested an update on all previous Regulation 28's. **QS22/50.4 It was resolved that** the Committee receive the report	NL/MJ
QS22/51 Quality Awards, Achievements and Recognition **QS22/51.1 It was resolved that** the Committee received the Quality Awards, Achievements and Recognition paper.	
QS22/52 Patient and Carers Experience Report **QS22/52.1 It was resolved that** the Committee received the Patient and Carers Experience Report and that any questions should be raised outside of the meeting.	
QS22/53 External Serious Incident Reviews MHLD [Iain Wilkie joined the meeting] **QS22/53.1**. The Chair noted that the reports on both incidents had been received in full by Committee members but a redacted version of the reports being shared in the public domain had been done so to protect the individuals involved and their families. It was noted that Serious Incident Reviews would not normally be reported in the public domain but that recognition was given to the seriousness of the incidents and that for the interests of transparency the reports were being shared in this way. It was noted that the focus for the Committee was about learning and what was being done to address this. **QS22/53.2** The Committee noted that there was an overall action plan that brought together the detailed action plans shared. It was noted that the action plan will be shared with the Adult Safeguarding Board at the appropriate time given that both external reviews had only just been received. It was noted that the Health and Safety Executive investigation is ongoing. **QS22/53.3** An independent Member raised concerns around mandatory training issues, staff records, communications and the need for confirmation that patients are dealt with in the round especially regarding substance misuse. The Interim Director Of Nursing Mental Health explained the current staffing arrangements. The Committee	

discussed the Section 136 and the issue of revolving doors, it was noted that a person cannot be detained under section 136. The Executive Director of Public Health advised that she would bring back some information on how the co-occurring approach around Section 136 is being handled. A discussion took place around on the job learning being more valuable than e-learning packages. The Interim Director of Mental Health advised that further work was required on maintaining adequate training records and that he would take this and how staff are managing substance missus forward outside the meeting to go through governance.	TO
QS22/53.4 The Chair noted that the Ty Llewelyn action plan had not yet been published in the public domain and that further work would be required before it is to ensure that actions appropriately address the recommendations. The Chief Executive noted that the Health Board wide action plan lacks outcomes and timescales, that what is currently presented is a good start, but required tangible outcomes. The Executive Director of Public Health agreed that she would look at the outcomes, it was noted that these should link to the QPR.	TO
QS22/53.5 The Interim Director of Mental Health advised he would be working with the Director of Transformation and Improvement and reaching out to other Health Boards to identify how they have embedded sustainable learning. The Chair requested that the Committee receive a more dynamic improvement plan that consolidated all of the findings from the external reviews whilst also incorporating systemic improvements identified from previous reviews. She expected this to be provided to the next Committee meeting.	
QS22/53.6 The Committee discussed observations of patients at HMP Berwyn, The Acting Associate Director of Quality Assurance advised that a piece of work on death in custody and thematics has been completed and he would review.	
QS22/53.7 It was agreed that the Ty Llewelyn action plan would be revisited and reviewed outside of the meeting. The Chair noted that the items listed in the private session of the meeting were not for discussion but for background reading.	
QS22/53.8 Jackie Allen reflected on the Mental Health Report and the ligature risks, advising that the CHC will be having a conversation with the Health Board to see if there would be anything they could do to assist.	
QS22/53.9 It was resolved that the Committee receive the report	
QS22/54 Chairs Assurance Reports **QS22/54.1 It was resolved that** the Committee received the Chairs Assruance Reports for information.	
QS22/56 Infection Prevention and Control Policy – Hand Hygiene **QS22/56.1** Jackie Hughes raised concerns around the wording and terminology of the policy, specifically around "staff" and "dress code" and agreed to circulate her comments after the meeting.	

QS22/56.2 It was resolved that Jackie Hughes agreed to circulate her comments on the policy after the meeting and that the policy would need to go through Infection Prevention Steering Group.	JH
QS22/57Health & Safety Policy - CCTV **QS22/54.1 It was resolved that** the Health and Safety Policy – CCTV was approved	
QS22/58 Complaints Policy and Procedure **QS22/58.2 It was resolved that** the Complaints Policy and Procedure was approved	
QS22/59 Issues Discussed in Previous Private Session **QS22/59.1** The Committee noted that the Hergest Serious Incident Review had been received.	
QS22/60 Documents Circulated to Members **QS22/60.1** The Committee noted that no documents had been circulated to Members.	
QS22/61 Agree Items for Chair's Assurance Report to Board **QS22/61.1** The Chair agreed to review these out of the meeting.	
QS22/62 Review of risks highlighted in the meeting for Referral to Risk Management Group **QS22/62.1** There were no risks highlighted in the meeting for referral.	
QS22/63 Review of Meeting Effectiveness **QS22/63.1** It was agreed to look at meeting effectiveness outside of the meeting.	
QS22/64 Date of Next Meeting **QS22/64.1** 3 May 2022	
QS22/65 Exclusion of Press and Public **QS22/65.1 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.	

QUESTIONS AND ANSWERS DEALT WITH OUTSIDE THE MEETING

Questions raised by the Chair outside the meeting on the Patient Safety Report	Answers given by the Acting Associate Director of Quality Assurance
I find myself reading this report and getting no assurance over the learning from our patient safety incidents. As we have discussed previously, there is no closing of the loop and instead we have a description of incidents that have occurred (albeit at least now with some immediate learning identified), but no outcome from investigations. The immediate learning that is described in many cases is transactional, referring to how people will be reminded of what they should be doing or stating what should be done - not the how. I have provided some examples below.	Focus on immediate learning which is transactional – for the identified incidents these are those occurring in the prior 2 months and reflects the rapid review. In most cases the actual investigations are not completed. We have been asked to really focus on the rapid reviews and rapid learning panels (24-72 hours post incident) but I do think we should flip this and focus on reporting to QSE the outcome of investigations as this is where most of the detailed learning and improvement actions arise from.
Of most concern to me though is despite the agenda item explicitly stating the "Patient Safety report - focus on Never Events/Regulation 28" there is in fact only 2 referred to in different sections of the report and in extremely brief detail. There is no update on previous ones or details of close down of previous. We still have nothing further reported to the QSE Committee regarding the Urology Never Event for example that took place over 2 years ago.	Lack of mention of Reg 28s – The two mentioned are the only two we have had for some time. The last R28 response was June 2021. The actions were referenced in the report at the time (implementation of an end of day safety huddle).
In terms of the HIW review of the patient discharge from YGC, I would like assurance to be provided to the next Committee in terms of the Make it Safe process. This is not the first case recently where the process has been less than robust and I think the Committee needs to have assurance that these have been isolated examples rather than a problem with the process itself. How is the quality of MiS and RLP being reviewed? There is also reference in the report to a separate investigation being undertaken into this case - what is this covering, i.e how is it different from the full investigation into the care and treatment of the patient?	Make it Safe Rapid Review at YGC– we have two investigations underway, the first covering the actual incident and the second specifically looking at the failure of the rapid review process. We will of course share the findings when complete. We have also gone back for all SIs since April and collated evidence of rapid review, rapid learning panel and SIR review action plans. This was summarised in a paper for Gill and presented at the last PSQ meeting.

P30 PSN Alerts	PSN057 Safety Alert – There has been a lack of clinical engagement in completing the necessary actions by the deadline, meetings were arranged but clinical staff did not attend, compounded by prioritisation over the winter period. Louise Howard Baker and Kath Clarke are pursuing this and it has been escalated. It is hoped progress will be made rapidly.
The updates aren't clear as to current status "underway" with a date of the next meeting isn't particularly helpful. There is no explanation provided as to why those that are overdue have not been completed or the priority given to it.	
I don't understand why PSN060 has no deadline action complete date (assuming that this is supposed to indicate when the action should be implemented) or why this says it's only applicable to Pharmacy. Pharmacy are not the only disciplines to administer oral medication so although I would expect them to lead, surely it should also refer to other areas as the others have done.	
P28 Never Event YGC The report describes human factors that contributed to the event being distraction and lack of situational awareness but the narrative refers to the surgeon and the ODP wandering off whilst the nurse comforted the patient. Was the surgeon called to an emergency? Is there a reason why the ODP had to find the notes at that point? Because distraction and lack of situational awareness usually occur when something unexpected happens such as a rapid deterioration of the patient. This makes me think that the team weren't giving the sign out process the importance that it requires - if it is seen as an unnecessary task to be "ticked off" it will be done quickly or not at all and anyone with doubts won't speak up. Did the investigation consider the work environment and non-technical skills at play?	Never Event YGC – Your assessment is correct, it was an emergency surgery and the sign out processes were not followed correctly. Various points on the incidents – These should of course be answered by the investigation. I think this links to the first point, I think the Committee needs the outcome of SI Reports more than rapid reviews.

	Officer/s	Minute Reference and summary of action agreed	Original Timescale	Latest Update Position	Revised Timescale
		BCUHB QUALITY, SAFETY& EXPERIENCE COMMITTEE - Summary Action Log Public Version			
		4th May 2021			
1	L Brereton	**QS21/78.2** A wider point was raised around the management of clinical policies and the route for approval. The Board Secretary confirmed she was looking at the governance route for policies with the Interim Director of Governance. The Executive Director of Workforce and OD suggested it might be helpful to consider the tiered approach taken by the Remuneration and Terms of Service Committee.	July	29.6.21 Review of policy on policies due to commence shortly, informed by governance review and approach across the Health Board. Process due for completion by September 21. 31.8.21 Governance review complete and new Integrated Governance Framework approved by Board. Further work required to identify and determine approval groups for different categories of documents (policies/procedures etc.). The review of the Policy on Policies (PoP) has commenced. However, due to significant staffing issues within the Office of the Board Secretary, the expected completion date has been put back. Provisional target date for approval at Audit Committee is now December. A project support manager has been appointed to support policy work (start date pending recruitment checks). 4.1.22 The interim Deputy Board Secretary is currently reviewing the Policy on Policies which will determine a more appropriate approval route for all policies. 18.2.22 The next iteration of the policy is being submitted to the CPPG in March, and subsequently the QSE	~~September~~ February May

26.04.22

		6th July 2021			
2	~~K Williams~~ S Hill	**QS21/97.4 QPR** The Chair also referred to a narrative comment about GP consultation performance but noted that no data had been provided. The Acting Head of Performance agreed to look at this	August	31.8.21 the separate COVID reports routinely include information on GP consultations. 7.9.21 L Reid did not feel the update above answered the original point which was that the QaPR included a narrative comment about GP consultation performance but did not include actual data. She felt this reduced the integrity of the report. This to be fed back to the Acting Director of Performance. 2.11.21 S Hill to follow up and ensure this action can be closed off. 05.01.22 The Performance team will include actual GP consultation activity in the next report.	~~Closed~~ ~~January~~ May
3	~~M Smith~~ A Thomas	**QS21/105.4 Mental Health** Provide a thematic analysis on psychological services to the November meeting.	November	21.7.21 Division seeking confirmation that this should be joint adult and CAMHS format. 7.9.21 C Stockport clarified this would be a joint report. 22.10.21 Paper deferred to January meeting 2.11.21 L Reid wished to clarify that the paper would address psychological services across the Health Board as a whole, not just within MHLDS. A Thomas confirmed the paper would be ready for the January meeting. Due to staff sickness, it has been necessary to defer the report again	~~November~~ ~~January~~ ~~March~~

				TO – an individual has returned to work – a meeting has taken placed this morning we have a handover of colleagues and will be on track.	
				GE – It is my first day in as Acting Executive Director of Therapies – I will be picking this action up and we will try and enable this to come back to the May meeting	May

7th September 2021					
4	S Green	**QS21/130.2 BAF** Consider whether the psychological impact of staff returning to work post-isolation should be built into a relevant risk either on the BAF or Corporate Risk Register	November	14.10.21 Staff who are returning to work who have been shielding have a site specific risk assessment (RA) undertaken on their return with adjustments made to ensure a Covid safe environment is in place with enhanced PPE if required. A consultant medical practitioner, the manager, HR Team and OH&S, supports the RA process. The staff wellbeing support service provides a range of emotional/psychological support services brought together to meet a range of needs for staff encompassing counselling (through the Occupational Health and Wellbeing service and RCS), clinical psychology, coaching and the support of a network of Wellbeing Champions. A pathway to support staff in crisis is also being finalised with the MHLD Division. A Strategic Lead for the Staff Wellbeing Service has been recruited – who is a Consultant Clinical Psychologist – who will manage and continue to further develop the staff wellbeing service across the Health Board, working with and leading a multi-disciplinary Wellbeing Cell to take forward this work, the latter reporting to the newly re-established Health and	~~Closed~~

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				Wellbeing Group, which met in September 2021. Reports and risks identified are escalated via the WOD Risk Management Group and report to the Strategic Occupational Health and Safety Group. If significant risks are identified, they will be escalated through the governance structure.	
				2.11.21 J Hughes suggested that the update above did not answer the question. S Green commented that she would reopen the action to ensure this was more explicitly built into the Covid risk.	End of January
				05.01.21 This is being updated on the risk register.	
				22.02.22 Following discussion with Jackie F Hughes, it has been agreed that if further evidence of staff requiring additional psychological support than that provided due to the psychological impact of returning to work, this would be assessed and either the associated risks already recorded would be amended or a new risk will be placed on the risk register and escalated through the governance structure if necessary to the BAF.	
	2nd November 2021				
5	G Harris	**QS2/169.3 Nurse Staffing** A comment was also made that the format and structure of the report made it difficult to identify harms that might have occurred as a result of staffing issues, and the Executive	January	05.01.22 Noted, this will be updated on the next report.	May

		Director of Nursing and Midwifery undertook to look at identifying these in a separate appendix for future reports.			
6	N Lyons	**QS21/173.3 QaPR** Provide assurance to the committee that sepsis performance issue was purely a data capture issue, and not a care intervention issue.	December	Further review of the Management of Sepsis shows that there is both a quality of data issue and also improvement needed in clinical management. The improvements needed are currently being developed and will be brought to QSE in March. Being reviewed as part of the Clinical Risk	~~March~~ May
7	M Joyes	**QS21.180.1 Quality Governance Assessment** Cross reference the original self-assessment against the Audit Wales report when received.	January	Dec 2021 – The Audit Wales Report has not yet been received. Feb 2022 – The report will be finalises during Feb/March and therefore will be brought to the May meeting.	~~March~~ May
11 January 2022					
8	S Hill	**QS22/11.1** An updated Quality and Performance report is being working on the lead Executive to take into consideration the comments made from the Committee outside of the meeting.		18.02.22 The development of the new performance reporting system is underway and incorporates the detailed feedback received as part of the engagement with Board members. The current timeline will deliver an integrated report on clinical and operational performance from April 2022. There is a multi- disciplinary project team in place to deliver the new system, with the clear expectation that the new report will meet the specific requirements of the three Sub-Committees of the Board which receive the performance report.	May
9	L Reid	**QS22/14.7b** The format of the HIW Report did not uploaded		This is being taken forward outside of the meeting and will return.	May

		effectively, a single improvement plan format was being produced based on improvement methodologies that will return to a QSE workshop. LR to decide how best to take assurance on this point after the meeting.			
	1 March 2022				
10	G Harris	**QS22/43 Recommend Quality Aspects of the IMTP** Gill Harris and Cheryl Carlisle to discuss cancer pathways off line.			
11	M Marcu	**QS22/44 Quality Priorities** Molly Marcu to pick up aligning the Quality Priorities with the BAF.		The BAF and Corporate Risk work is ongoing, the Quality Priorities will align with this work, this will go to Board in July 2022.	
12	M Joyes	**QS22/48 Harms Report** With regards to the Falls Policy section 7.4 be updated to include weekly group meetings, how the learning would be shared, how the accountability framework and weekly groups would be included and how all falls would be reported and reviewed.		The Falls Policy was updated and signed off outside of the meeting by Chairs Action. Suggest close	
13	M Marcu S Evans-Evans	**QS22/49 Corporate Risk Register Exception Report relating to Quality Risks**		The BAF and Corporate Risk work is ongoing, this will go to Board in July 2022.	

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		QS22/49.1 Further work is required to align the BAF and Corporate Risk Register.			
14	M Marcu S Evans-Evans – Nick Lyons	**QS22/49.5** The process of risk management and governance is to be reviewed outside of the meeting to ensure that the Committee are clear what is being asked of them.		The BAF and Corporate Risk work is ongoing, this will go to Board in July 2022.	
15	Philippa Peake-Jones/ M Joyes	**QS22/50 Patient Safety Report** **QS22/50.1** The Chair's questions raised outside the meeting and associated answers to be attached to the minutes.	May	Attached to Minutes Suggest close	
16	M Joyes	**QS22/50.1** The Never Event action plan that was sent back to the service return to the Committee.	May	On Agenda	
17	N Lyons	**QS22/50.3** A clinically focussed audit plan is required and that this should be reviewed at the next meeting.	May	On Agenda Suggest close	
18	M Joyes	An update on all previous Regulation 28's return to the Committee.	TBC		
19	T Owen	The Executive Director of Public Health to bring back some information on how the co-occurring approach around Section 136 us being handled.	TBC		

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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

To improve health and provide excellent care

Committee Chair's Report

Name of Committee:	Quality, Safety and Experience (QSE)
Meeting date:	1 March 2022
Name of Chair:	Lucy Reid, Committee Chair and Independent Board Member
Responsible Director:	Gill Harris, Executive Director of Nursing / Deputy CEO
Summary of business discussed:	The Committee received a patient story on a family's experience of the Sub Regional Neonatal Intensive Care Centre and the impact of the Covid restrictions and care that they had experienced. An update was provided on the work currently underway to align the clinical audit plan to significant clinical risks arising from the refresh of the corporate risk register, board assurance framework. The clinical audit plan will be considered for approval at the next meeting. At the meeting members also reiterated a request for a review of the corporate risk register paper in time for the next meeting in order to ensure the right level of assurance, citing inconsistencies in scoring and disparities between current and target risk ratings as examples. The Executive Director of Transformation, Strategic Planning and Commissioning presented an overview of some of the quality aspects of the Integrated Medium Term Plan aligned with BCUHB priorities. The Executive Director of Nursing / Deputy CEO presented the interim Quality priorities for the 2022/23, which were agreed, subject to alignment with the associated BAF risks, which would be received at the next meeting of the committee. This was due to members' request to ensure a risk based approach is taken to determining the priorities. Feedback from the workshop was shared with colleagues, with key aspects including the trial implementation of a new front sheet (with effect from the May meeting) to enhance report writing and assurance provided to the committee by authors, as well as work to revise the committee chair's report.

	This work will come into effect during the course of the first quarter of the financial year.

The Committee received a written report from the Executive Director of Nursing / Deputy CEO covering patient safety incidents, Independent Investigations, falls and healthcare acquired pressure ulcers, inquests, ombudsman, the Royal College of Surgeons - Vascular Review, Quality Grand Rounds, Morfa Ward Review update, Duty of Candour and Quality, Patient Safety Programme, Leading for Safety Improvement Programme, WHSSC Workshop attendance and an update on the new Head of Legal Services position.

The Committee reviewed and approved the Urology Service Review Terms of Reference for the Royal College of Surgeons, which the Health Board has commissioned, for the purposes of obtaining an independent and external review of the service.

The Committee considered and approved the policies below:

- A Policy on Infection Prevention and Controls
- A CCTV Policy
- A Complaints and Procedure Policy

The Committee reviewed Chairs' reports from the groups below, with no escalation issues arising:

- Patient Safety Quality Group
- Clinical Effectiveness Group
- Strategic occupational Health and Safety Group
- Patient and Carer Experience Group |
| **Key assurances provided at this meeting:** | The External Serious Incident Reviews relating to Hergest and Ty Llewlyn units were received in both the private and public parts of the QSE meeting, and were subsequently retracted from the Health Board website due to an ongoing Coroner's inquest.

Notwithstanding, this work continues at pace to ensure remedial actions are put in place, and to this end, the Committee scrutinised and challenged the content of the Hergest and Ty Llewelyn action plans.

Members requested a further iteration of the action plan to ensure an outcomes based focus with a transformational approach, across the entire mental health service. The revised action plan will be considered at the next meeting of the Committee in May and presented to the Board for assurance. |

	It is proposed that the Board receives the initial action plan at the May meeting, whilst delegating monitoring oversight to the QSE. The Executive Medical Director presented an update on the vascular improvement plan in response to the nine recommendations arising from the Royal College of Surgeons Review, such as developments in the pathway work, as well as the updated action plan. The Committee endorses the development of the Vascular Quality Panel (which provide an independent validation to the actions taken by the Health Board) and is assured by the appointment of Susan Aitkenhead as its Chair.
Key risks including mitigating actions and milestones	The Executive Director of Nursing/Deputy CEO presented a Harms review report, which highlighted high occurrence harms in relation to two key risk areas, pressure ulcers and falls. This was also reviewed alongside the mitigations that have been put in place within the falls policy. The revised falls policy was considered to contain robust content, however the committee considered further work is required in relation to the monitoring section. Further to this process, approval will be granted via chair's action. It is also worth noting that this policy is associated with some improvement actions identified by the Health and Safety Executive.
Targeted Intervention Improvement Framework Domain addressed	• Mental Health (adult and children) • Strategy, planning and performance • Leadership (including governance, transformation and culture) • Engagement (patients, public, staff and partners)
Issues to be referred to another Committee	No issues to be referred
Recommendation/ Matters requiring escalation to the Board:	The Board is asked to note the escalation of concerns around the patient safety report, which was due to be submitted to the Board's meeting of the 15th March, following its review by QSE. Due to concerns about its limited scope (for example absence of follow up and reporting of Never Events) and omission of incidents (associated learning) that have occurred in previous months. The Committee also requested that consideration is given of incorporating recurring themes within the clinical audit plan. The Board is asked to approve the approach to monitoring the action and improvement plans for the Mental Health division, following its receipt by the QSE on the 3rd May meeting.

Well-being of Future Generations Act Sustainable Development Principle	The Committee gave adequate consideration to the sustainable development principles: 1.Balancing short term need with long term planning for the future; 2.Working together with other partners to deliver objectives; 3. Involving those with an interest and seeking their views; 4.Putting resources into preventing problems occurring or getting worse; and 5.Considering impact on all well-being goals together and on other bodies)
Planned business for the next meeting:	Range of regular / standing items plus: - Quality Annual Report - Putting things Right Annual Report - Health and Safety Annual Report
Date of next meeting:	3.5.22

V0.2

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Executive Lead for Quality – Briefing Paper
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Mathew Joyes, Associate Director of Quality
Craffu blaenorol: **Prior Scrutiny:**	Mathew Joyes, Associate Director of Quality Gill Harris, Executive Director of Nursing and Midwifery
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 the Committee with the Executive Lead for Quality Briefing Paper.

Cefndir / Background:

This paper offers a summary of key quality information for the preceding period between meetings. Detailed information is contained within the reports presented to the Committee. The Committee is advised this report is live to the point of finalisation and therefore may present more detailed information than that within reports that cover a set reporting period.

Patient Safety Incidents

The Patient Safety Report provides further detail of patient safety incidents. However, in brief, the number of Never Events over the last 12 months and the current rate of Nationally Reportable Incidents (NRIs, formerly known as serious incidents) is of concern. An analysis of the position is being undertaken and will be reported to the Executive Team and onto the Committee.

However, the Committee will be aware of the main themes -

For Never Events, this is surgical safety (11 of 12 never events) and particularly YGC (7 of 12 never events, 6 related to surgical safety). The YGC hospital management team have been tasked with developing a broad improvement plan in response to various concerns the Committee is sighted upon, and is due to be presented to the Committee as a separate paper. Additionally, the Transformation and Improvement Directorate have recruited their first Quality Improvement Fellow with a focus for 6 months on improving surgical safety (and specifically the WHO Checklist) at YGC. The Quality Directorate has commissioned an extensive human factors training programme via AQUA which will commence in May.

For other Nationally Reportable Incidents, falls and pressure ulcers remain high prevalence harms. A detailed paper was presented at the last Committee on these two areas. More recently, the care of the deteriorating patient has become an emergent theme with a number of incidents related to the failure to recognise, act or escalate deteriorating patients. An audit of medical emergency team calls is underway and further improvement work is beginning to be planned.

Vascular

Vascular remains a service of concern within the Health Board and with Healthcare Inspectorate Wales (HIW). The Vascular Quality Panel is established and will meet for the first time in April, with an independent chair. A dedicated vascular quality team has been formed to support the work. A vascular helpline has been put in place. The Executive Medical Director continues to chair the Vascular Steering Group and oversee the delivery of the improvement plan. A separate paper is submitted for the Committee.

Urology

The Urology Steering Group has now been formed to develop and oversee an improvement plan. This will incorporate the plans for robotic surgery. The Executive Director of Integrated Clinical Services will chair the group. A urology network manager post is out for recruitment to support the work and improve cross-site working. The Royal College of Surgeons invited review application has been finalised based on the Committee's approval at its last meeting. The interim vascular network director is now providing support and leadership for urology services. A separate Chair's Report from the steering group is being submitted for the Committee.

Dementia

The new Dementia Nurse Consultants have continued to strengthen the delivery of care for patients living with dementia across services. A separate paper for the Committee details some of the latest work.

Triangulation Workshop

Senior quality leaders are organising a triangulation workshop to explore HIW findings, and other quality data, in order to ensure that services and areas of quality concern are recognised. This workshop will provide a detailed stock take and will provide assurance that routine reporting has identified and escalated areas of concern, and that this is reflected in the risk management process. The workshop will include the Executive Director of Nursing and Midwifery, Executive Medical Director, Executive Director of Integrated Clinical Services, Associate Director of Quality and Board Secretary. The workshop will be in early May 2022.

Ockenden Maternity Report

At the time of writing, the Ockenden Report into maternity safety had recently been released. The report provides a clear mandate for every health authority to ensure its maternity services are safe and patient focused. The Health Board is carefully digesting the findings, and will align with national work, to provide a thorough and detailed report to a future meetings of this Committee offering assurance and where necessary improvement actions.

On receipt of the report in Wales, a National Maternity Stakeholder & Leads meeting was scheduled and held on 13th April 2022, hosted by Welsh Government and facilitated by the Maternity and Neonatal Network, to consider the learning and actions required on an All Wales perspective. The following actions were confirmed;

- Development of a Maternity & Neonatal Safety Support Programme with the introduction of local and national Maternity & Neonatal Champions and Executive Sponsors. This Safety Support Programme will be hosted by Improvement Cymru.
- An SBAR will be presented to Nurse Executives to propose a plan to review the existing National Ockenden Assurance Document (produced following the first report in 2020 and Immediate Actions recommended) and look at how the recommendations from the CTMUHB thematic review of stillbirths, the CTMUHB Neonatal Deep Dive and the finding of the second Ockenden Report (2022) are captured. This document will be used to provide assurance within Health Boards and to WG at the Annual Performance Boards. It is proposed that these Maternity & Neonatal Performance Boards will be led by NHS Executives in the future.
- Welsh Government will host a Safety Summit in July 2022 to ensure national learning from the CTM intervention and wider reports including Ockenden. This will ensure stakeholder engagement for the Maternity and Neonatal Safety Support Programme.
- Recommendations and key actions from the summit will be integrated into the Network Work Plan and the Safety Support Programme to ensure that the learning and improvement required are prioritised and reflect the National needs for Services.
- Welsh Government has appointed an individual to lead on the National Engagement and Patient Experience Strategy as part of the Safety Programme Strategy and is actively engaging with Health Boards as part of her Introduction Programme.

- HEIW has been commissioned to review the future multidisciplinary workforce requirements for Services in Wales to reflect; Welsh Government's commissioned Birth Rate Plus National Methodology Review and the published RCOG Workforce Tool Kit .They will also lead on Commissioning levels and specific Leadership programme developments for Maternity Services.
- An individual has been seconded to Welsh Government to support an ongoing and overarching governance, assurance and improvement maternity plan, to reflect the Delivery Unit work, again to ensure that wider learning related to other UK and national maternity reviews and the CTM intervention work is captured.

Welsh Government will be issuing a letter to all Health Boards outlining the above actions, next steps and expectations.

Duty of Candour and Quality

The Health Board continues its active engagement in the national work to develop the guidance and requirements for the two duties coming into force next year. The Health Board's Associate Director of Quality represents NHS Wales' quality leads on the national steering group and staff from across the Health Board are engaged in work streams or have attended engagement workshops. Further detail will be provided to the Committee during the year as the guidance develops.

Quality Recognition

The Quality Awards and Achievements Paper highlights a range of successful quality initiatives and improvements.

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 – Contained within seperate papers on the agenda.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.

Templed adroddiadau'r Bwrdd/Pwyllgor
Board/Committee report

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

Cyfarfod a dyddiad: **Meeting and date:**	**Quality, Safety & Experience Committee (QSE)- 3rd May 2022**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Quarter 2 and Quarter 3 Clinical Effectiveness Report plus Cycle of Business for Clinical Effectiveness Group
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Dr Nick Lyons, Executive Medical Director
Awdur yr Adroddiad **Report Author:**	Dr Conrad Wareham, Interim Deputy Medical Director
Craffu blaenorol: **Prior Scrutiny:**	*Clinical Effectiveness Group (14th April 2022)*
Atodiadau **Appendices:**	Quarter 2 and Quarter 3 Clinical Effectiveness Reports plus Cycle of Business for Clinical Effectiveness Group

Argymhelliad / Recommendation:

For the committee to approve the audit plan for 22/23 and the reporting outlined in this report

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/A**

Os yw'r adroddiad hwn yn ymwneud â 'phenderfyniad strategol', h.y. bydd y canlyniad yn effeithio ar sut mae'r Bwrdd Iechyd yn cyflawni ei bwrpas statudol dros gyfnod sylweddol o amser ac ni ystyrir iddo fod yn benderfyniad 'o ddydd i ddydd', mae'n rhaid i chi gynnwys Asesiad o Effaith Cydraddoldeb (EqIA) ac asesiad effaith economaidd-gymdeithasol (SED) fel atodiad.

If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.

No EqIA needed for these reports

Sefyllfa / Situation:

The 2nd and 3rd Quarterly Clinical Effectiveness reports were prepared to be reported at Clinical Effectiveness Group (CEG) on 10th February, however the meeting was not quorate.

Presentation to Quality, Safety and Experience Committee requires the reports to first be presented to Clinical Effectiveness Group, however as this meeting did not go ahead as noted above, the reports were added to the first available Quality, Safety and Experience Committee **which will be 3rd May (following presentation at Clinical Effectiveness meeting, which will be 14th April).**

The Cycle of Business has been reviewed and updated to show when relevant reports are presented at Clinical Effectiveness Group, and will subsequently be taken to the following Quality, Safety and Experience Committee.

To provide ongoing assurance, the Clinical Effectiveness team attend all the local Clinical Effectiveness Groups, to ensure all audit findings are actioned on an ongoing and live basis, and also to escalate and have noted any concerns on details around an audit to monitor progress is made. Any concerns following these meetings are reported to the main Clinical Effectiveness Group meetings and in turn will be reported to Quality, Safety and Experience meetings.

Asesu a Dadansoddi / Assessment & Analysis
Goblygiadau Strategol / Strategy Implications N/A
Opsiynau a ystyriwyd / Options considered N/A
Goblygiadau Ariannol / Financial Implications N/A .
Dadansoddiad Risk / Risk Analysis N/A
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance N/A
Asesiad Effaith / Impact Assessment .N/A

Quarter 2

Clinical Audit Activity 2021-2022

CONTENTS   **PAGE**

1. Tier 1 Overview of Quarter 2 - Clinical Audit Activity 2021-2022

	Q1 Apr-Jun*	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar	Expected publication/activity 2022/2023
Estimated publications due	5	5	17	4	9
Actual publications	5	5	0	0	-
Part A due	3	6	10	15	9
Part A received	2	4	0	0	-
Part A overdue	1*	2*	0	0	-
Part B due	15	4	5	18	13
Part B received	12	2	0	0	-
Part B overdue	3**	2**	0	0	-

"Q1 includes details of the Part A & Part B returns due for Q4 2020/21 publications

* Overdue Part A (Outlier reports/ priorities for improvement)	**_** Overdue Part B (Improvement plans)_**
NACAP: Adult Asthma – due in Q1	NACAP: Adult Asthma – due in Q1
NACAP: COPD – due in Q2	National Core Diabetes Audit - due in Q1
Fracture Liaison Service (Falls & Fragility Fractures Audit Programme) – due in Q2	NACAP: Pulmonary Rehabilitation – due in Q1
	NACAP: COPD – due in Q2
	Fracture Liaison Service (Falls & Fragility Fractures Audit Programme) – due in Q2

2. BCUHB Returns

6 Part A returns and 4 part B returns were due in Q2 for publications released in Q1
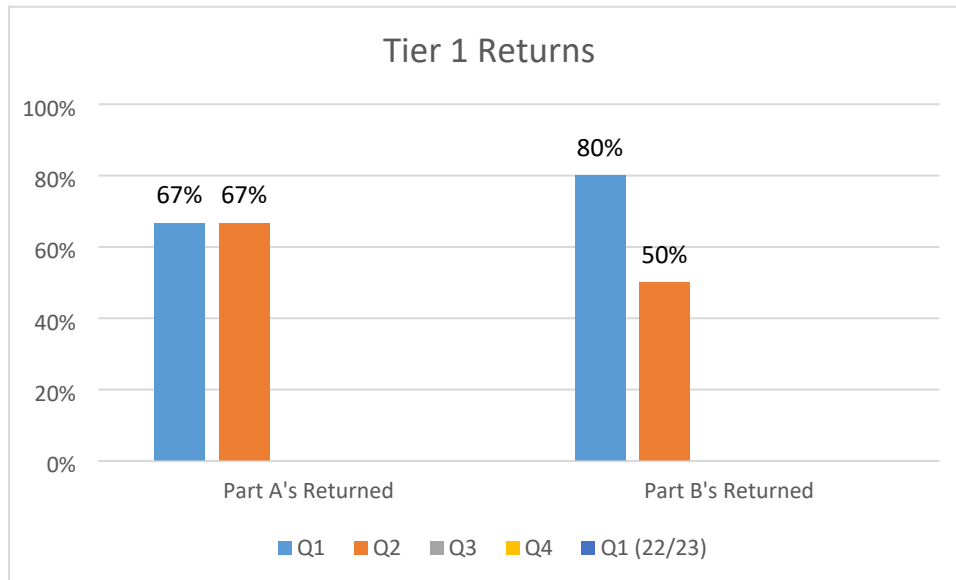
* The activity in the above graph for Q1 relates to publications that were published in Q4 2020/21

3. Part A and Part B forms received

The following two Part B returns were received during Q2 for 2021/22 publications:

National Asthma & COPD Audit Programme (NACAP): Children and Young People Asthma	BCUHB WG -Part A B-Child Asthma Sign	National Maternity & Perinatal Audit (NMPA)	Welsh Government-Part A8

4. Part A and B responses within deadline

Responses returned within deadline

	Q1 (19/20 publications)	Q2 (19/20 publications)	Q3 (19/20 publications)	Q4 (19/20 publications)	Q1 (20/21 publications)	Q2 (20/21 publications)	Q3 (20/21 publications)	Q4 (20/21 publications)	Q1 (21/22 publications)	Q2 (21/22 publications)
Part A		20%	20%	57%		75%	46%	33%	20%	50%
Part B	17%	40%	30%	29%		50%	54%	50%	60%	50%

■ Part A ■ Part B

5. Benchmarking from Tier 1 Reports

Key:

Comparison to National Benchmark:	
R	Where BCUHB reported performance is at or above the benchmark in less than 50% of KPIs
A	Where BCUHB reported performance is at or above the benchmark in between 50% and 74% of KPIs.
G	Where BCUHB reported performance is at or above the benchmark in 75% or more of KPIs.

Comparison to Last BCUHB Report:	
R	Where the previously reported BCUHB performance has deteriorated in more than 50% of Key performance indicators according to the latest National audit report
A	Where the previous reported BCUHB performance has been maintained or improved in between 50% and 74% of KPIs in the latest reporting period.
G	Where BCUHB has maintained or improved in 75% or more of KPIs since the previous reporting period

Q2 publications = x5 publications released during Q2 of 2021/2022

Tier 1 Project reference	Title	Performance against National Benchmark	Performance against Last BCUHB Report	Progress/ Completed Actions	Outstanding issues - by whom by when
Acute					
NCAORP/2021/01	National Joint Registry			• In the year 2020 compliance, consent and linkability for BCUHB was 85%, the aim is to be more than 95% compliant. • The number of cases performed across the three sites of BCUHB were drastically down on historical figures. The consent rates were excellent in Abergele (100%); moderate in Ysbyty Glan Clwyd (93%)	NB Welsh Government do not require an update (Part A or Part B) for this audit. • This report does not provide the level of data or recommendation, which health services can measure against. No return report required at this stage to Welsh Government. • The Regional Clinical Coordinator (RCC), will suggest a few professional changes to the way arthroplasty surgeons audit and learn from their data. They will also help stablishing Revision Units and link with Major Revision Centre for both hip and knee arthroplasty. They will seek to contrast opinions in this regard with BCUHB's clinicians and Ian Starks as the present lead for Orthopaedics.

Tier 1 Project reference	Title	Performance against National Benchmark	Performance against Last BCUHB Report	Progress/ Completed Actions	Outstanding issues - by whom by when
				and Wrexham Maelor (83%) and poor in Ysbyty Gwynedd (71%). The linkability was excellent in all units.	
Long Term Conditions					
NCAORP/2021/08	National Core Diabetes Audit (NDA)	G	G	• Maintained compliance in line with national average	• Action plan in development, due to be completed December 2021
Older People					
NCAORP/2021/22	National Audit of Breast Cancer in Older Patients (NABCOP)	There is no comparative data - Due to Covid the usual cancer registration data were unavailable for this report	There is no comparative data – reported over rolling 4 years.	• Maintained Data collection during the COVID 19 pandemic	• Action plan in development, due to be completed December 2021
Other					

Tier 1 Project reference	Title	Performance against National Benchmark	Performance against Last BCUHB Report	Progress/ Completed Actions	Outstanding issues - by whom by when
NCAORP/2021/35	The National Clinical Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Comparable data not available	Comparable data not available	•	• Explore routine emotional screening of young people who have epilepsy using a validated screening tool. • Explore access to psychology support integrated into our epilepsy services for children. • Epilepsy12 is developing a new tool for 2021 to help teams evidence in real-time the core elements of care planning for the children and young people with epilepsy in their care – CEAG to discuss this once available • Allocated time within our epilepsy services to complete routine governance and audit work: ongoing discussion at CEAG re strategic issues; Area teams to raise this within their areas • Improve timely availability of MRI scans under GA (within the Health Board) and Video Telemetry (in partnership with Alder Hey) • Re-establishing joint epilepsy clinics in each area to support young people moving on to adult service: Regionally through Neurosciences Board. Area – local epilepsy leads • To be completed by October 2022 by local audit leads
NCAORP/2021/36	National Clinical Audit of Psychosis	G West only All Wales Benchmark not National	G West only	• BCU is at or above the All Wales benchmark of 75% or more. • BCUHB EIP service is in the process of being developed. The first phase will	• Action plan in development, due to be completed December 2021

Tier 1 Project reference	Title	Performance against National Benchmark	Performance against Last BCUHB Report	Progress/ Completed Actions	Outstanding issues - by whom by when
				develop the East team, this is currently being recruited, hopefully by December 2021. Central Team will be next which will have support from the East (May 2022) and the final phase will develop the existing provision in the West by the end of 2022. The service will then be able to meet the required standards for National Clinical Audit Psychosis and Welsh Government.	

Q1 publications = x 5 publications released during Q1 of 2021/2022

Long Term Conditions					
NCAORP/2021/09	**National Paediatric Diabetes Audit (NPDA)**	G	A	• Maintained compliance in line with national average. • Two thirds of KPI's above 90% compliance.	• Action plan in development, due to be completed October 2021
NCAORP/2021/10	**NACAP - Children and Young People Asthma**	R *(West data only submitted for this reported)*	First report only West. Data had not started for Central & East	• Since this report was published, Data has been submitted from the other two sites (East & Central) • **Central:** The discharge bundle which outlines the importance for documenting exposure to cigarette smoke and offers support with smoking cessation and which will support better delivery of targets with respect to PAAP and checking of inhaler technique has been developed and is being launched amongst both medical and nursing staff this month (November 2021) **Completed** • **East** Implement teaching to promote steroids in first 1 hour (Sept 21) **Completed.** Nurses have undertaken a session in October 21 and also had an asthma in situ stimulation within the last 2 months this	• **West** – Increase medical time to asthma clinic via job planning process (July 2022) • **West** - Only data for West was included in this report (Jun 2019 – Jan 2020). *(Although West submitted data for this this publication, no data has been submitted since Dec 2019).* • **West -** There is already evidence on impact of paediatric asthma nurses, their role in particular in education, inhaler technique, managing acute exacerbations at home. Although they are usually linked to an acute unit, much of their role is in the community. It would be hugely beneficial if we had one, as they support a lot of the safe discharge safety netting, and would enable us to comply with the clinic review after discharge. As for many services, because we manage with few datix and incidents related to asthma in children, it is not really a priority, but audits like this highlight the gaps in service. Since 2005 • **Central** - Review follow-up arrangements and clinic capacity in order to find out what investment/resource is needed to deliver a follow-up service within the 4-week timeframe (Jan 2022). Update received this is ongoing (Nov 21) • **East -** Discharge paperwork for viral induced wheeze as well as asthma (Jan 2022)

		<td style="background-color:red"></td>		included a take home message as a learning outcome of the training	• **East -** Review implementation of new OPD review forms and prompts (Nov 2021)
					• **East -** Review follow up arrangements and clinic capacity in order to find out what investment/resource is needed to deliver a follow up service within the 4 week timeframe (Jan 2022)
NCAORP/2021/12	NACAP - COPD	R *(Central data only submitted for this reported)*	G *(Central data only submitted for this reported)*	• West now participating • Discussions are ongoing with regards to starting/improving participation on all three BCU sites with Hospital Medical Director, Consultants, Clinical Director & Senior Associate Medical Director	• No data submitted for East. Letter received from NACAP re non-participation for Wrexham Maelor. Response to the letter was sent. This will be highlighted to CEO. • East non-participation. Central: Not recommenced site participation since second surge (last data entry Aug 2020)
Older People					
NCAORP/2021/20	FFFAP - Fracture Liaison Service			• Discussions regarding data collection are ongoing with area management team	• Not participating
Women & Children					
NCAORP/2021/34	National Maternity and Perinatal Audit (NMPA) Technical Report: Feasibility of evaluating perinatal mental health services	Specific BCUHB data not included in the report	Specific BCUHB data not included in the report	• Action plan completed within deadline. Full engagement with project.	Officials in the Government Perinatal Mental Health Policy Team are going to discuss this report with the National Lead for Perinatal Mental Health and correspondence on the report will be sent to all specialist perinatal mental health teams in Wales. The Perinatal Mental Health Team in BCUHB will note the findings of the report and implement them where possible.
	National Maternity and Perinatal Audit (NMPA) Sprint Report: NHS Maternity Care for Women with a Body Mass Index of 30 kg/m2 or Above	Specific BCUHB data not included in the report	Specific BCUHB data not included in the report	• Original action plan completed within deadline. However the Women's Division have elected to review/amend the action plan not yet received. This means that the plan is now delayed.	Action plan in progress but overdue.

6. Audit – Proforma process (Part A and Part B)

In October 2020 in response to the ongoing COVID-19 pandemic, the Welsh Government extended the return date of Part A proforma's to 8 weeks and to 16 weeks for Part B Proforma's.

7. Tier 2

The Tier 2 Clinical Audit plan 2021/2022 is attached below:

Clinical Audit plan
2021-22 v070721 - Mas

Each Division has prioritised and agreed upon topics for inclusion within Tier 2, of which 38 audits have been identified using a systematic approach:

- **Frequency** *('how often' or 'how many'?)*
- **Degree of risk** *(likelihood of something going wrong or not being done).*
- **Level of concern** *(how important is the question?)*
- **Outcome** *(what is the impact in relation to potential for improvement/harm?)*

Trigger for audit
(more than one answer possible per project)

Category	Value
Int/ext guidance	33
Corporate policy	22
External review	26
Reaudit/continuous	35
Risk Register	8
Claims Audit	1
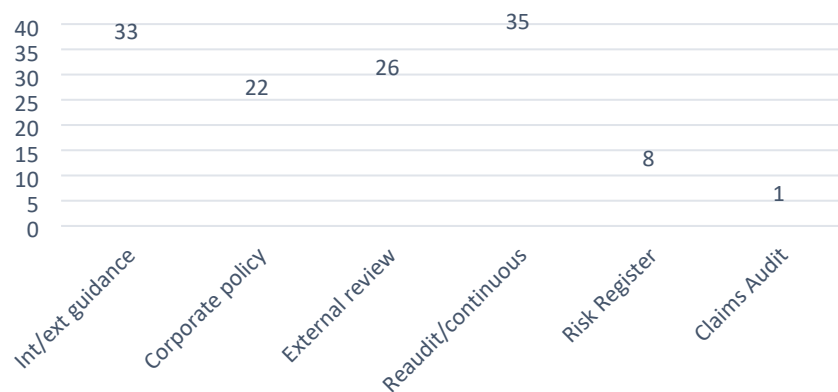
Risk Assessment

2
6%

■ Critical   ■ High   ■ Medium   ■ Low

Which BCUHB priority does this support
(more than one answer possible per project)

Priority	Value
Safe, Clean Care/Infection Prevention	5
Safe Value-based health care	2
Reduce patient harms	22
Quality and Safety	8
Keeping People Safe from Avoidable Harm	6
Highly reliable clinical care	23

Current Stage
(taken from update provided)

Stage	Value
Complete	4
Preparation and planning : Development of aims, standards, methodology	4
Measuring performance: Data collection, analysis, report writing	9
Implementing Change: Developing action plan	5

Progress with Audit
(taken from update provided)

Legend:
- **Red** - Cause for concern, no progress towards completion
- **Amber** - Delayed, with evidence of actions to get back on track
- **Green** - Progressing on schedule or Completed

Pie chart values: 0%, 0%, 33%, 67%

Reasons identified for non-progression/delay of audit

Resource implications	Lack of capacity	Governance implications	Other
4	1	0	2
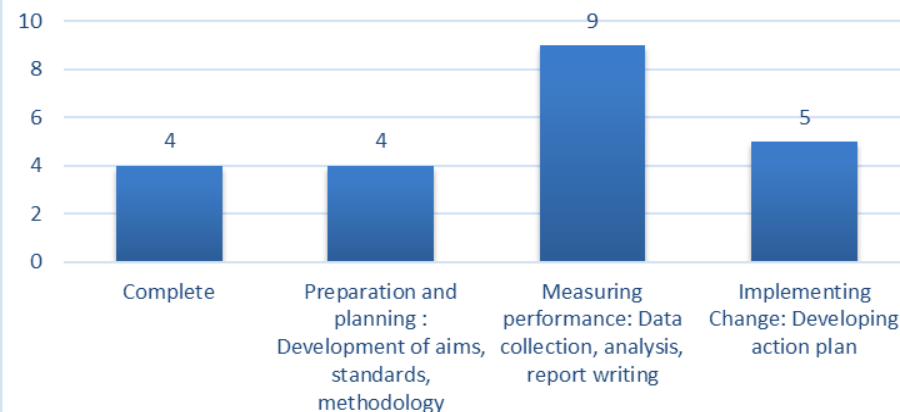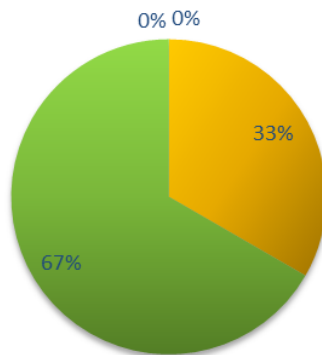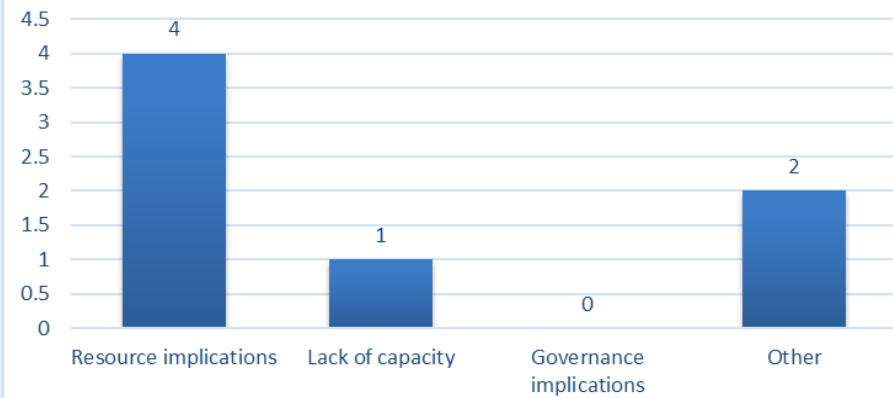
8. Tier 3

The self-registration database was developed and launched in August 2020 (link below). Sixty-five projects have been registered in Q2, 171 in total for 2021/22. Reports have been received for 31 (18%). The self-registration database can be found here: http://7a1a1srvinforep/Tier3ClinicalAuditProjectSubmission

Tier 3 - Main reason for audit (West, Central, East)

Tier 3 - Staff group conducting audit (West, Central, East)
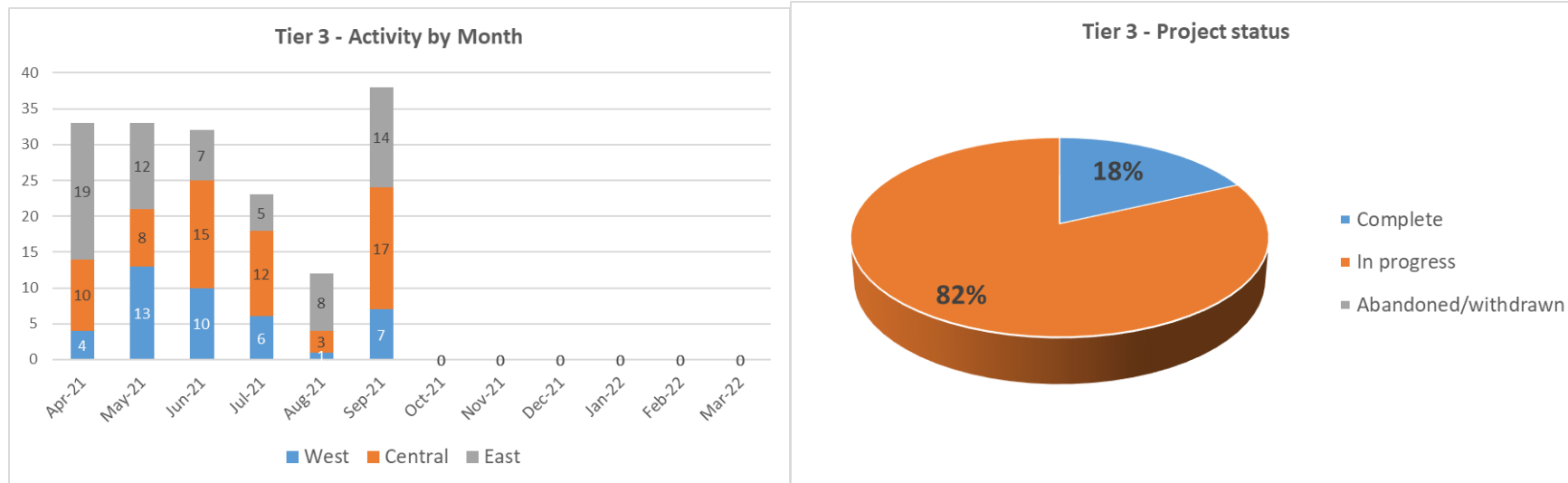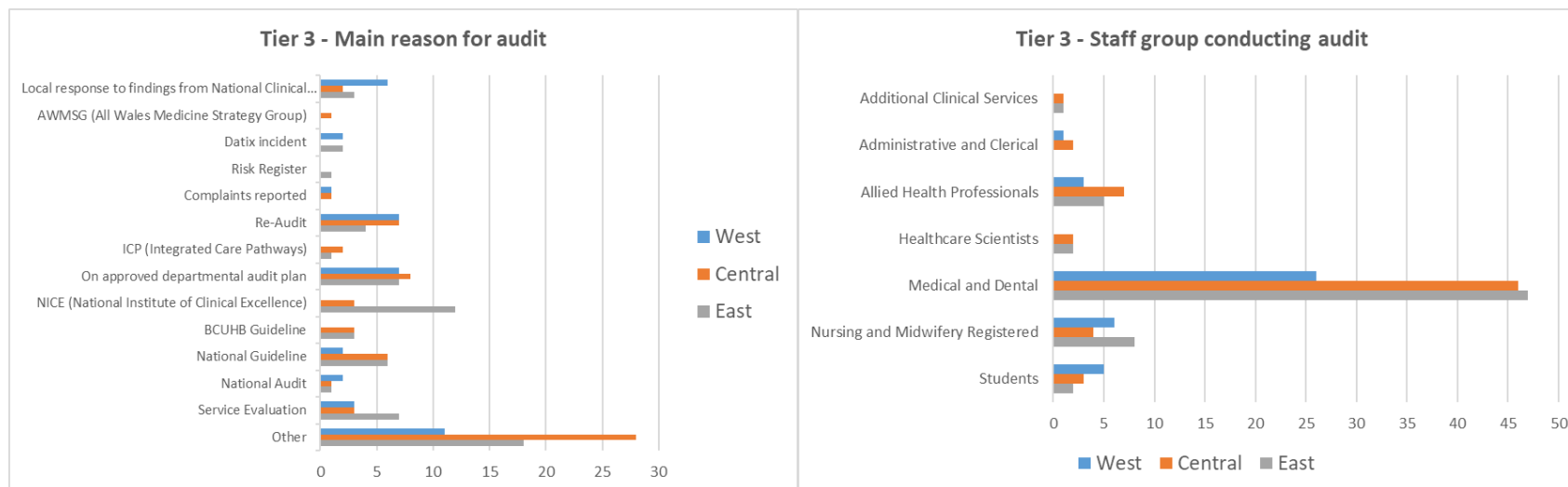
9. Good Practice/Improvements in Quarter 2

AMaT:
The organization has purchased Audit Monitoring and Tracking (AMaT) software to record and monitor national, corporate and local audit information and NICE guidance compliance.

An Engagement Implementation Group was established in August 2021 to discuss the roll out of this software within the Health Board. The Clinical Effectiveness department has continued to receive training from AMaT in Q2 with plans for AMaT to provide wider training opportunities being planned for Q3.

The Clinical Effectiveness Team are piloting the NICE compliance element with the Women's Directorate with further roll out planned for Q3.

Tier 1 National Audit data for 2020/21 and Q1 of 2021/22 have retrospectively been inputted to the system and publications during Q2 have been inputted in real time for monitoring and tracking of the response to these national audit publications.

Quarter 3

Clinical Audit Activity 2021-2022

CONTENTS   **PAGE**

1. Tier 1 Overview of Quarter 3 - Clinical Audit Activity 2021-2022

These clinical audits are mandated by Welsh Government or other regulatory bodies such as Medicines & Healthcare products Regulatory Agency (MHRA). Local available resources should be prioritised to support these audits. Nationally mandated audits require the completion of the assurance proforma (Parts A and B) to be returned to Welsh Government. Part B documents the actions being taken to address the audit report findings. NB: All National Clinical Audit and Outcome Review Plan (NCAORP) projects must be incorporated within relevant Divisional/Directorate annual clinical audit plans.

The tables below show the position on 31/01/2022

	Q1 Apr-Jun*	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar	Expected publication/activity 2022/2023
Estimated publications due	5	4	16	6	10
Actual publications	5	4	16	0	-
Part A due	3	6	9	16	10
Part A received	2	4	2	0	-
Part A overdue	1*	2*	7*	0	-
Part B due	15	4	5	13	18
Part B received	12	2	1	0	-
Part B overdue	3**	2**	4**	0	-

"Q1 includes details of the Part A & Part B returns due for Q4 2020/21 publications

* Overdue Part A (Outlier reports/ priorities for improvement)	** Overdue Part B (Improvement plans)
NACAP: Adult Asthma – due in Q1	NACAP: Adult Asthma – due in Q1
NACAP: COPD – due in Q2	National Core Diabetes Audit (2020)- due in Q1
Fracture Liaison Service (Falls & Fragility Fractures Audit Programme) – due in Q2	NACAP: Pulmonary Rehabilitation – due in Q1
National Core Diabetes Audit (2021) – due in Q3	NACAP: COPD – due in Q2
National Heart Failure Audit – due in Q3 signed off in Q4	Fracture Liaison Service (Falls & Fragility Fractures Audit Programme) – due in Q2
Cardiac Rhythm Management – due in Q3 signed off in Q4	National Core Diabetes Audit (2021) – due in Q3
PCI audit – due in Q3 signed off in Q4	National Clinical Audit of Psychosis – due in Q3
MINAP – due in Q3 signed off in Q4	National Audit of Breast Cancer in Older Patients (NABCOP) – due in Q3 – *Draft response recd, awaiting final sign-off*
National Maternity & Perinatal Audit – due in Q3	National Paediatric Diabetes Audit (NPDA) – due in Q3 – *Draft response recd, awaiting final sign-off*
National Clinical Audit of Psychosis – due in Q3	

2. BCUHB Returns

Nine Part A returns and five Part B returns were due in Q3 for publications released in Q1, Q2 & Q3
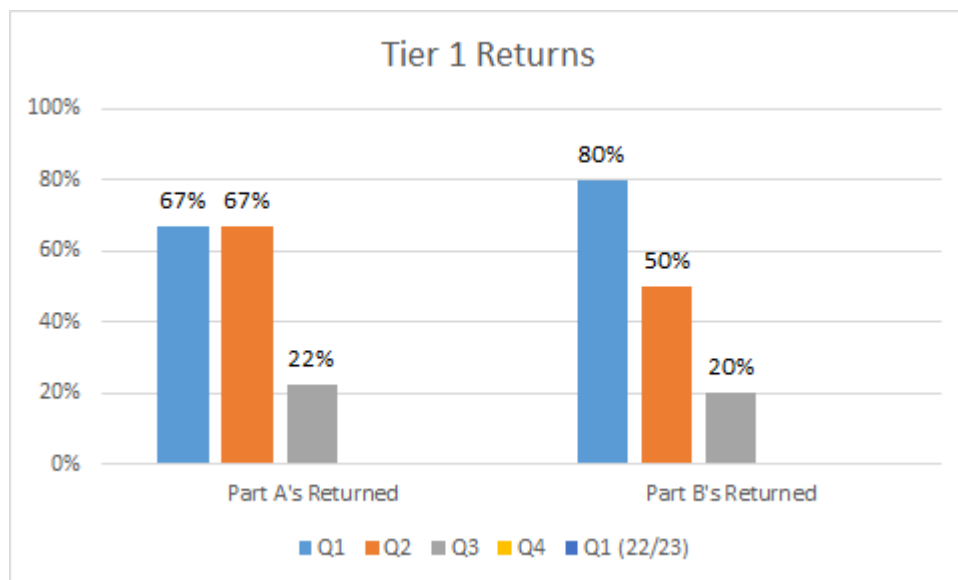
Tier 1 Returns chart showing Part A's Returned (Q1 67%, Q2 67%, Q3 22%) and Part B's Returned (Q1 80%, Q2 50%, Q3 20%)

* The activity in the above graph for Q1 relates to publications that were published in Q4 2020/21

3. Part A and Part B forms received

One WG assurance part B return was received during Q3 for a 2021/22 publication:

The National Clinical Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	[W] 2021 Welsh Government-Part AB

4. Part A and B responses within deadline

The COVID pandemic (surge three) has affected receipt of required part A and B during this period. As we return to business as usual in January 2022, there is a need to focus on and improve the quality and timeliness of reports received. Staff capacity to data collect and drive the audit cycle at divisional; / local and corporate level are a factor in this.

In response a business case was submitted through the organisation approval process in October 2021 (outcome is awaited). Additional steps focus on a) strengthening the review and assurance process led by the Corporate Clinical Effectiveness Team, b) providing additional tools for divisions to use which provide a more structures and consistency in action planning, and c) training and support to staff to better equip them to discharge their audit responsibilities, see below detail:

- The **escalation process** (introduced Dec 2020 - for checking and agreeing submission of audit action plans) has been further strengthened in February. The timeframe for action plan submission to the Corporate Clinical Effectiveness Team is reduced slightly to enable issues to be identified / addressed and resolved before agreement of the final version. In this way improving both action plan timeliness and quality.
- We have increased the support we provide to Divisions:
    - New **Clinical Effectiveness Intranet page** has been launched - with resources and audit details hyperlinked to increase the divisions visibility of tier 1,2, and 3 activity and provide a resource for training.
    - External audit **training** has been secured from CASC – the first of 3 planned sessions is scheduled for February 2022 (fully subscribed). Further training sessions are being secured for later in the year and links have been made with Education with view to developing a learning network within which to share technical resources and updates after the initial training.
    - C**linical Effectiveness weekly Clinics** have been established – first clinic 03.02.22. These provide access to specialist advice on all matters relating to clinical effectiveness.
    - To strengthen our ability to document and manage post audit actions, and crucially secure service change / improvement, an **audit action plan template** will be released 11.02.22. This will be supported by a **"Lunch and Learn" training session** 25.02.22. Ongoing support needs are being evaluated in liaison with audit leads at the time of writing, with a view to ensuring continued support from the Clinical Effectiveness specialist team.
- **Health Check meetings** (between the Head of Clinical Effectiveness and divisional triumvirate) have been established to increase / ensure required visibility of audit activity and thereby promote the use of audit within the divisional business and QI assurance cycle.

Part A returns

Escalation process introduced

Legend: Received on time, Received late, Not received, In progress

Part B returns

Escalation process introduced

Legend: Received on time, Received late, Not received, In progress

5. Benchmarking from Tier1 Reports

Key:

	Comparison to National Benchmark:	
R	Where BCUHB reported performance is at or above the benchmark in less than 50% of KPIs	
A	Where BCUHB reported performance is at or above the benchmark in between 50% and 74% of KPIs.	
G	Where BCUHB reported performance is at or above the benchmark in 75% or more of KPIs.	

	Comparison to Last BCUHB Report:	
R	Where the previously reported BCUHB performance has deteriorated in more than 50% of Key performance indicators according to the latest National audit report	
A	Where the previous reported BCUHB performance has been maintained or improved in between 50% and 74% of KPIs in the latest reporting period.	
G	Where BCUHB has maintained or improved in 75% or more of KPIs since the previous reporting period	

Q3 publications = x16 publications released during Q3 of 2021/2022

Tier 1 Project reference	Title	Performance against National Benchmark	Performance against Last BCUHB Report	Progress/ Completed Actions	Outstanding issues - by whom by when
Acute					
NCAORP/2021/02	National Emergency Laparotomy Audit	G	G	•	• Action plan in development, due to be completed April 2022
Long Term Conditions					
NCAORP/2021/07	Pregnancy in Diabetes Audit Programme	G	A	• Maintained compliance in line with national average	• Action plan in development, due to be completed February 2022
NCAORP/2021/14	Renal Registry			•	• Action plan in development, due to be completed April 2022.
NCAORP/2021/16	All Wales Quality Standards for Audiology – Adult Rehabilitation	G	There is no comparative data for previous report	• BCU wide all 9 standards and the overall score exceeded national benchmark. Benchmark for standards raised from 75% to 80% since previous audit.	• Action plan in development, due to be completed April 2022 (draft already provided)
Older People					
NCAORP/2021/17	Stroke Audit (SSNAP)	A	A	•	• Action plan in development, due to be completed March 2022
NCAORP/2021/17	Stroke Audit (SSNAP) Post Acute Organisational Audit Report	Specific BCUHB data not included in the report	Specific BCUHB data not included in the report	•	• Action plan in development, due to be completed March 2022

Tier 1 Project reference	Title	Performance against National Benchmark	Performance against Last BCUHB Report	Progress/ Completed Actions	Outstanding issues - by whom by when
NCAORP/2021/18	Falls & Fragility Fractures Audit Programme: National Hip Fracture database	A	G	• Maintained compliance in line with national average • Maintained compliance when compared to previous reporting period	• Action plan in development, due to be completed March 2022
NCAORP/2021/19	Falls & Fragility Fractures Audit Programme: In-patient Falls Audit	R	There is no comparative data for previous report	•	• Action plan in development, due to be completed March 2022
Heart					
NCAORP/2021/24	National Heart Failure Audit (NAHF)	A	A	• Wrexham improved in two thirds of KPI's when compared to previous reporting period. • YG performance was higher than the national mean or national standard in more than two thirds of cases.	• Action plan in development due on February 3rd 2022
NCAORP/2021/25	National Audit of Cardiac Rhythm Management (NACRM)	A	G	• BCUHB has maintained or improved performance in 75% of KPIs or more since the previous reporting period	• Action plan in development due on February 3rd 2022
NCAORP/2021/26	National Audit of Percutaneous Coronary Intervention (NAPCI)	G	A	• BCU is at or above the benchmark is 75% of KPIs or more	• Action plan in development due on February 3rd 2022

Tier 1 Project reference	Title	Performance against National Benchmark	Performance against Last BCUHB Report	Progress/ Completed Actions	Outstanding issues - by whom by when
NCAORP/2021/27	Myocardial Ischaemia National Audit Project (MINAP)	G	G	• BCUHB improved in two thirds of KPI's when compared to previous reporting period. • BCUHB performance was higher than the national mean or national standard in more than two thirds of cases.	• Action plan in development due on February 3rd 2022
NCAORP/2021/28	National Vascular Registry Audit	A	A	• Two thirds of KPI's improved when compared to previous reporting period.	• Action plan in development, due to be completed March 2022
NCAORP/2021/29	National Audit of Cardiac Rehabilitation (NACR)	G	G	• YGC and Wrexham have been awarded Green certification again for performance in seven KPIs	• Part A due on February 9th 2022
Cancer					
NCAORP/2021/32	National Gastrointestinal Cancer Audit Programme: - Oesophago-Gastric Cancer Audit	A	G	• Maintained compliance when compared to previous reporting period	• Action plan in development, due to be completed December 2021
Women's and Children's Health					

Tier 1 Project reference	Title	Performance against National Benchmark	Performance against Last BCUHB Report	Progress/ Completed Actions	Outstanding issues - by whom by when
NCAORP/2021/34	National Maternity & Perinatal Audit (NMPA)	G	G	•	• Action plan in development due on February 3rd 2022

6. Audit – Proforma process (Part A and Part B)

In October 2020 in response to the ongoing COVID-19 pandemic the Welsh Government extended the return date of Part A proforma's to 8 weeks and to 16 weeks for Part B Proforma's. In May 2021 the Health Board Medical Director resumption of original timeframes. Welsh Government confirmed in February 2022 that submission of part A and B is no longer mandated. Participation in the Tier 1 audit program however remains mandatory. It remains the responsibility of the Health Board to secure its own quality assurance. In 2022 the Clinical Effectiveness Team, with the support of Senior colleagues and engagement of Clinical Teams, is focused on strengthening internal assurance, to ensure that we are a) participating in required Tier 1 audit and b) acting on the results in a SMART way, to improve patient care and inform quality surveillance. See previous point 4 above.

7. Tier 2

These 'local must do' audits support delivery of the Quality Improvement Strategy goals and priorities, including accreditation requirements specific to the service, NICE guidance compliance, safety audits, audit related to high risk activity and corporately agreed service improvement priorities. These audits should take priority over completing tier 3 audits. NB: All Corporate projects agreed at BCUHB Clinical Effectiveness Group as priorities must be incorporated within relevant Division/Directorate annual clinical audit plans.

The Tier 2 Clinical Audit plan 2021/2022 is attached below:

Clinical Audit plan
2021-22 v070721 - Mas

Each Division has prioritised and agreed upon topics for inclusion within Tier 2, of which 38 audits have been identified using a systematic approach:

- · **Frequency** (*'how often' or 'how many'?*)
- · **Degree of risk** (*likelihood of something going wrong or not being done*).
- · **Level of concern** (*how important is the question?*)
- · **Outcome** (*what is the impact in relation to potential for improvement/harm?*)

Which BCUHB priority does this support
(more than one answer possible per project)

Priority	Value
Safe, Clean Care/Infection Prevention	5
Safe Value-based health care	2
Reduce patient harms	22
Quality and Safety	8
Keeping People Safe from Avoidable Harm	6
Highly reliable clinical care	23

Current Stage
(taken from update provided)

Stage	Value
Complete	4
Preparation and planning : Development of aims, standards, methodology	4
Measuring performance: Data collection, analysis, report writing	9
Implementing Change: Developing action plan	5

Progress with Audit
(taken from update provided)

- 0% 0%
- 33%
- 67%

■ Red - Cause for concern, no progress towards completion

■ Amber - Delayed, with evidence of actions to get back on track

■ Green - Progressing on schedule or Completed

Reasons identified for non-progression/delay of audit

Reason	Value
Resource implications	4
Lack of capacity	1
Governance implications	0
Other	2

8. Tier 3

This activity relates to those audits that should be agreed by the Division/Directorate and included within their local, annual forward plan for clinical audit activity. These should be risk based. All Tier 3 projects must be approved by their Divisional/Directorate or Primary Care Lead.

The self-registration database was developed and launched in August 2020 (link below). 107 projects have been registered in Q3, 278 in total for 2021/22. Reports have been received for 46 (17%). The self-registration database can be found here:

http://7a1a1srvinforep/Tier3ClinicalAuditProjectSubmission

Activity by Month

N=278

	April	May	June	July	August	September	October	November	December	January	February	March
West	4	13	10	6	1	7	7	9	15	0	0	0
Central	10	8	15	12	3	17	12	21	8	0	0	0
East	19	12	7	5	8	14	8	17	10	0	0	0

■ West ■ Central ■ East

Project Status

N=278

0%

17%

83%

■ Complete ■ In progress ■ Abandoned/withdrawn

Project Status - by locality

N=278

	West (N=72)	Central (N=106)	East (N=100)
In progress	85%	81%	85%
Complete	15%	19%	15%

■ Complete ■ In progress ■ Abandoned/withdrawn

Staff group conducting the audit
N=278

Chart: Staff group conducting the audit (West, Central, East)
- Add Prof Scientific and Technic
- Additional Clinical Services
- Administrative and Clerical
- Allied Health Professionals
- Estates and Ancillary
- Healthcare Scientists
- Medical and Dental
- Nursing and Midwifery Registered
- Students

Legend: West, Central, East

Main Reason for the Audit
N=278

Chart: Main Reason for the Audit (West, Central, East)
- Local response to findings from National Clinical Audit
- AWMSG (All Wales Medicine Strategy Group)
- Datix incident
- Risk Register
- Complaints reported
- Equality & Human Rights
- Re-Audit
- ICP (Integrated Care Pathways)
- On approved departmental audit plan
- NICE (National Institute of Clinical Excellence)
- BCUHB Guideline
- National Guideline
- National Audit
- Local Concern
- Service Evaluation
- COVID
- Other

Legend: West, Central, East

Audits against NICE
N=29

Chart: Audits against NICE
- West: In progress 100%, Complete 0%
- Central: In progress 75%, Complete 25%
- East: In progress 94%, Complete 6%

Legend: Complete, In progress, Abandoned/withdrawn

Type of NICE guidance audited
N=29

Chart: Type of NICE guidance audited (West, Central, East)
- Technological Appraisal (TA)
- Clinical Guidelines (CG)
- Interventional Procedure (IPG)
- Quality Standard (QS)
- NICE Guidance (NG)
- Diagnostic Guidance (DG)
- Not identified

Legend: West, Central, East

COVID-19 Audits
(Covid mentioned in Project Title, Description or Aim)
N=21

9. Good Practice/Improvements in Quarter 3

AMaT:
The organisation has purchased Audit Monitoring and Tracking (AMaT) software to record and monitor national, corporate and local audit information and NICE guidance compliance.

Tier 1 National Audit data for 2021/22 have been inputted to the system and publications are inputted in real time for monitoring and tracking of the response to these national audit publications

While implementation was substantially stepped down in Q3 as staff were redeployed to respond to COVID surge 3, staff engagement continued (principally through provision of staff training) to prepare for future planned roll out in 2022.

Full resumption of AMaT implementation in 2022 is contingent upon staff resource. Subject to this being in place LocSSIPs audits, Peer review of Consent, Staff Wellbeing Service and Hospital Acquired Thrombosis Tier 2 Corporate audits will piloting the system for registration, monitoring, data capture and reporting during Q4.
.

Forthcoming Training in Q4:

21st February 2022 9.45 am - 4pm 'Clinical Audit Training' Facilitated by Clinical Audit Support Centre Trainers
25th February 2022 'SMART Action Planning for Tier 1 audits" by Interim Head of Clinical Effectiveness.
4th March 2022 12-1:00 "Understanding Mortality Data - CKSK and Beyond", by Informatics

10. Areas for action:

Participation in Tier 1 audit:

Timeliness and quality of Tier 1 responses (Part A and B) in the following projects:

- National Lung Cancer Audit
- National Vascular Registry
- National Asthma & COPD Audit Programme: Adult Asthma
- National Core Diabetes Audit
- National Asthma & COPD Audit Programme - Pulmonary Rehabilitation work stream

National Audit leads to be identified for the following projects:

- National Asthma & COPD Audit Programme: Adult Asthma East
- National Diabetes foot care Audit West
- National Paediatric Diabetes Audit: West and BCUHB wide
- National Diabetes Transition Report: Central and West
- National Early Inflammatory Arthritis Audit: East

Support needed to run the National Fracture Liaison service Database in BCUHB

Data collection issues to be resolved for the following projects:

- NACAP: Adult Asthma: East, West and Central
- NACAP: COPD: Central and East
- National Inpatient Falls: Central
- National Asthma & COPD Audit Programme (NACAP): Children and Young People Asthma: West and Central

- National Early Inflammatory Arthritis Audit (NEIAA): East

National Emergency Laparotomy Audit: Care of the Elderly review for patients aged 70 years and over is required by national standard. This is currently not being achieved due to insufficient COTE specialists on the acute sites. This has been escalated and is currently under workforce review.

Quality of audit action plans – including divisional governance and oversight of audit progress to ensure they are resourced / completed / with timely and required action taken to assure / improve patient care / outcomes. Use of template action plan and access to targeted support ie 2022 Clinical Effectiveness Intranet Page; Weekly Clinics; Lunch and Learn sessions; CASC training.

Staff resource for a) audit data collection, monitoring, and oversight, b) for **AM**aT implementation.

Clinical Effectiveness Group cycle of business 2022/23

Item	Lead	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-22
Welcome and members present	Chair	✓		✓		✓		✓		✓	
Apologies	Chair	✓		✓		✓		✓		✓	
Quorum	Chair	✓		✓		✓		✓		✓	
Review and agree CE Group Terms of Reference	Chair			✓						✓	
Declarations of Interest	Chair	✓		✓		✓		✓		✓	
Patient Story	Rachel Wright			✓		✓		✓		✓	
Review and agree meeting Cycle of business	Chair	✓		✓							
Review and agree minutes from previous meeting	Chair	✓		✓		✓		✓		✓	
Review and update meeting Action Log	Chair	✓		✓		✓		✓		✓	
NICE Assurance Sub-group Triple A report	TBC			✓				✓			
Radiation Protection Committee Triple A Report	Helen Hughes			✓							
North Wales Managed Clinical Services Quality Committee Triple A Report	Helen Hughes			✓							
Pathology (including Blood Transfusion Committee and Point of Care) Triple A Report	Bernie Astbury									✓	
Secondary Care CEG Triple A Report	TBC							✓			
BCUHB Trauma Board Sub Group and Triple A Report	Rob Perry									✓	
Clinical Law and Ethics Sub-group Triple A Report	Ben Thomas			✓				✓			
Resuscitation Committee Triple A Report	Sarah Bellis / Chris Shirley							✓			
Mental Health and Learning Disability Clinical Effectiveness Sub-group Triple A Report	Alberto Salmoiraghi										
Research & Innovation Strategic Partnership Sub-group Triple A Report	Lynne Grundy					✓					
Research & Development	Lynne Grundy	✓				✓				✓	

Item	Owner					
Drug and Therapeutics Sub-group Triple A Report	Teena Grenier / Susan Murphy		✓			
Reducing Avoidable Mortality Steering Group Triple A Report	Damian McKeon	✓				✓
Strategic Delivery Group for Palliative and End of Life Care Triple A Report	Alison Foster		✓		✓	✓
Chair's Triple A report for submission to QSE Committee	Chair	✓	✓	✓	✓	✓
Medical Education	Emma Woolley	✓				✓
East Locality Clinical Effectiveness Group (CEG) - Chairs triple A report	Mrs Geeta Kumar	✓	✓	✓	✓	✓
Central Locality Clinical Effectiveness Group (CEG) - Chairs triple A report	Dr Tania Bugelli	✓	✓	✓	✓	✓
West Locality - Quality, Safety and Clinical Effectiveness Group - Chairs triple A report	Dr Karen Mottart / Helena Blower	✓	✓	✓	✓	✓
Clinical Effectiveness Risks on Tier 1 Risk Register (appropriateness of scoring and mitigating actions) - link with Clinical effectiveness/audit quarterly reports?	Chair - To be Agreed					
Quarterly update on Mandatory Accreditation Audits from, Radiology, Pharmacy and Pathology.	Helen Hughes, Teena Grenier, Bernie Astbury			✓	✓	
Annual Meeting Effectiveness Review 2021/2022	Chair					
Any Other Urgent Business (AOUB) *Matters for referral to other groups *Matters impacting on policy and/or practice * Matters to be brought forward to review next meeting	All	✓	✓	✓	✓	✓
Policies / Procedures and Other Written Controlled Documents	All	✓	✓	✓	✓	✓
SOPS / Pathways / Patient Leaflets	All	✓	✓	✓	✓	✓
Draft Audit Annual Plan 2022/2023 (Tier 1 and Tier2)	Chair	✓				

Standing Agenda Item	Item	Responsible										
	Draft Clinical Audit Annual Report 2021/2022	Chair								✓			
	Quarter 1 Clinical Audit Report (April - June 2022)	Chair					✓						
	Quarter 2 Clinical Audut Report (July - Sept 2022)	Chair								✓			
	Quarter 3 Clinical Audit Report (Oct - Dec 2022)	Chair											
	Draft NICE policy	Chair			✓								
	Quarterly Mortality Report	Damian McKeon	✓							Q2		✓	
	HCAI Covid Death Review Process for agreement	Damian McKeon / Carolyn Owen	✓		✓								

QSE

Strategic Occupational Health & Safety Group

Clinical Effectiveness Group

Patient and Carer Experience Group

Patient Safety a Quality Group

Feb-23	Mar-22
✓	
✓	
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Betsi Cadwaladr University Health Board

National Clinical Audit & Outcome Review Programme

All health boards / trusts participating in national clinical audits and outcome reviews must electronically send a completed front page and Part A version of this form to the mailbox address below within 8 weeks of the publication of reports and, a completed Part B within 16 weeks. sue.yorwerth@wales.nhs.uk

Audit / Registry Title: National Audit of Children & Young People Asthma

Date of published report: 13th May 2021

YGC Clinical Lead: Lee Wisby, Wrexham Clinical Lead: Liz Richards, YG Clinical Lead: Mair Parry

Is the HB currently participating in this audit? YES (indicate as appropriate)
if the answer is "Yes" are all relevant services included in the audit? YES (indicate as appropriate)
If your organisation or any relevant services are not participating, please indicate why

If you are participating please complete the following table.

% of patients fitting inclusion criteria reported in current audit cycle or registry.	unknown
% of patients fitting inclusion criteria with full dataset in this audit cycle or registry.	unknown

Has the audit formally identified your organisation or any parts of your organisation as an "Outlier"? NO (indicate as appropriate)

If the answer is YES please describe what actions are being taken to address concerns	

PART A. What are the key national and local findings / recommendations from the last published report which your organisations needs to address (see guidance note below)

National	• **85% of hospitals should have a respiratory nurse specialist**
	• **80% of hospitals should have access to fractional exhaled nitric oxide as a diagnostic tool**
	• **Exposure to first or second-hand smoke should be documented in 95% of CYP**
	• **95% of CYP should receive systemic steroids within one hour of arrival at hospital**
	• **95% of CYP should receive personalised asthma action plan, check of inhaler technique and request for 4-week follow-up appointment as part of discharge bundle**
Ysbyty Glan Clwyd	• **We have a respiratory nurse specialist but we do not have access to FeNO**
	• **There is no documentation of smoke exposure in approx. 25% of our patients**
	• **We document provision or review of an asthma action plan in approximately 25% of patients** • **We document a check of inhaler technique in approximately 75% of patients** • **We request 4-week follow-up in approximately 60% of our patients, when requesting a 4-week follow-up appointment, we are never able to meet that target**
	• **When we do request a 4-week follow-up appointment, we are never able to meet that target**
Wrexham Maelor	• **We have (2FT equivalent) respiratory nurse specialists but we share them with the allergy services. We do not have access to FeNO**
	• **There is no documentation of smoke exposure in approximately 25% of our patients (mainly acute admissions as new proforma for OPD has prompt to address this)**
	• **We document provision or review of an asthma action plan in approximately 85% of patients** • **We document a check of inhaler technique in approximately 85% of patients** • **We request 4-6week follow-up in approximately 60% of our patients, but we are never able to meet that target due to clinic overbooked**
Ysbyty Gwynedd	• **Despite significantly reduced resources, the site wanted to participate in this audit in order to highlight deficiencies, and ultimately improve the service**

Part A Guidance Note

The recommendations which your organisation needs to address must be listed. On a separate sheet however, you may choose to highlight areas which the audit recognises you are doing particularly well (this information may be useful to other health boards / trusts looking for information to guide their service improvement).

National findings are common problems identified across the audit where healthcare nationally is generally falling below the standard identified by the audit. If your organisation is meeting these standards or performing significantly better than the audit average it should not be necessary to list them (see comment above).

Local findings are where specific weaknesses have been identified within you organisation. This may be an organisation wide issue or relate to individual hospitals or services, but significant variation in the delivery of services across the organisation should be highlighted.

For information a link to NICE guidance on how audit data is mapped to recommendations and quality measures is provided below:
https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-uptake-of-nice-guidance

PART B. Describe the actions already taken or in the process of being developed to address the key findings and recommendations above with timescale and details of named lead.

Action (provide additional detail on separate page(s) when required)	**Timescale** (incl. milestones)	**Clinical Lead**
Ysbyty Glan Clwyd		
Develop a discharge bundle which outlines the importance of documenting exposure to cigarette smoke and offers support with smoking cessation	**2 months (September 2021)**	**Suzanne Jones**
Develop a discharge bundle which supports better delivery of targets with respect to PAAP and check of inhaler technique	**2 months (September 2021)**	**Suzanne Jones**
Review follow-up arrangements and clinic capacity in order to find out what investment/resource is needed to deliver a follow-up service within the 4-week timeframe	**6 months (January 2022)**	**Aradhana Ingley Lee Wisby**
Wrexham Maelor		
Discharge paperwork for viral induced wheeze as well as asthma	**6 months (January 2022)**	**Lisa Owen/ Jo Hughes**
Review implementation of new OPD review forms and prompts	**4 months (November 2021)**	**Liz Richards/ Lisa Owen**
Implement teaching to promote steroids in first 1 hour	**2 months (September 2021)**	**Liz Richards**

Review follow up arrangements and clinic capacity in order to find out what investment/resource is needed to deliver a follow up service within the 4 week timeframe	6 months (January 2022)	Liz Richards/ Lisa Owen
Ysbyty Gywnedd		
Previous business cases for paediatric asthma specialist nurse rejected by HB There is already evidence on impact of paediatric asthma nurses, their role in particular in education, inhaler technique, managing acute exacerbations at home. Although they are usually linked to an acute unit, much of their role is in the community. It would be hugely beneficial if we had one, as they support a lot of the safe discharge safety netting, and would enable us to comply with the clinic review after discharge. As for many services, because we manage with few datix and incidents related to asthma in children, it is not really a priority, but audits like this highlight the gaps in service	Since 2005	Mair Parry
Increase medical time to asthma clinic via job planning process	Within 12 months (July 2022)	Mair Parry

If there are resource implications in the actions detailed above are they included in the health board / trust integrated medium term plans?
NO (please indicate as appropriate).
If the answer is **No,** how is the matter being addressed?

Ysbyty Glan Clwyd: Collect appropriate data and discuss with CD

Wrexham Maelor: Collect clinic data and discuss within department although have already doubled MDT clinic capacity in last 18 months

Ysbyty Gywnedd: CD will continue to raise as an area that needs addressing and resources within the organisation

Part B Guidance Note
The over-riding principle is that actions being taken must relate directly to the issues highlighted in Part A and, **lead to clear evidence of improvement when services are next re-audited**.

Information from audits and reviews hasn't always been used effectively in the past to improve services, but in future **must directly align with organisation's quality improvement programmes and lead to improved patient care**. Information demonstrating there has been a comprehensive review of report findings which are clearly feeding into local action plans is important

Information from audits and reviews should demonstrate a pattern of year on year improvement

Bear in mind that many important improvements are often linked to relatively simple changes of procedure or process

Information provided should be focussed on addressing the audit / review findings. Organisations must resist the temptation to include information on quality improvement initiatives which have little or no direct relevance to the specific findings and recommendations listed in Part A.

Where findings confirm significant variation of services within an organisation, details of how variation is being addressed and, the learning from the best performing units is being shared should be provided. Clear evidence that report details are feeding into change across the organisation is important.

Where appropriate, organisations should also provide information to demonstrate how they are using the learning from other high performing organisations in Wales or from across the wider audit.

Issues to bear in mind:
- Health boards should take the opportunity to maximise the investment in national audits and utilise findings to direct service improvement.
- Report plans should demonstrate information from audits and reviews is part of on-going local governance
- Reports should feed into on-going MDT working across the organisation
- Information to show reports are driving/guiding change and improvement is important
- information from audits should provide evidence on ongoing year on year improvement

Overall Assessment

How would you assess your organisations progress in relation to this Audit?

Current status	Tick Status	Status Definitions
Red	**X YG**	Cause for concern. No progress towards completion. Needs evidence of action being taken.
Amber	**X WXM**	Delayed, although action is being taken to ensure progress.
Green	**X YGC**	Progressing on schedule with clear evidence of progress.

The completed assurance pro-forma should be signed by the health board clinical lead for the audit / review and the Medical Director or their representative.

Health Board clinical lead for the audit / review: Lee Wisby, Mair Parry, Liz Richards

Medical Director's Office: Dr Liz Bowen, Central Area Medical Director

Date: 4th August 2021

Betsi Cadwaladr University Health Board

National Clinical Audit & Outcome Review Programme

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Audit / Registry Title: National Maternity and Perinatal Audit: Technical Report

Title of published report: Evaluating perinatal mental health services using linked national maternity and mental health data sets

HB Clinical Lead / Champion: Fiona Giraud: Director of Midwifery and Women's Services

Is the HB currently participating in this audit? YES
if the answer is "Yes" are all relevant services included in the audit? YES
If your organisation or any relevant services are not participating please indicate why

If you are participating please complete the following table.

% of patients fitting inclusion criteria reported in current audit cycle or registry.	NK
% of patients fitting inclusion criteria with full dataset in this audit cycle or registry.	NK

Has the audit formally identified your organisation or any parts of your organisation as an "Outlier"? NO (indicate as appropriate)

If the answer is YES please describe what actions are being taken to address concerns	

PART A.   What are the key national and local findings / recommendations from the last published report which your organisations needs to address (see guidance note below)

National	• R1 National organisations responsible for the evaluation of perinatal mental health services should aim to use a data set that includes all live births and stillbirths as a 'spine' against which all other data sets (maternity, general/acute and mental health inpatient data) can be linked. (Organisations responsible for the evaluation of perinatal mental health services)
	• R2 Both data sets of admissions to psychiatric hospitals and of admissions to general/acute hospitals should be used to identify women with a mental health admission before and during the perinatal period. (Organisations responsible for the evaluation of perinatal mental health services)
	• R3 Options of linking with data sets that include records of mental health care provided in the community should be explored so that perinatal mental health problems that are treated in the community can also be identified, and reported separately. (Organisations involved in the study and assessment of perinatal mental health services)
	• R4 The classification with eight groups of mental health diagnoses described in this report should be considered to study and evaluate perinatal mental health services. (Organisations involved in the study and assessment of perinatal mental health services; providers of mental health services and providers of maternity services, and services users)
	• R5 The implementation of guidelines for perinatal mental health services and other initiatives to improve these services should be evaluated using national linked data sets. (National policy makers, including NHS England, NHS Scotland and NHS Wales; organisations involved in the study and assessment of perinatal mental health services)
Local	• The recommendations refer to non-clinical issues which need to be discussed with colleagues. Discussions have been arranged so that possible improvements can be identified.

Part A Guidance Note

The recommendations which your organisation needs to address must be listed. On a separate sheet however, you may choose to highlight areas which the audit recognises you are doing particularly well (this information may be useful to other health boards / trusts looking for information to guide their service improvement).

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https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-uptake-of-nice-guidance

PART B. Describe the actions already taken or in the process of being developed to address the key findings and recommendations above with timescale and details of named lead.

Action (provide additional detail on separate page(s) when required)	**Timescale** (incl. milestones)	**Clinical Lead**
Officials in the Government Perinatal Mental Health Policy Team are going to be discussing this report with the National Lead for Perinatal Mental Health and correspondence on the report will be sent to all specialist perinatal mental health teams in Wales. The Perinatal Mental Health Team in BCUHB will note the findings of the report and implement them where possible.	**When the report is written**	**Emma Adamson (Specialist Perinatal Mental Health Midwife) and Deborah Griffin (Service Manager Perinatal And Psychiatric Liaison)**

If there are resource implications in the actions detailed above are they included in the health board / trust integrated medium term plans ?
NO
If the answer is **No,** how is the matter being addressed?
The resource implications of this plan are not yet known.

Part B Guidance Note
The over-riding principle is that actions being taken must relate directly to the issues highlighted in Part A and, **lead to clear evidence**

of improvement when services are next re-audited.

Information from audits and reviews hasn't always been used effectively in the past to improve services, but in future **must directly align with organisation's quality improvement programmes and lead to improved patient care**. Information demonstrating there has been a comprehensive review of report findings which are clearly feeding into local action plans is important

Information from audits and reviews should demonstrate a pattern of year on year improvement

Bear in mind that many important improvements are often linked to relatively simple changes of procedure or process

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The completed assurance pro-forma should be signed by the health board clinical lead for the audit / review and the Medical Director or their representative.

Health Board clinical lead for the audit / review: Fiona Giraud: Director of Midwifery and Women's Services..
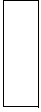
Medical Director's Office:

[signature: G A Cramin]

Date: 05/08/2021

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	Dr Alexander (Consultant)/ Karin Howarth (Gen Manager Community Services (Centre))	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	Ind/ve 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 Balasundaram Ramesh, 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 Balasundaram Ramesh, 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
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. Safe, Clean Care/Infection Prevention	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. Safe, Clean Care/Infection Prevention	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

Ref	Title						Category	Period	Timescale	Rationale	Lead	Committee/Group	Registered	Frequency	Priority
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 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 patient harms. Quality and Safety. Safe, Clean Care/Infection Prevention	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	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
P&MM/21/01	Antimicrobial Point Prevalence Audit (Inpatients)	Y		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	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	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

Ref	Description						Category	Period	Date	Objective	Lead	Committee			Risk
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	Quality and Saferty. Highly reliable clinical care	Jan-21	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
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)	NWMCS 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)	NWMCS 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)	NWMCS 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)	NWMCS 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)	NWMCS Quality Committee	Yes	Yes	Critical
NEW IR(ME)R CE 2021	Ionising Radiation(Medical Exposures) Regulation compliance audit - ensuring orthopaedics formally document clinical evaluation 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:	
Critical	Control weakness could have a significant impact on the system, function or process and achievement of organisational objectives in relation to compliance with laws and regulations or the efficient and effective use of resources.
High	Control weakness could have a significant impact on the system, function or process but does not have an impact on the achievement of organisational objectives (as above)
Medium	Control weakness has a low impact on the achievement of the key system, function or process or a low degree of risk associated with exposure.
Low	Control weakness has no impact on the achievement of the key system, function or process objectives; however, improved compliance would improve overall control.

✓Betsi Cadwaladr University Health Board

National Clinical Audit & Outcome Review Programme

All health boards / trusts participating in national clinical audits and outcome reviews must electronically send a completed front page and Part A version of this form to the mailbox address below within 8 weeks of the publication of reports and, a completed Part B within 16 weeks. Angela.taylor2@wales.nhs.uk

Audit / Registry Title: National Clinical Audit of Seizures and Epilepsies for Children and Young People: Round 3 Cohort 2 **(2019 - 2020)**

Date of published report: July 2021

HB Clinical Lead / Champion: Dr Kathryn Foster, Consultant Paediatrician

Is the HB currently participating in this audit? YES
if the answer is "Yes" are all relevant services included in the audit? YES

If your organisation or any relevant services are not participating please indicate why
No time

If you are participating please complete the following table.

% of patients fitting inclusion criteria reported in current audit cycle or registry.	??
% of patients fitting inclusion criteria with full dataset in this audit cycle or registry.	8/47 17%

Has the audit formally identified your organisation or any parts of your organisation as an "Outlier"? YES / NO (indicate as appropriate)

If the answer is YES please describe what actions are being taken to address concerns	There have been ongoing difficulties in collecting and collating the data for this audit which date back several years. Our compliance has gone down due to COVID and associated capacity related issues (e.g. redeployment of clerical and clinical staff, ongoing adjustments to services impacting on capacity and demand). In addition, EEG have withdrawn their support for this audit. We are relooking at our processes across CYP services and engaging with EEG – this is ongoing

	work and we are working with our clinical effectiveness department to ensure we significantly increase our engagement with Cohort 4.

PART A.   What are the key national and local findings / recommendations from the last published report <u>which your</u> organisations needs to address (see guidance note below)

National	**1. All Health Boards and Trusts should ensure that:** **• All children and young people with epilepsy are provided with psychosocial support and signposting to help them manage their condition and their related worries or anxieties, • All children and young people with epilepsy have ongoing screening for mental health problems using a validated tool as part of their routine epilepsy care. Where there are concerns about mental health, children and young people are referred to an appropriate mental health service via an agreed pathway. There should be timely access to diagnosis and treatment.** This is an area that we need to continue to develop. Clinicians and epilepsy nurses have good awareness of universal and 3rd sector organisations and resources to support emotional health of young people. Integrated children's services model supports referring young people who require specialist support to our CAMHS, learning disability and other services. The waiting list for these services are challenging at present, reflecting the ongoing pressures for these specialist services. Our CEAG are looking at implementing a validated screening tool over the next 6 months.
	2. Hospital and community commissioners should commission increased integrated psychosocial and mental health support for children and young people receiving care for long-term conditions. This should be co-located within the epilepsy clinic, and inclusive of co-morbidities. There are some ongoing high level workstreams both nationally and within the Health Board looking at provision of psychology within children's services. At present we do not have specific psychology services within our epilepsy teams, however, we are exploring this as part of the Health Board and areas discussions which are ongoing.
	3. All Health Board and Trust managers and epilepsy clinical teams should implement standardised approaches to epilepsy care planning content provision to ensure that essential elements of care are always provided for all children and young people with epilepsy and these are reviewed on an ongoing basis. This is established across the Health Board and routinely discussed and reviewed as part of the work of the CEAG and area

	epilepsy team meetings.
	4. Health Board and Trust managers, epilepsy clinical teams, school head teachers, and school nurses should agree processes to facilitate appropriate, up-to-date health care planning within education and two-way information sharing. Existing processes in place, which will be reviewed and enhanced with the onging work around the new ALN Act over the coming 12 months Epilepsy12 is developing a new tool for 2021 to help teams evidence in real-time the core elements of care planning for the children and young people with epilepsy in their care. To place on agenda for CEAG for agreement once this is available
	5. Epilepsy services should be supported by their Trust or Health Board's management and the commissioning organisations to: **• Develop a defined epilepsy team approach to service provision and service improvement, • Allocate time within job plans to support team functions including dedicated time for audit participation and related quality improvement actions.** We have an established team approach: At CYP level the CEAG (meets quarterly) and we have regular area epilepsy team meetings. Need to ensure we review and refresh membership & TOR for these groups and ensure Epilepsy12 and areas from recommendations are on these agendas. Highlighted ongoing issue that there is insufficient time within job plans of either doctors or epilepsy nurses to meet mandatory audit requirements and challenges over time with service development – this is being escalated within areas and at CYP CAG level.
	6. Hospital commissioners, NHS Regional Offices, Regional Partnership Boards, NHS England and NHS Wales should ensure that there is capacity to provide timely access to necessary epilepsy investigations (such as EEG, ECG, MRI and CT), so that children and young people are not disadvantaged by the variation in availability of diagnostic services between Health Boards and Trusts. COVID has impacted on the availability of MRI for young people requiring general anaesthetic - this is improving with the current Health Board recovery plan for this work. Otherwise we have good access to EEG, ECG and imaging. In addition through our regional network, access to specialised services through Alder Hey. Alder Hey does have some ongoing waiting list

	difficulties for those young people requiring Video-telemetry
	7. All Health Board and Trust managers should employ sufficient Epilepsy Specialist Nurses and consultant paediatricians "with expertise" in epilepsy to ensure all children and young people with epilepsy can reliably receive responsive, individualised, specialist input into their care for epilepsy and related concerns, for example, psychological and developmental issues. We have identified senior paediatricians with expertise in epilepsy in each area from both our acute and community paediatric services, and a specialist epilepsy nurse in each area. We have processes in place to ensure that families receive a best quality and responsive service. We have strong links with established services, for example CAMHS, learning disability teams and are exploring how we can develop our skill mix within out epilepsy teams to support young people's emotional and psychological needs.
	8. All Health Board and Trust managers and hospital and community commissioners should ensure that adult and paediatric epilepsy teams are resourced to allow, and have time allocated in job plans, for joint transition-related clinical appointments and quality improvement work . We are not currently compliant with this. Having previously had transition clinics held jointly with adult neurologists, due to retirement and service reconfiguration, these are not currently running. This has been escalated to the Neurosciences Board and Director for Neurosciences within the Health Board and a meeting to discuss and develop a way forward has been planned.
	9. OPEN UK regional networks, NHS England, NHS Wales, BPNA, RCPCH, Health Education England and Health Education and Improvement Wales should work together to review the Epilepsy12 findings in their area and ensure there are: **• Sufficient paediatric neurologists to provide timely assessment and ongoing management, • Robust referral pathways to paediatric neurology such that children and young people are not disadvantaged by the variation in access to specialists between Health Boards and Trusts.** We access specialist paediatric neurologists through our contract with Alder Hey Children's Hospital. We have an established model in which our paediatric neurologists deliver co-led clinics within our 3 North Wales Hospitals several times per year. Over COVID these have moved to joint video consultations, and we are in the process of re-establishing these face to face.
	10. The specialist CESS centres should collectively: **• Review the referral criteria to ensure these are clear, consistent, and embedded in shared care pathways from secondary care and paediatric neurology, and • Agree a communications strategy to raise awareness of referral criteria**

	and encourage early referral of appropriate children and young people. We are compliant, as part of our role with the regional CESS network through our contract with Alder Hey Children's Hospital

Part A Guidance Note

The recommendations which your organisation needs to address must be listed. On a separate sheet however, you may choose to highlight areas which the audit recognises you are doing particularly well (this information may be useful to other health boards / trusts looking for information to guide their service improvement).

National findings are common problems identified across the audit where healthcare nationally is generally falling below the standard identified by the audit. If your organisation is meeting these standards or performing significantly better than the audit average it should not be necessary to list them (see comment above).

Local findings are where specific weaknesses have been identified within you organisation. This may be an organisation wide issue or relate to individual hospitals or services, but significant variation in the delivery of services across the organisation should be highlighted.

For information a link to NICE guidance on how audit data is mapped to recommendations and quality measures is provided below:
https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-uptake-of-nice-guidance

PART B. Describe the actions already taken or in the process of being developed to address the key findings and recommendations above with timescale and details of named lead.

Action (provide additional detail on separate page(s) when required)	**Timescale** (incl. milestones)	**Clinical Lead**
Response to Recommendation 1: Explore routine emotional screening of young people who have epilepsy using a validated screening tool.	**12 months – October 2022**	**Gemma Macey (Consultant Paediatrician)**
Response to Recommendation 2: Explore access to psychology support integrated into our epilepsy services for children.	**12 months – October 2022**	**Hamilton Grantham Consultant Paediatrician)**
Response to Recommendation 3: Epilepsy12 is developing a new tool for 2021 to help teams evidence in real-time the core elements of care planning for the children and young people with epilepsy in their care – CEAG to discuss this once available	**Depends on when Epilepsy12 circulate the new tool**	**Chair of CEAG at the time this is received**

Response to Recommendation 5: Allocated time within our epilepsy services to complete routine governance and audit work: ongoing discussion at CEAG re strategic issues; Area teams to raise this within their areas	**As soon as practicable and review progress in 6 months- April 2022**	**Chairs of CEAG regionally: Consultant Paediatricians: Praveen Jauhari (East), Hamilton Grantham (Central), Kathryn Foster (West)**
Response to Recommendation 6: Improve timely availability of MRI scans under GA (within the Health Board) and Video Telemetry (in partnership with Alder Hey)	**April 2022**	MRI in the HB – **Praveen Jauhari (East), Hamilton Grantham (Central), Kathryn Foster (West)** VT in Alder Hey – **Hamilton Grantham (Consultant Paediatrician)**
Response to Recommendation 8: Re-establishing joint epilepsy clinics in each area to support young people moving on to adult service: Regionally through Neurosciences Board. Area – local epilepsy leads	**April 2022**	Regionally **through Neuroscience Board** Area **through local Epilepsy leads:– Hamilton Grantham, Praveen Jauhari, Kathryn Foster**

If there are resource implications in the actions detailed above are they included in the health board / trust integrated medium term plans ?
NO (please indicate as appropriate).
If the answer is **No,** how is the matter being addressed?
Clinician time for governance and audit is being escalated at an area level by our area epilepsy leads.

Re-establishing joint clinics with adult neurology has been escalated to the HB Neurosciences Board

Access to psychology within epilepsy services – Ongoing liaison with lead psychologist for children within the health board (SHR) and hope this will fit in with the current Matrix Plant work being undertaken.

Part B Guidance Note

The over-riding principle is that actions being taken must relate directly to the issues highlighted in Part A and, **lead to clear evidence of improvement when services are next re-audited**.

Information from audits and reviews hasn't always been used effectively in the past to improve services, but in future **must directly align with organisation's quality improvement programmes and lead to improved patient care**. Information demonstrating there has been a comprehensive review of report findings which are clearly feeding into local action plans is important

Information from audits and reviews should demonstrate a pattern of year on year improvement

Bear in mind that many important improvements are often linked to relatively simple changes of procedure or process

Information provided should be focussed on addressing the audit / review findings. Organisations must resist the temptation to include information on quality improvement initiatives which have little or no direct relevance to the specific findings and recommendations listed in Part A.

Where findings confirm significant variation of services within an organisation, details of how variation is being addressed and, the learning from the best performing units is being shared should be provided. Clear evidence that report details are feeding into change across the organisation is important.

Where appropriate, organisations should also provide information to demonstrate how they are using the learning from other high performing organisations in Wales or from across the wider audit.

Issues to bear in mind:
- Health boards should take the opportunity to maximise the investment in national audits and utilise findings to direct service improvement.
- Report plans should demonstrate information from audits and reviews is part of on-going local governance
- Reports should feed into on-going MDT working across the organisation
- Information to show reports are driving/guiding change and improvement is important
- information from audits should provide evidence on ongoing year on year improvement

Overall Assessment

How would you assess your organisations progress in relation to this Audit?

Current status	Tick Status	Status Definitions
Red		Cause for concern. No progress towards completion. Needs evidence of action being taken.
Amber	✓	Delayed, although action is being taken to ensure progress.
Green		Progressing on schedule with clear evidence of progress.

The completed assurance pro-forma should be signed by the health board clinical lead for the audit / review and the Medical Director or their representative.

Health Board clinical lead for the audit / review: …

Dr G Hamilton Grantham (Community Clinical Director Central Area)………………21/10/2021…

Dr Kathryn Foster 22/10/2021 approved but no signature

Medical Director's Office:

Dr Liz Bowen, Medical Director, Central Area

Date: 07/12/21

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	Dr Alexander (Consultant)/ Karin Howarth (Gen Manager Community Services (Centre))	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	Int/ext 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 Balasundaram Ramesh, 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			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 Balasundaram Ramesh, Dr Karen Mottart reporting to the Secondary Care Quality Committee and thereafter QSG	Consent and Capacity Strategic Working Group	Yes	Yes	Critical

Ref	Title					Category	Timescale	End date	Rationale	Lead	Reporting to			Priority
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
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. Safe, Clean Care/Infection Prevention	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. Safe, Clean Care/Infection Prevention	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. Safe, Clean Care/Infection Prevention	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

Ref	Title						Domain	Period	Date	Purpose	Lead	Group			Priority
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	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
P&MM/21/01	Antimicrobial Point Prevalence Audit (Inpatients)	Y		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	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	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

ID	Description	Y1	Y2	Y3	Y4	Y5	Aim	Start	End	Objective	Lead	Group	A	B	Priority
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 Saferty. Highly reliable clinical care	Jan-21	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
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)	NWMCS 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)	NWMCS 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)	NWMCS 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)	NWMCS 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)	NWMCS 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 lain 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:	
Critical	Control weakness could have a significant impact on the system, function or process and achievement of organisational objectives in relation to compliance with laws and regulations or the efficient and effective use of resources.
High	Control weakness could have a significant impact on the system, function or process but does not have an impact on the achievement of organisational objectives (as above)
Medium	Control weakness has a low impact on the achievement of the key system, function or process or a low degree of risk associated with exposure.
Low	Control weakness has no impact on the achievement of the key system, function or process objectives; however, improved compliance would improve overall control.

Cyfarfod a dyddiad: **Meeting and date:**	**Quality, Safety and Experience Committee, 3rd May 2022**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Psychological Therapies
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gareth Evans, Acting Executive Director Therapies and Health Science
Awdur yr Adroddiad **Report Author:**	Gareth Evans, Acting Executive Director Therapies and Health Science
Craffu blaenorol: **Prior Scrutiny:**	None
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

The Committee is asked to approve the actions set out in this paper for psychological therapy services.

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**	
If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.				Y/N to indicate whether the Equality/SED duty is applicable		N	

Sefyllfa / Situation:

This paper sets out the proposed activity to be undertaken in respect of an outstanding action from agenda item QS21/105 at the Quality, Safety and Experience Committee in July 2021.Due to the ongoing absence of key staff over several months the action has remained incomplete.

Cefndir / Background:

On the 6th July 2021 the Quality, Safety and Experience Committee (QSE) considered an agenda item (QS21/105) which was a joint 'exception' report from the Mental Health and Learning Disabilities Division (MHLD) and Children and Adolescent Mental Health Services (CAMHS). The report highlighted the key issues of significance to the Quality, Safety and Experience (QSE)

Committee and on this occasion, the focus was on the management actions in place around the Targeted Intervention Improvement Framework (TIIF).

The minute of the meeting, QS21/105.4, records the following; "The Chair acknowledged the amount of work to be delivered as part of the targeted intervention and the preventative and early intervention side of the service which will need the development of less medicalised service models. The increase in psycho-social cases will need good partnership working with Local Authorities. She referred to the need to significantly improve access to psychological therapies and that the Committee needs to see rapid progress on this."

The action log from the meeting subsequently records an action around psychological therapies as QS21/105.4 Mental Health: Provide a thematic analysis on psychological services to the November meeting.

Subsequent QSE meetings have received the following updates in respect of this action:

- 21.7.21 Division seeking confirmation that this should be joint adult and CAMHS format.
- 7.9.21 C Stockport clarified this would be a joint report.
- 22.10.21 Paper deferred to January meeting
- 2.11.21 L Reid wished to clarify that the paper would address psychological services across the Health Board as a whole, not just within MHLDS. A Thomas confirmed the paper would be ready for the January meeting.
  Due to staff sickness, it has been necessary to defer the report again

At the QSE committee held on the 1st March 2022 a commitment was made from the Acting Executive Director of Therapies and Health Science to bring an update to the next QSE meeting outlining how the action is to be progressed.

Asesiad/Assessment & Analysis

Psychological therapies have been defined as "treatments and interventions that are derived from specific psychological theories and formulated into a model or treatment protocol. They are delivered in a structured way over a number of sessions by a suitably qualified practitioner." *(Matrics Cymru Guidance for Delivering Evidence-Based Psychological Therapy in Wales, 2017).* Further clarity in relation to children is made where psychological interventions are defined as: "…purposeful courses of action driven by a formulation which itself will be based on an assessment of need and informed by one or more psychological theories. The formulation should consider where in the child or young person's system an intervention can be most effective for improving psychological resilience and wellbeing" *(Matrics Plant, Guidance on the Delivery of Psychological Interventions for Children and Young People in Wales, 2019).*

Matrics Cymru is the result of collaborative working between service user and carer representatives in Wales, Welsh Government, the National Psychological Therapies Management Committee (NPTMC) and Public Health Wales to help build effective, equitable and accessible psychological therapy services across Wales. Whilst the focus of Matrics Cymru is on psychological therapy provision within mental health services, for adults, older adults, and people with a learning disability, many of the general principles also apply to the delivery of psychological therapy within physical health settings.

The service structure and the focus of work within psychological services for children, young people and families differs sufficiently from the model outlined in Matrics Cymru to require adapted guidance. Matrics Plant was therefore published, designed for practitioners working in psychological services for children, young people and families to assist in the development, planning and delivery of a Wales wide approach to providing psychological services to children, young people and their families. It was developed under the auspices of the All Wales Together for Children and Young People Programme Board and overseen by the National Psychological Therapies Management Committee (NPTMC) that developed Matrics Cymru.

Given the availability of both frameworks and the expectations of their use in NHS Wales, the following action is suggested for BCUHB. Whilst it is likely that some of this data is already available as evidence for the specific psychological therapy components identified within the Targeted Improvement Framework, this action is expected to enhance and support the evidence available to the organisation.

Action 1: Map our current position across all adult (physical and mental health) and children's services using the existing Matrics Cymru and Matrics Plant frameworks. Timeline – By September 2022.

Across Wales Health Board Psychological Therapies Management Committees (PTMCs) are expected to play a key role in supporting, informing and assuring wider service development toward standards set out in Matrics Cymru and Matrics Plant. Local PTMCs work to identify and prioritise areas for improvement though a function that oversees:

• The implementation of the National Psychological Therapy Plan
• Data collection and analysis
• Prepare reports for Health Board committees and the National PTMC
• Oversee provision of training and supervision
• Support service managers in setting up systems to ensure clinical and manage supply and demand
• Promote service/practice-based research to advance the evidence base in collaboration with academic institutions, service users and carers

Given the intent to map our current position in relation to psychological therapies across BCUHB, it is also proposed to review the governance and terms of reference for the BCUHB Psychological Therapies Management Committee.

Action 2: Review the terms of reference for the BCUHB Psychological Therapies Management Committee. Timeline – By July 2022.

A core component of both the Matrics Cymru and Matrics Plant frameworks is the construct of psychologically minded (or informed) organisations and services. Whilst both Matrics Cymru and Matrics Plant are specifically guidance for the delivery of psychological therapies, they both identify that the efficacy of psychological therapy will be significantly enhanced if delivered within psychologically minded organisations. Psychologically minded services are "those in which – at all stages of assessment and intervention – the psychological needs of service users are considered and addressed through the use of evidence-based interventions. Furthermore, a psychologically minded service focuses upon the quality of relationships between practitioners and service users in the delivery of all treatment and interventions. These relationships provide the foundation for service delivery." *(Psychological Therapies in Wales Policy Implementation Guidance, 2012)*

Achieving this goal requires commitment and contribution at strategic and operational levels from clinicians, managers, partners, and from people who access services. Embedding psychologically-informed approaches requires a whole system change, one in which all clinical staff working in BCUHB should have the basic level of knowledge and understanding necessary to communicate effectively with service users/carers and deliver care which takes account of people's psychological and emotional presentation and needs. Furthermore, staff from all disciplines have a role to play in the identification of psychological problems and many are then involved in the delivery of specific evidence based psychological interventions and therapies at different tiers of the service. It is proposed that, under the leadership of the PTMC, BCUHB develop a plan to embed psychologically informed care within the organisation in order to provide effective treatments through psychologically minded staff and systems.

Action 3: The Psychological Therapies Management Committee will oversee the construction of a plan to develop a framework for psychological informed care with BCUHB. Timeline – By December 2022.

Taken together the three proposed actions reframe the original action of QS21/105 to not only provide a thematic analysis on psychological services but also to consider the governance of the PTMC and a way forward for BCUHB in regard to being a psychologically minded organisation.

Strategy Implications

The proposed actions align themselves to support the Targeted Intervention Improvement Framework (TIIF) for Mental Health and CAMHS.

Options considered

None

Financial Implications

None

Risk Analysis

Organisational risks relating to psychological therapies will be reviewed as part of the proposed activity outlined in this report.

Legal and Compliance

No legal implications of the proposal are identified. The outcome of the proposed actions will be reported back to the Quality, Safety & Experience Committee.

Impact Assessment

None

Board/Committee report template

This template combines the former coversheet and report template. Authors should attempt to restrict reports to no more than four pages where possible. Any necessary supplementary information can be attached as appendices but the Board Members should be able to understand the key issues and make an informed decision from the report alone.

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

Meeting and date:	3.5.22
Public or Private:	Public
Report Title:	Briefing on Dementia Hospital Charter for Wales 2022
Responsible Director:	Gill Harris
Report Author:	Prof Tracey Williamson, Consultant Nurse for Dementia
Prior Scrutiny:	None
Appendices:	Dementia Hospital Charter for Wales document in Welsh and English versions Appendices 1 – Welsh Version Appendicies 2 – English Version

Recommendation:
That the Charter is received and acknowledged by the Committee

Please tick as appropriate							
For Decision/ Approval		For Discussion		For Assurance		For Information	x
Y/N to indicate whether the Equality/SED duty is applicable						N	
N/A							

Sefyllfa / Situation:

This paper is intended to brief the Commitee as to the publication of a Dementia Hospital Charter for Wales on 6.4.22 which has implications for all hospitals in the Health Board.

Cefndir / Background:

The Charter is the latest in a set of publications aimed at driving up standards of dementia care across health and social care settings in Wales. The Charter comprises 105 principles that hospitals should follow if they are to be dementia friendly. Its development was faciliated by Improvement Cymru which has a dedicated team and programme of work to enhance dementia care nationally. The Charter is mainly intended to complement existing Dementia Standards for Wales but it is also relevant to the Wales Action Plan for Dementia, NICE Dementia guidance and many of BCUHB's own action plans/learning from complaints processes etc.

The Charter work is one of five dementia work streams required by Improvement Cymru. Other work streams are Engagement; Memory Assessment/Learning Disability/Mild Cognitive Impairment; Dementia Connectors; and Workforce Development/Measurement/Learning & Development.

The Charter is focused specifically on hospital care which makes it relevant to all discipines of staff who contribute to a dementia patient's journey and the experience that the patient and their family have when using our services. The hospital experience is affected by the wider context of what happens prior to hospital attendance/admission and during/after transition out of hospital. Therefore the Charter has implications for a range of partners and its implementation needs to be a collective and multi-agency approach.

Improvement Cymru have developed a 'padlet' online repository where resources from the Charter launch, the Charter documents and other respources are available. It includes a self-assessment tool for organisations to use to appraise their current position and a VIPS quality improvement platform for staff to use. VIPS stands for Values, Individual's needs, Perspectives. The padlet can be accessed here: https://padlet.com/ImprovementCymru/LansioSiarter_CharterLaunch

During the national Charter launch in early April 2022, Gill Harris took part in the Q&A panel and Sophia Keene (Quality & Practice Development Nurse in MHLD), showcased 'Walking with Purpose' dementia guidance work that she led.

Asesu a Dadansoddi / Assessment & Analysis

Strategy Implications

The Charter was developed with input from a range of BCUHB staff with dementia knowledge and expertise and is a useful tool. Whilst a large number of principles are included, these are very brief so careful interpretation will be needed to establish progress to-date, undertake gap analysis, and plan goals to be achieved which are in turn suitably resourced. Sustainability is key so the Charter does not become a tick list and this will require Board support and adequate investment alongside effective change management strategies. Weaknesses in the Charter (raised but not strongly evident in the final version) will be picked up by the Consultant Nurses for Dementia leading its implementation e.g family carer needs/experiences/engagement/communication and diversity in its widest sense.

The governance of dementia work in BCUHB is under review so that steps can be taken to embed dementia firmly in the new operating model. The Charter implementation will require new groups/mechanisms to be set up to develop the shared vision for hospital dementia care and to effect its delivery. Whilst Improvement Cymru suggest a meeting structure, one is needed that better fits the new operating model. As 2022 is regarded by Improvement Cymru as the 'preparation phase' for Charter implementation, there is time to get these foundations right.

The Committee should especially note four principles in the Governance section of the Charter:

1. The health board is signed up to the Dementia Friendly Hospital Charter for Wales and the Dementia Statements are used to inform approaches to care
2. There is a senior member of staff within each region who guides and monitors delivery of the regional dementia strategy
3. The health board has an Executive Board member designated with responsibility for dementia care
4. There is a communication strategy for the Dementia Friendly Hospital Charter.

Options considered

Once self-assessment and further ground work has been undertaken, it is expected that a Business Case for enhancing dementia care, including Charter delivery, will be developed for consideration later in the year. Meanwhile the Committee is requested to support adoption of the Charter.

Financial Implications

Yet to be determined (see above) however substantive and varied investment is anticipated if we are to fully adopt Charter principles and effect ambitious yet sustainable improvements, including Transformation support.

Risk Analysis

The main risk is missing out on a useful tool to help drive up dementia standards, if the Charter is not adopted.

Legal and Compliance

As above, reporting and monitoring arrangements are yet to be determined.

Impact Assessment

As above, yet to be determined but can be expected to be far reaching.

Siarter Ysbytai sy'n Deall Dementia yng Nghymru

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

GWELLIANT CYMRU | IMPROVEMENT CYMRU

Alzheimer's Society Cymru | Unedig Yn Erbyn Dementia United Against Dementia

"Pan fyddwch wedi cwrdd ag un person â dementia, byddwch wedi cwrdd ag un person â dementia"

Mae pawb yn wahanol.

Mae'r ddogfen hon yn esbonio cynnwys y Siarter Ysbytai sy'n Deall Dementia yng Nghymru. Bydd yn rhannu'r Siarter yn adrannau i'w gwneud yn haws rheoli deall Dementia a'i wneud yn haws ei ddeall.
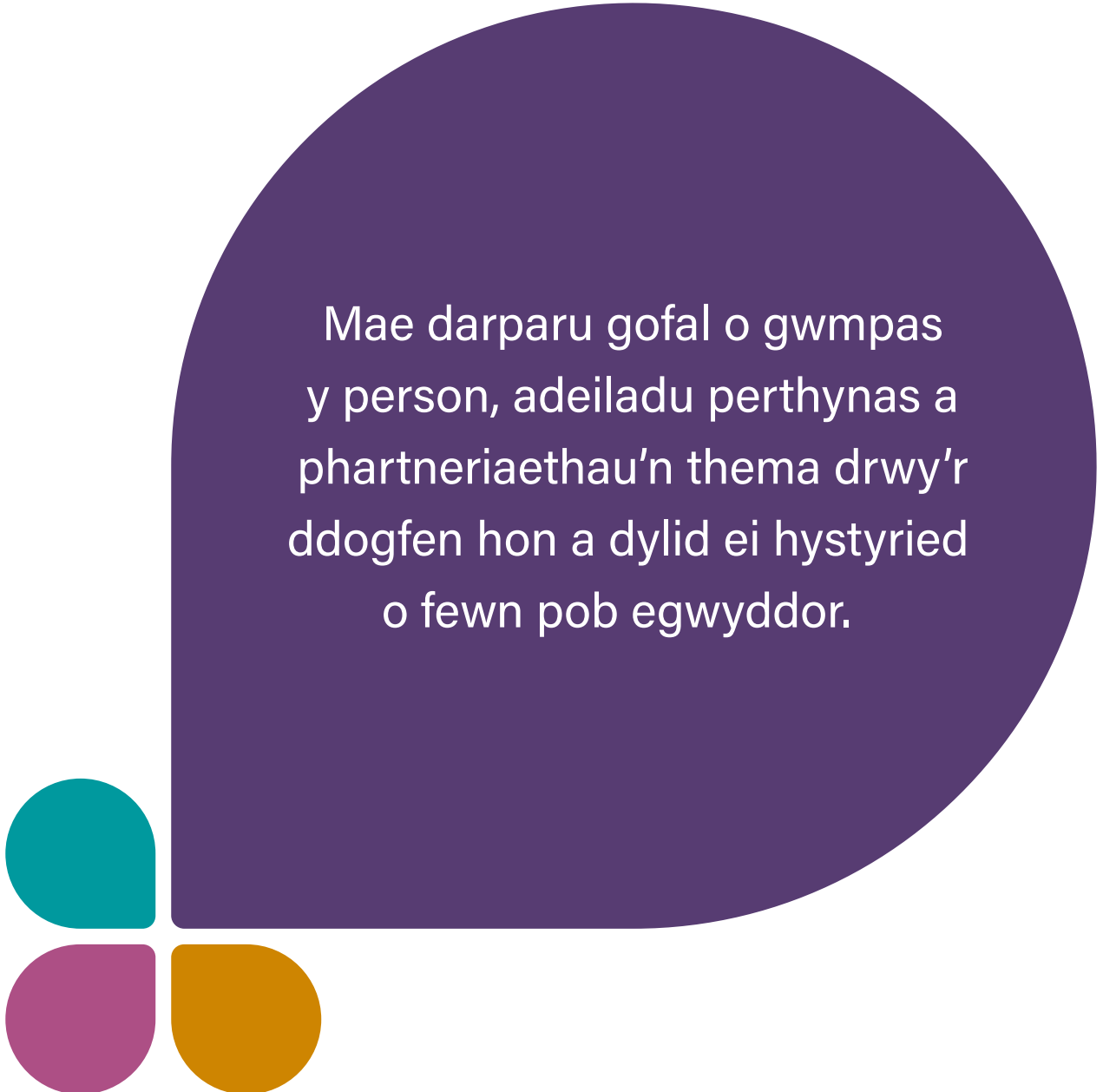
Mae'r ddogfen hon ar gyfer pawb sydd â diddordeb mewn darparu gofal dementia ac yn canolbwyntio ar y person, gan gynnwys y canlynol ond nid y rheiny'n unig:

- Gweithwyr proffesiynol gofal iechyd
- Pobl sydd â dementia
- Gofalwyr, aelodau'r teulu a chefnogwyr
- Rheolwyr ac arweinwyr
- Y cyhoedd

Fel y cyfryw, mae'r ddogfen wedi'i hadolygu i wneud y cynnwys mor hawdd i'w ddeall â phosibl.

Neges allweddol:

Bydd staff ysbytai'n siarad â'r sawl sydd â dementia, darparwyr gofal a theuluoedd am yr hyn y gallant ei ddisgwyl wrth gael gofal.

Mae darparu gofal o gwmpas y person, adeiladu perthynas a phartneriaethau'n thema drwy'r ddogfen hon a dylid ei hystyried o fewn pob egwyddor.

Rhagair

Gall mynd i'r ysbyty achosi dryswch, trallod a deliriwm weithiau i bobl sydd â dementia a'u gofalwyr a'u cynhalwyr.

Diben a chanlyniadau'r Siarter Ysbytai yw gwneud lle ar gyfer gwelliant ym mhrofiad pobl sy'n byw gyda dementia mewn gofal ysbyty.

Profiad sy'n cydnabod y personau, eu hamrywiaeth a'u dewisiadau sy'n cael eu llunio drwy gydnabod urddas, parch charedigrwydd.

Mae'r Siarter Ysbytai o'r cychwyn wedi dilyn pwyslais ar gyd-gynhyrchu. Mae darparu lleisiau cryf drwy'r Siarter gyda phwyslais ar ofal diogel yn canolbwyntio ar y person wedi'i seilio ar garedigrwydd ac urddas yn cael eu hystyried o fewn yr egwyddorion drwy gydol y Siarter.

Ar hyn o bryd nid oes gwella ar Dementia, ond gydag addasiadau gall newidiadau cadarnhaol gael eu gwneud i'r byd lle mae pobl â dementia yn byw.

Lleisiau dementia - Voices from Wales

Cyflwyniad

Mae Siarter Ysbytai sy'n Deall Dementia yng Nghymru (y Siarter) yn amlinellu'r egwyddorion y dylai ysbyty sy'n deall dementia eu darparu. Dylai hyn gefnogi'n llwyr Cynllun Gweithredu Cymru ar gyfer Dementia 2018- 2018-22, a'r weledigaeth yw:

'Creu cymdeithas heb stigma … Lle mae pobl sydd â dementia yn parhau i fynd o gwmpas eu bywyd ac yn cael eu deall gan y cyhoedd yn fwy cyffredinol sy'n gwybod sut i ddarparu cefnogaeth.'

Mae'r Siarter yn darparu ffocws i bobl sydd â dementia a'u gofalwyr tra byddant yn yr ysbyty. Mae'n amlinellu'r gofal, y driniaeth a'r ddealltwriaeth angenrheidiol i gyflawni gweledigaeth y Cynllun Gweithredu ar Dementia a Llwybr Safonau Cymru ar Dementia. Yn 2019 dechreuodd Gwelliant Cymru, gyda chefnogaeth Llywodraeth Cymru, y broses o ddatblygu Siarter Ysbytai sy'n Deall Dementia yng Nghymru.

Dechreuodd y cefndir i'r Siarter yn Lloegr yn 2012 pan lansiodd y Gynghrair Genedlaethol ar Dementia (NDAA) 'Right Care: a call-to-action' i greu ysbytai sy'n deall Dementia, a chyhoeddodd Siarter ar gyfer ysbytai Lloegr yn 2015.

Diben y Siarter Ysbytai sy'n Deall Dementia yng Nghymru

Diben y Siarter yw galluogi ysbytai i greu profiad ac amgylcheddau sy'n deall dementia ac sy'n bodloni anghenion pobl sydd â dementia, eu gofalwyr a'u cefnogwyr yng Nghymru.

Bydd y Siarter...

- Yn gweithredu fel datganiad byr a chlir o'r egwyddorion allweddol sy'n cyfrannu at ysbyty sy'n deall dementia.

- Yn darparu set o egwyddorion a dangosyddion a fydd yn canolbwyntio ar anghenion pobl sydd â dementia a'u teuluoedd, eu gofalwyr a'u cefnogwyr.

- Yn rhoi gwybod i bobl beth i'w ddisgwyl pan fyddant yn cael gofal ac yn ymweld ag ysbyty sy'n deall dementia.

- Yn adeiladu ar y sail a gynigir gan egwyddorion y Coleg Brenhinol Staff Nyrsio, Partneriaeth, Asesiad, Gofal ac Amgylchedd (SPACE). Mae hyn yn cynnwys y datblygiadau a'r adnoddau diweddaraf y gall ysbytai eu defnyddio i ddarparu gofal a chefnogaeth dementia.

- Yn cynnig canllaw gwelliant i helpu ysbytai gyda'u hunanasesiad yn erbyn yr egwyddorion deall dementia. Caiff y pwyntiau hyn eu trafod yn fanylach yn ddiweddarach yn y ddogfen hon.

Bydd yr agweddau hyn yn cael eu trafod yn ddiweddarach yn y ddogfen.

Y Datganiadau Dementia

Mae'r Datganiadau Dementia, a gyhoeddwyd yn 2017, yn adlewyrchu'r hyn mae pobl sydd â dementia a'u gofalwyr yn ei ddweud sy'n hanfodol i'w hansawdd bywyd. Cafodd y datganiadau hyn eu datblygu gan bobl sydd â dementia a'u gofalwyr, ac mae'r hawliau hyn wedi'u hymgorffori yn y Ddeddf Cydraddoldeb, deddfwriaeth Gallu Meddyliol, deddfwriaeth iechyd a gofal a chyfraith hawliau dynol rhyngwladol. Caiff y datganiadau eu cefnogi'n llwyr gan Gynllun Gweithredu ar Dementia Cymru 2018-22 ac maent yn cynnwys:

- Mae gennym yr hawl i gael ein hadnabod am yr hyn ydyn ni, yr hawl i wneud dewisiadau am ein bywyd gan gynnwys cymryd risg a chyfrannu i'r gymdeithas. Ni ddylai ein diagnosis ein diffinio ni, ac ni ddylem fod â chywilydd ohono ychwaith.

- Mae gennym yr hawl i barhau gyda bywyd bob dydd a bywyd teuluol heb wahaniaethu na chost annheg. Mae gennym hawl hefyd i gael ein derbyn a'n cynnwys yn ein cymuned a ddim yn byw ar wahân neu mewn unigrwydd.

- Mae gennym hawl i gael diagnosis yn gynnar ac yn gywir.

- Mae gennym hawl i gael triniaeth a gofal wedi'i gyllido'n iawn ar sail tystiolaeth, gyda chydymdeimlad, yn cael ei ddarparu gan bobl wedi'u hyfforddi sy'n ein deall ni a'r ffordd mae dementia'n effeithio arnom. Rhaid i hyn fodloni ein hanghenion ble bynnag rydym yn byw.

- Mae gennym hawl i gael ein parchu a'n cydnabod fel partneriaid mewn gofal, gan dderbyn cael addysg, cefnogaeth, gwasanaethau a hyfforddiant i'n galluogi i gynllunio a gwneud penderfyniadau am y dyfodol.

- Mae gennym hawl i wybod a phenderfynu a ydym am fod yn rhan o waith ymchwil sy'n edrych ar achos, gwella, gofal ar gyfer dementia a chael ein cefnogi i gymryd rhan.

- Mae gennym hawl i gael ein trin heb wahaniaethu a chael ein parchu a'n cydnabod fel unigolion a'n diwylliannau.

Ac yng Nghymru:

- Mae gennym yr hawl i gael asesiad, gofal a chefnogaeth yn y Gymraeg heb orfod gofyn am hynny (yn unol ag egwyddor y cynnig rhagweithiol) os dyna mai sydd orau gennym ac os dyna sydd arnom ei angen.

Mae'r Siarter yn cefnogi dogfennau a deddfwriaeth allweddol yng Nghymru:

Cynllun Gweithredu Cymru ar gyfer Dementia

Mae'r Cynllun Gweithredu'n gosod allan strategaeth glir er mwyn i Gymru fod yn genedl sy'n deall dementia ac sy'n rhoi gwerth ar hawliau pobl sydd â dementia i fyw mor annibynnol â phosibl yn eu cymunedau. Mae'n addo ystyried hawliau, dymuniadau a dewisiadau pobl sydd â dementia wrth weithredu'r cynllun.

Llwybr Safonau Dementia Cymru Gyfan

Datganiadau yw Llwybr Safonau Dementia Cymru Gyfan sy'n adlewyrchu'r hyn mae pobl yn credu fydd yn gwneud gwahaniaeth cadarnhaol i ofal dementia yng Nghymru. Cawsant eu datblygu dros ddwy flynedd gan gynnwys dros 8000 o bobl sydd â dementia, i sefydliadau gwirfoddol i ymarferwyr ledled Cymru a'r Deyrnas Gyfunol. Ar ôl nodi rhestr o fwy na chant o safonau posibl, maent wedi'u cwtogi i 20 sy'n cael eu gweld fel elfennau allweddol i hyrwyddo gofal sy'n deall dementia ar draws Cymru.

Fframwaith Safonau Iechyd a Gofal

Mae'r Fframwaith Safonau Iechyd a Gofal yn cefnogi'r GIG a chyrff sy'n bartneriaid wrth ddarparu gwasanaethau effeithiol, amserol, hwylus o safon ym mhob sefyllfa iechyd. Cafodd saith thema eu datblygu drwy ymwneud â chleifion, clinigwyr a rhan-ddeiliaid, a'u nodi fel meysydd blaenoriaeth i'r GIG gael ei fesur yn eu herbyn. Mae'r fframwaith safonau'n tanlinellu pwysigrwydd darparu gwasanaethau yn Gymraeg.

Mae'r Siarter yn alinio â dogfennau allweddol eraill:

- Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015

- Blaenoriaethau trosfwaol Comisiynydd Pobl Hŷn Cymru

- Effaith y pandemig COVID-19 ar ofal ysbyty i bobl â dementia. Coleg Brenhinol Seiciatreg 2020

- Y Fframwaith Dysgu a Datblygu Gwaith Da 2016

- Model Gartref yn Gyntaf: Rhyddhau i Adfer yna Asesu (Cymru) 2021
- Creu lleoedd a mannau iachach i'n cenedlaethau presennol a'r dyfodol
- Cymru Iachach: ein cynllun ar gyfer Iechyd a Gofal Cymdeithsol 2018
- Deddf Gwasanaethau Cymdeithasol a Llesiant (Cymru) 2014
- Mesur Iechyd Meddwl (Cymru) 2010
- Mwy na geiriau/More than just words 2016
- Cynllun Gweithredu ar Dementia. Cryfhau darpariaeth i ymateb i COVID-19 2021

Egwyddorion SPACE

Set o bum egwyddor yw SPACE sy'n llunio ymrwymiad ar y cyd i wella gofal i bobl â dementia a'u teuluoedd. Ar sail tystiolaeth gan bobl sy'n byw gyda dementia, gofalwyr ac ymarferwyr, mae pob egwyddor yn cael ei hystyried yn hanfodol i ddarparu gofal. Cafodd yr egwyddorion eu datblygu gan y Coleg Nyrsio Brenhinol a'u diweddaru yn 2019, ac maent wedi eu creu i'w defnyddio mewn amrywiaeth eang o sefyllfaoedd iechyd a gofal cymdeithasol ac i wella'r Siarter. Yn ystod yr ymgynghori ar Siarter Cymru teimlai rhan-ddeiliaid bod angen dwy egwyddor ychwanegol, felly mae Gwirfoddoli a Llywodraethiant wedi'u cynnwys (SPACE-VG).

Mae egwyddorion SPACE-VG yn cynnwys:

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Pam mae Gwelliant Cymru, NDAA a'i bartneriaid yn arwain y gwaith hwn?

Oherwydd ei rôl greiddiol a'i safle strategol, gall Gwelliant Cymru:

- Hwyluso a chefnogi parodrwydd a gweithrediad yr egwyddorion deall dementia mewn ysbytai (gyda chefnogaeth Llywodraeth Cymru).

- Meithrin perthnasoedd a phartneriaethau, gan gysylltu â phobl ac asiantaethau perthnasol gan gynnwys y rhai sy'n cynllunio, darparu a gofalu mewn ysbytai.

- Rhannu arfer da ar draws lleoliadau, sefydliadau a rhanbarthau gan hyrwyddo gwelliant.

Datganiad o Weledigaeth

'Mae dementia yn flaenoriaeth ym mhob un o'n hysbytai yng Nghymru ac mae'r Siarter yn amlinellu ein gwerthoedd a'n hegwyddorion yn genedlaethol a rhanbarthol ar sut i gyflawni hynny. Mae'r gwerthoedd a'r egwyddorion hyn ar gyfer pawb o'r staff yn yr ysbytai, y gymuned a lleoliadau gofal eraill. Mae'n dangos beth y gall pobl sydd â dementia a'u gofalwyr ei ddisgwyl wrth fynd i'r ysbyty o'u cartrefi eu hunain.'

Gwerthoedd a Rennir dros Gymru Gyfan

- Mae sefydliadau a staff ysbytai wedi ymrwymo i wrando, dysgu, galluogi, bod yn garedig a gofalgar. Gall staff ar bob lefel ochr yn ochr â phobl sy'n byw gyda dementia a gofalwyr wneud gwahaniaeth cadarnhaol gyda'i gilydd wrth sicrhau gofal da.

- Mae gwaith partneriaeth cryf rhwng y person, staff ysbytai, gofalwyr y person, teulu a chefnogwyr. Dylai hyn hefyd gynnwys sefyllfaoedd cymunedol megis cartrefi gofal a chyrff eraill sy'n ymweud â gofal y person.

- Caiff pobl sydd â dementia, eu gofalwyr, teulu a'u cefnogwyr gyfle a gwybodaeth briodol ac amserol iddynt allu gwneud dewisiadau am ofal, i wella eto eu hannibyniaeth a'u cyfle i wneud penderfyniadau.

- Mae ysbytai a lleoliadau gofal iechyd yn cymryd camau gweithredol i ddarparu'r hyn sydd i bob person sydd â dementia ei angen yn ystod ei gyfnod yn yr ysbyty. Bydd pobl yn teimlo'u bod yn cael croeso a'u clywed, gydag amrywiaeth o ddiwylliannau, profiadau ac anghenion gan grwpiau megis BAME, LGBTQIA+, siaradwyr Cymraeg a phobl ag anableddau dysgu'n cael eu cydnabod a'u gwerthfawrogi.

Byddwn...

- Yn deall efallai y bydd yn well gennych siarad â ni a chael eich gofal yn Gymraeg. Byddwn yn sicrhau y gallwch wneud hynny.

- Yn sicrhau bod pobl sydd ag anghenion cyfathrebu ac iaith yn gallu cael gwasanaeth priodol, gan gynnwys gwasanaethau cyfieithu i gefnogi eu hanghenion gofal.

- Yn sicrhau bod pobl sydd â nam ar y synhwyrau, megis golwg neu glyw gwael, yn gallu cael eu sbectol a'u cymorth clyw. Pan fyddant mewn cyflwr gwael, dylid cymryd camau i'w trwsio mor fuan â phosibl. Pan fydd diffyg llwyr ar y synhwyrau, megis dallineb neu fyddardod, dylid darparu'r wybodaeth mewn ffordd y gall y person ei deall. Gall hyn olygu cyfieithu adnoddau ysgrifenedig i'r braille neu ddefnyddio dehonglydd ar gyfer iaith arwyddion.

- Yn cynnig i bobl o wahanol gymunedau ethnig wybodaeth am dementia sy'n briodol i'w diwylliant ac yn ddealladwy. Dylai hyn gynnwys gwybodaeth am y gwasanaethau presennol a sicrhau bod pobl yn deall mai cyflwr meddygol yw dementia.

- Ni fyddwn yn beirniadu pobl o wahanol gymunedau am gael dealltwriaeth o ddementia sy'n wahanol i'n dealltwriaeth ni. Rhaid inni sicrhau na fydd cael barn neu gred wahanol yn golygu nad yw pobl sydd â dementia yn cael y gofal a'r gefnogaeth angenrheidiol neu a fyddai'n llesol iddynt.

- Yn sicrhau urddas pobl bob amser. Yn helpu pobl gyda glanweithdra a gofal personol yn ôl eu hangen i sicrhau cymaint o annibyniaeth ag sy'n bosibl.

- Yn peidio byth â siarad am rywun o'u blaen heb iddynt fod yn rhan o'r sgwrs. Mae'n bwysig inni weld y person, nid y dementia. Gwnewch yn siwr wrth siarad am y person fod yr iaith yn barchus, yn osgoi labeli a sylwadau negyddol.

- Yn bod yn ofalus pryd a ble y byddwn yn siarad am wybodaeth breifat pobl.

- Yn cyfathrebu â phobl fel y dymunant heb ddefnyddio iaith sy'n trin y person fel plentyn.

- Yn peidio â dechrau dadl gyda phobl sy'n byw gyda dementia. Os na bydd anghydweld neu anhawsterau, yn delio â nhw mewn ffordd garedig, broffesiynol ac allan o glyw pobl eraill.

- Yn peidio byth ag anwybyddu pobl a bod eu hofnau a'u pryderon bob amser yn cael eu cymryd o ddifrif. Dylem gymryd amser i ddeall anghenion pobl a delio â nhw.

- Yn cefnogi pobl pan fyddant yn bryderus, yn ceisio deall pam maen nhw'n teimlo fel hynny ac ymateb i'w hanghenion gan eu cefnogi mewn ffordd ddiogel.

- Yn hyrwyddo ac yn cefnogi gofal emosiynol pobl. Mae hyn yr un mor bwysig â chyflawni tasgau ymarferol.

- Yn gweithio ar y cyd â'r rhai sy'n adnabod y person orau.

- Yn deall, pan fydd pobl yn bryderus, eu bod yn gallu ymddwyn yn wahanol. Gall hyn darfu ar y person, ei ofalwr, ei gefnogwyr, teulu a staff. Dylem sicrhau pawb ein bod yn ymwybodol o hyn ac yn siarad amdano gyda'n gilydd.
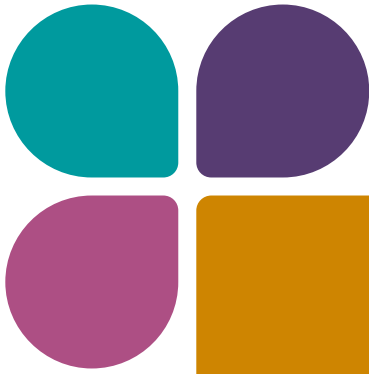
Mae ysbytai Cymru wedi ymrwymo i ennill y Siarter Ysbytai sy'n Deall Dementia yng Nghymru. Mae egwyddorion SPACE-VG sy'n dilyn yn amlinellu ymrwymiad ysbytai Cymru i ofalu am y rhai sydd â dementia.

S – STAFFIO

Ei weld, ei ddatrys!

Caiff staff ar bob lefel ganiatâd ac anogaeth i wneud gwahaniaeth wrth lunio gofal da. Mae dysgu a datblygu staff mewn gofal dementia yn bwysig a chaiff cyfleoedd i gael hyfforddiant eu gwerthfawrogi, eu cefnogi gyda buddsoddiad ynddynt. Caiff staff eu recriwtio sy'n cytuno â gwerthoedd a daliadau'r Siarter

Egwyddorion y Siarter:

- Caiff staff eu gwerthfawrogi, mae nhw'n gyfarwydd â rhannu arfer da, a chaiff y gwaith da wnânt ei ddathlu.

- Ar bob lefel mae rol arweinyddiaeth penodi ô wedi eu nodi sy'n gyfrifol am weithredu'r Siarter ac am ddarparu gofal dementia yn ddiogel. Mae'r rolau hyn yn weladwy, maent yn hawdd eu cyrchu, ac mae staff yn deall strwythur y sefydliad a phwy sy'n gyfrifol.

- Mae staff gofal dementia arbenigol ar gael, ac yn rheolaidd yn cynnig cefnogaeth a chyngor lle mae angen o fewn gosodiadau cleifion mewnol a lleoliadau cymunedol.

- Bydd pob agwedd ar ofal a chynllunio gofal yn cwmpasu'r person, aelodau'r teulu, cefnogwyr a staff cartref gofal lle mae'n briodol.

- Mae'r staff i gyd yn ymateb i anghenion y person gydag agwedd o ddiddordeb a chynorthwyol, gan gydnabod ac ymateb i anghenion pobl.

- Mae staff yn darparu gofal personol mewn ffordd amserol a gwneir addasiadau i alluogi a chefnogi'r unigolyn.

- Mae addysg a datblygiad dementia yn orfodol i'r staff i gyd a'r gwirfoddolwyr sy'n gweithio mewn adrannau clinigol gyda phobl sy'n byw gyda dementia. Dylai'r hyfforddiant fod ar lefel briodol sy'n cael ei disgrifio yn y Fframwaith Gwaith Da. Dylai hyn gynnwys sut i asesu anghenion a chynllunio gofal. Pan fydd y gofal wedi digwydd, dylem weld a yw hyn wedi gwneud gwahaniaeth i'r person.

- Caiff sylwadau o brofiad y person eu harchwilio gan ddefnyddio cyfarpar megis Mapio Gofal Dementia. Defnyddir y wybodaeth hon wedyn i ddatblygu ffyrdd i symud ymlaen a chefnogi dysgu.

- Bydd staff yn galluogi pobl i gymryd rhan mewn gweithgareddau yn ogystal â gofal. Gall hyn fod mor syml â sgwrs neu ddarparu ysgogiad ar ffurf pethau maen nhw'n eu mwynhau fel gweithgareddau hamdden.

- Mae staff yn ymwybodol bod ymddygiad pobl yn fath o gyfathrebu, felly gall fod angen help arnynt i addasu er mwyn bodloni anghenion yr unigolyn hwnnw ar y funud honno.

- Bydd staff bob amser yn eu cyflwyno'u hunain yn briodol i gleifion, gofalwyr a theuluoedd. Mae'r ymgyrch 'Helo, fy enw i yw' yn un ffordd o wneud hyn.

- Mae staff yn ymwybodol o bwysigrwydd sicrhau bod siaradwyr Cymraeg yn cael cynnig gwasanaethau yn y Gymraeg ac ieithoedd eraill. Bydd recriwtio a hyfforddi staff yn cefnogi hyn.

- Mae gan staff wybodaeth ymarferol o egwyddorion yr holl gyfreithiau sy'n ymwneud â damentia, er enghraifft, y Ddeddf Gallu Meddyliol (2005) a'r Mesur Iechyd Meddwl (2009).

- Caiff staff eu hannog a'u cynorthwyo i ofalu am eu hiechyd eu hunain. Mae gweithlu iach yn gysylltiedig â chael gwell canlyniadau i bobl sydd â dementia.

P – PARTNERIAETH

Gweithio gyda'n Gilydd

Mae'n bwysig i bobl sydd â dementia, teuloedd, asiantaethau gofal, cyfleusterau gofal cartref a gweithwyr proffesiynol weithio gyda'i gilydd i gael y canlyniadau gorau. Dylai pawb gael eu cydnabod yr un fath wrth ddarparu gofal a chefnogi'r symud rhwng gosodiadau gofal a'r cartref. Mae partneriaethau'n cynnwys dewis a rheolaeth mewn penderfyniadau sy'n adlewyrchu anghenion a barn pawb am y cymorth angenrheidiol.

Egwyddorion y Siarter:

- Mae'r sefydliad yn defnyddio egwyddorion 'Triongl Gofal' rhwng y sawl sydd â dementia, gweithwyr iechyd proffesiynol a'u teulu/gofalwyr. Mae angen ystyried John's Campaign neu brosiectau eraill sy'n canolbwyntio ar y teulu, gofalwyr a chefnogwyr.

- Ystyrir bod newid di-dor rhwng gosodiadau gofal a'r cartref yn hanfodol. Bydd rhyddhau yn dechrau ar y dyddiad yr eir i'r ysbyty. Dylai naill ai'r sawl sydd â dementia neu rywun a all gynrychioli ei anghenion gymryd rhan wrth gydlynu ei ofal.

- Dylai dewis iaith ac anghenion diwylliannol gael eu cofnodi a'u gweithredu i fod yn rhan o'r gofal. Dylai hyn bob amser gael ei gyfleu rhwng y staff dan sylw.

- Pan fydd pobl sydd â dementia sy'n byw ar eu pen eu hunain yn cael eu rhyddhau o'r ysbyty, byddant yn cael archwiliad llesiant cyn pen 24 awr. Gall hyn gael ei ddarparu gan aelod o staff y gwasanaethau iechyd, gofal cymdeithasol neu gorff elusennol.

- Bydd gan y person ddogfen sy'n rhoi gwybodaeth ddefnyddiol i chi amdanyn nhw a'u bywyd megis dogfen 'Dyma Fi'. Bydd y ddogfen hon yn cael ei chadw gyda nhw bob amser a'i diweddaru gan bartneriaid gofal a gweithwyr iechyd proffesiynol. Mae hyn yn sicrhau y gall pawb fod yn rhan ar lefel bersonol a bod yn ymwybodol o anghenion a dewisiadau'r person.

- Caiff pobl sydd â dementia a'u gofalwyr a'u teuluoedd gyfleoedd i ddweud sut y maent wedi cael gofal a pha fath o brofiad oedd hynny.

- Mae cyfathrebu da a gallu cael gwybodaeth glir hanfodol wrth gynllunio rhyddhau. Bydd hyn yn helpu deall y rhyddhau gan y bobl dan sylw, yn gyfle i godi cwestiynau neu bryderon ac yn arwain at ryddhau i'r cartref neu osodiadau gofal eraill yn ddiogel.

- Dylai pobl sydd â dementia a'u teuluoedd, gofalwyr a chefnogwyr i ddatblygu cynlluniau i'w cynnal gartref ar ôl eu rhyddhau. Gall hyn olygu dod o hyd i wasanaethau a gweithgareddau yn yr ardal leol a chysylltu â nhw.

- Dylid archwilio materion fel PŵerTwrnai Parhaus, Cynllunio Gofal Ymlaen Llaw (gwneud penderfyniadau am driniaeth cyn bod yn sâl) a thrafodaethau am ddiwedd oes ac edrych arnynt eto. Dylid gwneud hyn gyda sensitifrwydd ac ystyried anghenion a sefyllfa pobl dan sylw.

- Gall cymorth profedigaeth fod yn ddefnyddiol i deuluoedd a gofalwyr, a chynigir y cymorth hwn cyn i berson farw.

A - ASESIAD

Adnabod y person

Mae asesiadau bob amser yn canolbwyntio ar y person ac yn ceisio nodi cryfderau er mwyn galluogi paratoi cymorth ar sail eu hanghenion. Mae asesiad yn cynnwys nodi a thrin amrywiaeth o gyflyrau a symptomau, fel deliriwm, iselder, gofal ymataliaeth a phoen. Defnyddir 'Dyma Fi' neu ddogfen gyfatebol i ddod i adnabod y person ac mae gwybodaeth ar ar gael i bob aelod o'r staff.

Egwyddorion y Siarter:

- Dylai asesiadau gynnwys:
    - » y person sy'n byw gyda dementia
    - » y gofalwr / y teulu
    - » staff cartrefi gofal
    - » cynrychiolydd neu eiriolwr ar ran y person
    - » asiantaethau gofal eraill os yn briodol

- Mae asesu'n cwmpasu anghenion cymdeithasol, emosiynol ac ysbrydol pobl, gan gynnwys eu huchelgais a'u nodau unigol, yn ogystal â'u hanghenion iechyd corfforol a meddyliol.

- Mae asesu'n cynnwys pa iaith a dull cyfathrebu mae pobl â dementia yn ei ddweud sydd orau ganddyn nhw a beth sydd ei angen arnyn nhw. Caiff hyn ei adolygu'n gyson wrth i amgylchiadau'r person newid. Bydd hyn yn cynnwys defnyddio'r Gymraeg a/neu ieithoedd eraill.

- Asesiad o gredoau ysbrydol neu grefyddol. Dylai hyn gynnwys beth y maen nhw'n dymuno ei weld i barhau i addoli neu fod yn rhan o gymuned ysbrydol neu grefyddol tra yn yr ysbyty.

- Mae ysbytai'n gweithio ar y cyd â sefydliadau fel Diverse Cymru er mwyn sicrhau bod addasiadau rhesymol yn cael eu gwneud i gefnogi amrywiaeth ddiwylliannol ac ethnig.

- Caiff poen ei asesu'n rheolaidd tra yn yr ysbyty. Pan ragnodir meddyginiaeth, dylai staff asesu a yw'r cyffuriau lladd poen yn cael unrhyw effaith er mwyn gallu gwneud addasiadau. Dylid cynnal asesiadau eraill wrth ystyried dulliau eraill o leihau poen.

- Ni chaiff pobl eu 'labelu', ac mae staff yn deall ac yn ystyried arferion, dymuniadau ac ymatebion rheolaidd yr unigolyn. Ni ddylid anwybyddu newidiadau mewn ymddygiad person.

- Cynhelir asesiad o fywyd beunyddiol person yn ei gartref/chartref ei hun (lle bo modd) gan fod yr amgylchedd hwnnw yn un cyfarwydd. Bydd hyn yn sicrhau gwell dealltwriaeth o allu ac arferion y person.

- Bydd trafodaeth yn ymwneud ag unigrwydd tra yn yr ysbyty. Lle bo angen, cytunir ar gynllun cymorth gyda'r person er mwyn lleihau unigrwydd o ryddhau'r unigolyn o'r ysbyty.

- Ceir cynlluniau rhyddhau clir yn ymwneud â meddyginiaethau, er mwyn sicrhau diogelwch. Dylai hyn gynnwys asesiadau o'r person cyn ei ryddhau o'r ysbyty (lle bo modd) a gall gynnwys monitro pellach yn y gymuned.

- Er bod diagnosis o ddementia yn cael ei wneud y tu allan i'r ysbyty fel arfer, fodd bynnag, pan gaiff ei wneud yn yr ysbyty, fe ddilynir cyfarwyddiadau cylchlythyr a chanllawiau côd READ Llywodraeth Cymru. Bydd hyn yn galluogi'r person i gael ei atgyfeirio a'i roi mewn cyswllt â'r gwasanaeth asesu cof yn lleol ynghyd â'r Meddyg Teulu. Bydd hyn yn sicrhau mynediad i driniaeth, gwybodaeth a chymorth ôl-ddiagnostig.

- Caiff person â dementia ei gefnogi i wneud penderfyniadau'n ymwneud â'u gofal cyhyd â phosib. Os nad yw'r gallu gan y person i wneud penderfyniad penodol, dylid defnyddio unrhyw Atwrneiaeth Arhosol priodol. Os nad oes Atwrneiaeth Arhosol yn ei le, gall aelod o'r teulu neu ofalwr gyfleu barn y person, neu bydd Eiriolwr Gallu Meddyliol Annibynnol yn helpu i wneud penderfyniadau ar ei ran/rhan. Dylid helpu'r person â dementia i fod yn rhan o'r penderfyniadau yma drwy gydol y broses.

- Dylid annog trafodaethau'n ymwneud â gofal i'r dyfodol a defnyddio 'Cynllun Gofal Ymlaen Llaw' cyn gynted â phosib er mwyn sefydlu dymuniadau diwedd oes a'r dymuniadau gofal.

- Pan fydd person yn nesáu at ddiwedd ei oes, mae cyfathrebu amserol yn digwydd gyda'r person, ei ofalwr a'r teulu neu'r eiriolwr.

- Yn achos pobl sy'n siarad Cymraeg, darperir gofal gan ymarferwyr sy'n siarad Cymraeg gan osgoi'r defnydd o wasanaethau cyfieithu a lle mae iaith yn rhwystr, defnyddir cyfieithwyr ar y pryd.

- Er mwyn adnabod dirywiad corfforol yn gynnar, dylai staff wneud bob ymdrech i ddeall sut mae'r person yn ymddwyn fel arfer (pan yn iach) gan dalu sylw arbennig i ddryswch newydd neu ddirywiad. Os nad yw'r hyn y mae'r person yn ei wneud yn rhan o'u hymddygiad arferol, yna dylid trin y dryswch fel un newydd.

Gyda'r person ac o'i gwmpas

Mae gofal yn garedig, yn galluogi, yn ymateb, a lle bo modd, yn hybu hunanofal a chryfderau, sgiliau a galluoedd unigol. Mae gofal yn cefnogi ac yn galluogi'r person i gynnal synnwyr o'i hunan a'i berthynas ag anwyliaid.

Egwyddorion y Siarter:

- Mae deddfwriaeth hawliau dynol a chydraddoldeb yn hanfodol wrth ddatblygu gofal i bobl â dementia mewn ysbytai.

- Gwneir pob ymdrech ymarferol i geisio canfod safbwynt, barn a dymuniadau'r person sydd â dementia, ei ofalwr, ei deulu neu'i eiriolwr. Dylai'r safbwyntiau hyn helpu i lunio'u cynllun a'r modd y darperir gofal.

- Defnyddir dogfennau fel 'Dyma Fi' i wneud cysylltiadau â phobl sy'n byw gyda dementia. Dylid eu darllen, eu hadolygu a'u diweddaru'n rheolaidd.

- Darperir gwybodaeth mewn ffordd sy'n hygyrch ac yn addas i'r person. Gall hyn gynnwys addasiadau ar gyfer colli clyw a golwg a newidiadau mewn sgiliau iaith.

- Darperir gofal, gwybodaeth a chymorth i'r person i ddewis yr iaith y mae'r person yn dymuno ei defnyddio yn ôl yr angen neu'r gofyn.

- Mae staff yn sicrhau y gall pobl â dementia gadw cysylltiad corfforol a pherthynas â'u hanwyliaid a phobl arwyddocaol yn eu bywydau.

- Darperir gofal gan dîm o staff sy'n darparu cyngor ac ymyrraeth i fynd i'r afael ag anghenion.

- Lle bo modd, gwneir addasiadau er mwyn gwneud yn siŵr bod y gofal yn sensitif i'w anghenion diwylliannol. Os nad oes modd sicrhau hynny bob amser, yna dylid cynnal trafodaeth rhwng yr unigolyn, y teulu a'r gofalwyr neu eiriolwr er mwyn gweld a oes ffyrdd eraill o ddarparu gofal.

- Mae gofal yn galluogi pobl i fod yn gorfforol ac yn wybyddol fywiog. Gall hyn gynnwys cymryd rhan mewn gweithgareddau sy'n bwysig iddyn nhw neu gynnal sgiliau cyfredol fel gofal personol er enghraifft, ymolchi a gwisgo, brwsio'u gwallt ac annog annibyniaeth.

- Mae gofal yn cynnwys cynnal sgwrs a gwybodaeth i gefnogi iechyd corfforol a meddyliol. Mae hefyd yn cynnwys dewisiadau'n ymwneud â byw'n iach ar gyfer pobl pan fyddan nhw'n dychwelyd adref. Mae hon yn neges bwysig i helpu pobl i aros yn iachach am gyfnod hirach.

- Mae gan bobl â dementia'r hawl i fynediad cyfartal i ofal lliniarol wrth nesáu at ddiwedd eu hoes. Dylai hyn gynnwys meddyginiaeth ar gyfer rheoli symptomau poen a chynlluniau i'w cadw'n gyfforddus.

- Mae staff yn ymwybodol o ddewis yr unigolyn o'u dymuniadau ar gyfer derbyn gofal diwedd oes, sy'n cynnwys mynd adref neu fynd i hosbis. Dylai staff wybod sut i gael gafael ar y wybodaeth hon ar gyfer yr unigolyn a'u teuluoedd.

- Mae dillad ac offer sydd eu hangen ar gyfer gweithgareddau therapiwtig ar gael i bawb yn rhad ac am ddim.

- Gall gofal gynnwys technoleg. Dylai fod mynediad i Wi-Fi rhad ac am ddim yn ogystal â dyfeisiadau technolegol.

- Cefnogir pobl â dementia i gymryd risgiau cadarnhaol fel modd o barhau i hybu eu hannibyniaeth a'u hapusrwydd, fel cymryd rhan mewn gweithgareddau hamdden os yw'n ddiogel i wneud hynny.

- Bydd eiriolwr annibynnol ar gael i bobl yn ôl yr angen.

- Gall y person neu'r teulu a gofalwyr ddewis derbyn neu wrthod cynlluniau gofal dementia mewn ysbyty.

A – AMGYLCHEDD

Galluogi'r unigolyn

Mae'r amgylchedd yn gyffyrddus, yn grymuso ac yn hyrwyddo annibyniaeth. Mae'r amgylchedd yn annog symudedd, gweithgaredd a rhyngweithio cymdeithasol. Mae cynllunio a chynnal a chadw ysbytai yn cynnwys creu ardaloedd sy'n deall ac yn ymateb i ofynion dementia. Mae cefnogaeth gan bob adran o safbwynt eu cynllunio, cyflawni'r gwaith a'u cynnal.

Egwyddorion y Siarter:

- Mae pobl sy'n byw gyda dementia a staff yn gweithio gyda'i gilydd i sicrhau bod yr amgylchedd yn addas, gyda chymorth asesiad The King's Fund Dementia Environmental Assessment. Ymysg y meysydd o ddiddordeb mae wardiau, clinigau cleifion allanol, llefydd parcio cyfeillgar, cyfleusterau toiled, yn cynnwys rhai ar gyfer gofalwyr, aelodau o'r teulu a chefnogwyr o fewn wardiau ac ardaloedd triniaeth ac adrannau damweiniau ac achosion brys (adrannau brys) a mân anafiadau.

- Cefnogi arwyddion, symbolau a marcwyr llwybrau drwy adeiladau a'u bod nhw'n gyson ar draws ysbytai'r rhanbarth.

- Darparu addasiadau i hyrwyddo symudiad yr unigolyn i symud o gwmpas yr amgylchedd yn ddiogel yn hytrach na chyfyngu ar ei symudiad.

- Paratoi 'pecyn croeso' a bod hwnnw'n cael ei gyfieithu i ddewis iaith yr unigolyn. Bydd y pecyn hwn yn egluro pa adnoddau, offer a chyfleusterau sydd ar gael yn yr ysbyty. Dylai'r pecyn gynnwys gwybodaeth am ystafell y gofalwyr a'r teulu, gwybodaeth bwysig sy'n nodi sut y gall gofalwyr a theulu helpu gyda gofal yr unigolyn (os ydyn nhw'n dymuno gwneud hynny) tra yn yr ysbyty.

- Cyfle i bobl i gyfarwyddo â chynllun y ward fel rhan o'r broses dderbyn. Dylai staff dreulio amser yn dangos i bobl ble mae popeth a chynnig help os ydyn nhw'n ymddangos yn ansicr. Gallai hyn gynnwys defnyddio celfi ac offer a allai fod yn wahanol i'r hyn a geir adref fel tapiau a handlenni.

- Lle bo hynny'n bosibl, sefydlu mannau sy'n gyfeillgar i'r rhai sydd â dementia ynghyd â chefnogaeth y tu allan y gall pobl â dementia, gofalwyr a theuluoedd fynd allan i'w mwynhau.

- Bydd mannau tawel wedi'u cynllunio ar gyfer pobl er mwyn sicrhau cyfyngu ar sŵn a phrysurdeb.

- Mae'r amgylchedd yn helpu pobl i weld, clywed a chyfathrebu'n well yn ogystal â hybu annibyniaeth.

- Trafodir y defnydd o dechnoleg, er enghraifft, clychau a radio sydd ar gael o fewn yr amgylchedd ynghyd â'r defnydd o osodiadau a'r defnydd priodol o ddodrefn ac offer.

- Mae'r staff yn wyliadwrus ynghylch newidiadau mewn tymheredd a goleuni, a chaiff y rhain eu rheoli er cysur i'r unigolyn.

- Ceisir osgoi symud a newid gwelyau yn yr ysbyty lle bo modd. Weithiau, mae'n amhosibl osgoi symud i leoliad arall felly rhaid gwneud pob ymdrech i gefnogi'r unigolyn a hysbysu'r gofalwr a'r teulu. Mae hyn yn cynnwys i ble mae'r person wedi symud iddo, y rhesymau am y symud a'r camau a gymerwyd i'w cefnogi ac addasu i'r amgylchedd newydd.

- Mae pobl yn derbyn pob cymorth a gofal i farw gydag urddas. Ystyrir materion fel mynediad i ystafell sengl neu addasiadau i'r amgylchedd ar gyfer y person sy'n marw a'i deulu a'i ofalwyr er mwyn cefnogi preifatrwydd.

- Bydd gan yr unigolyn le hygyrch i gadw'i eiddo personol a chysurlon. Bydd staff wrth law i helpu'r unigolyn i'w defnyddio a'u mwynhau.

- Mae gan bobl fynediad at eitemau sylfaenol fel dannedd gosod, sbectol, cymhorthion clyw a chymhorthion ac addasiadau eraill sy'n sicrhau eu bod yn dawel eu meddwl ac yn teimlo'n ddiogel. Mae'r staff yn gofalu bod y rhain yn lân ac yn gweithio'n iawn.

G - GWIRFODDOLI

Cyfleoedd

Caiff gwirfoddolwyr gyfleoedd i ddysgu a datblygu er mwyn cefnogi pobl â dementia a'u teuluoedd. Dylai hynny gynnwys darparu cymorth sy'n canolbwyntio ar yr unigolyn ar gyfer gweithgareddau ystyrlon a gofal bugeiliol mewn modd diogel ac urddasol. Mae gwirfoddolwyr yn cefnogi staff cyflogedig ond dydyn nhw ddim yn cymryd eu lle.

Egwyddorion Siarter Gwirfoddolwyr:

- Cynnal sesiwn ymwybyddiaeth Ffrindiau Dementia Alzheimer's Society Cymru.

- Bod yn ymwybodol o anghenion ieithyddol pobl â dementia, eu gofalwyr, cefnogwyr a'u teulu. Lle bo gofynion iaith, dylai cymorth fod ar gael yn y Gymraeg neu mewn ieithoedd eraill, gan gynnwys iaith arwyddo.

- Caiff gwirfoddolwyr eu goruchwylio a'u cefnogi'n rheolaidd yn eu rôl. Fe fyddan nhw'n cael eu hannog i gymryd rhan mewn cyfleoedd dysgu a datblygu a ddarperir gan fyrddau iechyd Cymru.

- Sicrhau bod y person yn gyffyrddus ac yn barod i gymryd rhan mewn gweithgareddau. Dylid defnyddio eitemau cyfathrebu hanfodol fel dannedd gosod, sbectol a chymhorthion clyw. Mewn achosion o ddiffygion synhwyraidd, dylid cefnogi'r gwirfoddolwyr i ehangu eu gwybodaeth a'u sgiliau.

- Caiff rôl gwirfoddolwyr eu diffinio'n glir ym mholisïau'r bwrdd iechyd. Mae hyn yn cael ei gyfleu a'i ddeall gan y gwirfoddolwyr ac aelodau o staff sy'n gweithio gyda nhw.

- Ceir amrywiaeth o brofiadau gwirfoddoli ledled yr ysbyty. Mae'r rhain yn cynnwys gwaith sy'n pontio'r cenedlaethau, gan fod pobl sy'n delio â dementia yn arbenigwyr drwy brofiad ynghyd ag aelodau o'r staff sy'n gwirfoddoli. Mae rhanbarthau yn mynd ati i recriwtio ac yn croesawu cais gan wirfoddolwyr o gefndiroedd a gallu amrywiol.

LL - LLYWODRAETHU

Yr amser iawn, yn y lle iawn, a'r person iawn

Mae llywodraethu yn golygu sicrwydd ein bod yn gwneud yr hyn yr ydym yn dweud y byddwn yn ei wneud. Cynhelir archwiliadau, arolygon ynghyd â siarad â phobl er mwyn sefydlu sut hwyl 'rydym yn ei gael ar bethau. Os nad yw pethau fel y dylent fod, cymerir camau adferol. Mae systemau ar waith i gefnogi gwelliant parhaus yn ansawdd y gofal ar gyfer pobl â dementia a'u gofalwyr tra yn yr ysbyty. Dylai hyn gynnwys rhoi gwybodaeth i bobl mewn ffordd sy'n dangos ein bod yn deall dementia a bod yr ysbyty'n mabwysiadu ffyrdd o weithio sy'n cefnogi staff i ddarparu gofal sy'n dangos eu bod yn deall pobl sydd â dementia.

Egwyddorion y Siarter:

a. Strwythurau llywodraethu:

- Mae'r bwrdd iechyd wedi ymrwymo i Siarter Ysbytai sy'n Deall Dementia yng Nghymru a defnyddir y Datganiadau Dementia i lywio'r dulliau gofal.

- Mae uwch aelod o staff ym mhob rhanbarth yn arwain ac yn monitro'r broses o gyflawni'r strategaeth ddementia rhanbarthol.

- Mae gan y bwrdd iechyd aelod o'r Bwrdd Gweithredol sydd wedi'i benodi i fod yn gyfrifol am ofal dementia.

- Mae gan arweinwyr arbenigol dementia clinigol fynediad i hyrwyddwyr dementia / gweithwyr cyswllt a gwirfoddolwyr a all weithio gyda phob ardal i gefnogi'r ddarpariaeth o ran gofal dementia.

- Ceir Grŵp Ffrwd Waith Siarter Ysbytai Deall Dementia yng Nghymru sy'n cysylltu â'r bwrdd dementia rhanbarthol. Mae'n cynnwys bob grŵp staff, y trydydd sector ac aelodau o'r cyhoedd sy'n monitro'r gofal a ddarperir gan gynnwys safbwyntiau pobl â dementia, eu gofalwyr ac aelodau o'r teulu.

- Caiff ansawdd y gofal ei fonitro'n fewnol ac yn allanol drwy Grŵp Tasg Adolygu Partneriaid Rhanbarthol y Siarter.

- Darperir diweddariad cyson o'r gofal ar gyfer dementia i fyrddau dementia rhanbarthol a'r bwrdd partneriaeth ranbarthol gan Grŵp Llywio'r Siarter Ysbytai Deall Dementia yng Nghymru.

- Mae'r cytundebau gyda staff asiantaeth a chontractwyr yn nodi sut y byddan nhw'n cynnal egwyddorion y Siarter ac yn ymwneud â'u gweithredu.

- Mae'r sefydliad yn gefnogol i fenter Ffrindiau Dementia Cymdeithas Alzheimer Cymru

- Mae gan y sefydliadau arferion safonol, cadarn, a hygyrch er mwyn sicrhau diogelwch ac adrodd yn ôl ar broblemau.

- Mae'r sefydliad yn arddel egwyddor "gweld a sortio" er mwyn mynd i'r afael â themâu sy'n ymwneud â gofal ac anghenion pobl sy'n byw gyda dementia.

b. Adnoddau Dynol:

- Darperir cefnogaeth i staff i weithio'n hyblyg pan fyddan nhw'n gofalu am berson â dementia.

- Mae polisïau a gweithdrefnau'n helpu i ymladd yn erbyn stigma tuag at weithwyr sy'n cael eu heffeithio gan ddementia a gwneir addasiadau rhesymol er mwyn eu galluogi i barhau i weithio.

c. Adborth:

- Mae system gadarn ar waith ar gyfer casglu adborth ystyrlon yn amserol, gan gasglu profiadau pobl â dementia, eu gofalwyr ac aelodau staff. Lle mae'r adborth yn amlygu meysydd sydd angen eu gwella, fe ddylid treulio amser yn ystyried y materion ac ymateb yn ôl y gofyn. Dylai'r ymatebion fynd i'r afael â'r mater gan amlygu unrhyw gamau y dylid eu cymryd er mwyn gwella profiad pobl sy'n byw gyda dementia.

- Mae'r system hon a ddefnyddir ar gyfer casglu adborth i'w gweld yn glir ac ar gael yn rhwydd pan fydd ei hangen.

Egwyddorion Cyfathrebu:

- Mae strategaeth gyfathrebu ar gyfer Siarter Ysbytai sy'n Deall Dementia yng Nghymru.

- Mae'r polisïau ar gyfer canmol a chwyno ar gael mewn fformat sy'n addas ar gyfer pobl â dementia a'u teuluoedd.

- Trefnir grwpiau ffocws ynghyd a dulliau cysylltu eraill yn rheolaidd gyda phobl sydd â dementia a'u gofalwyr, ynghyd â phartneriaid allanol, lle bo hynny'n briodol.

- Mae'r ysbyty yn cymryd rhan yn yr Archwiliad Cenedlaethol ar gyfer Gofal Dementia gan ddefnyddio dull amlddisgyblaethol.

- Mae Gwasanaeth Cyngor a Chysylltiadau Cleifion (PALS) ar gael ac wedi'i gyfeirio'n glir, gan ddarparu gwybodaeth am ofal a chymorth penodol ar gyfer dementia. Maen nhw wedi'u hyfforddi i ddeall anghenion pobl â dementia, eu gofalwyr, eu cefnogwyr ac aelodau o'u teulu.

- Mae gwasanaethau eiriolaeth ar gyfer pobl sy'n byw gyda dementia a gofalwyr yn ddigon hawdd cael gafael arnyn nhw.

- Mae cyngor crefyddol ac ysbrydol ar gael yn hawdd ac yn wasanaeth 24 awr ar gyfer pobl sy'n byw gyda dementia.

- Mae gwasanaethau'n darparu cynnig gweithredol yn y Gymraeg lle mai dyna yw prif iaith y person. Cefnogir staff i ddarparu gofal yn y Gymraeg. Darparir gwasanaethau a gofal yn y Gymraeg ac ieithoedd eraill yn ôl y galw. Anogir staff i wella'u sgiliau o'r iaith Gymraeg.

- Mae'r gwasanaethau yn cynnwys darparu cyfieithiad i brif iaith y person er mwyn cefnogi'r gallu i gyfathrebu a gofalu. Mae hyn hefyd yn cynnwys y defnydd o Iaith Arwyddo Brydeinig (BSL) drwy gyfrwng person fyddai'n abl i ddefnyddio iaith arwyddo.

- Fe roddir gwybod i bobl sy'n byw gyda dementia a'u gofalwyr o'r cyfleodd sydd ar gael a'r hawl ganddyn nhw i ddewis os ydyn nhw'n dymuno cymryd rhan mewn ymchwil.

Yn ychwanegol at y Siarter hwn, mae:

- Ffurflen parodrwydd cyn-asesiad i'w chwblhau sy'n seiliedig ar ba mor barod mae'r bwrdd iechyd i weithio tuag at fabwysiadu'r Siarter.

- Offeryn hunanasesu ar-lein - Care Fit For VIPS a fydd yn ddefnyddiol i bob partner er mwyn pennu safbwynt y bwrdd iechyd o ran bodloni'r egwyddorion ac adolygu cynnydd wrth roi'r Siarter ar waith.

- Cynllun twf (gweithredu) i gynorthwyo'r holl bartneriaid i fodloni egwyddorion y Siarter.

Mae darparu gofal o gwmpas person, adeiladu perthynas a phartneriaethau'n thema drwy'r ddogfen hon a dylid ei hystyried o fewn pob egwyddor.

GYDA DIOLCH

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Dyma'r partneriaid sydd wedi gweithio gyda Gwelliant Cymru a Chymdeithas Alzheimer Cymru i greu'r Siarter Ysbytai Deall Dementia yng Nghymru ar y cyd:

- Age Cymru
- Arolygiaeth Iechyd Cymru
- British Deaf Association
- Byrddau Partneriaeth Ranbarthol Cymru
- Gofal a Thrwsio Cymru
- Arolygiaeth Gofal Cymru
- Gofalwyr
- Comisiynydd yr Iaith Gymraeg
- Crystal Creative Digital Agency
- Cydweithrediaeth Iechyd GIG Cymru
- Dementia Matters Powys
- Diverse Cymru
- Gwasanaeth Ambiwlans Cymru
- Gwelliant Cymru
- Llywodraeth Cymru
- National Institute for Health Research
- People living with dementia
- Prifysgol Abertawe

- Prifysgol Bangor
- Prifysgol Caerdydd
- Prifysgol De Cymru
- Prifysgol Caerwrangon
- Royal College of Psychiatrists
- Gofal Cymdeithasol Cymru
- TIDE
- Uned Gyflwyno GIG Cymru
- WCVA (Cyngor Gweithredu Gwirfoddol Cymru)
- Ysbytai GIG Cymru

Gyda'n diolch arbennig i:

- 3 Nations Dementia Working Group
- Cymdeithas Alzheimer Cymru
- Gwelliant Cymru
- Lleisiau DEMENTIA
- National Dementia Action Alliance
- Ymarferwyr, gwirfoddolwyr a staff o bob lleoliad ledled Cymru

[1]https://fundingawards.nihr.ac.uk/award/13/10/80

Am y wybodaeth ddiweddaraf ewch i'n gwefan a chofrestru ar gyfer ein e-gylchlythyr misol: www.gwelliant.cymru

Gallwch hefyd ein dilyn ar y cyfryngau cymdeithasol:

Dilynwch ni ar Twitter @GwelliantCymru

Cyfle i'n hoffi ni ar Facebook

Tanysgrifiwch ar YouTube

Cysylltwch â ni ar ein tudalen LinkedIn

Gwelliant Cymru

Rhif 2 Capital Quarter
Stryd Tyndall
Caerdydd
CF10 4BZ

Learn Improve and Assure

Dementia Friendly Hospital Charter for Wales

"When you have met one person with dementia, you have met one person with dementia"
Everyone is different.

This document explains the content of the Dementia Friendly Hospital Charter for Wales. It will break the Charter into sections to make becoming dementia friendly more manageable and easier to understand.

This document is for anyone interested in providing good person-centred dementia care including, but not limited to:

- Healthcare professionals
- People living with dementia
- Carers, family members and supporters
- Managers and leaders
- The general public.

As such, the document has been reviewed to make content as easy to understand as possible.

Key message:

Hospital staff speak to the person with dementia, care partners and families about what they can expect when receiving care

Providing care centred around the person, building relationships and partnerships runs throughout this document and should be considered within each principle.

Foreword

Hospital admissions can trigger, confusion, distress and sometimes delirium for someone with dementia and their carers and supporters.

The purpose and outcomes of the Hospital Charter is to make space for an improvement in the experience of people affected by Dementia in hospital care settings.

An experience that recognises their personhood, diversity and preferences that are shaped by recognising the importance of dignity respect and kindness.

The Hospital Charter from the beginning followed an emphasis of co-production Lleisiau Dementia as an independent voice were involved from the very beginning. Providing strong voices through the Charter development with an emphasis on safe care which is person centred underpinned by kindness and dignity which are considered within the principles throughout the charter.

At present Dementia has no cure but with adjustments positive changes can be made to the world people affected with Dementia live in.

Lleisiau dementia - voices from Wales

Introduction

The Dementia Friendly Hospital Charter for Wales (the Charter) outlines the principles that a dementia friendly hospital should provide. This should fully support the Dementia Action Plan for Wales 2018-22, where the vision is to:

'Create a society without stigma… Where people living with dementia continue to go about their lives and are understood by the wider public who know how to provide support'.

The Charter provides a focus for people living with dementia and their carers whilst they are in hospital. It outlines the care, treatment and understanding required to achieve the vision of the Dementia Action Plan and All Wales Dementia Pathway of Standards. In 2019 Improvement Cymru, part of Public Health Wales, supported by Welsh Government, began the process of developing a Dementia Friendly Hospital Charter for Wales.

The background to the Charter started in England in 2012, when the National Dementia Action Alliance (NDAA) launched the 'Right Care: a call-to-action' to create dementia friendly hospitals and published a Charter for English Hospitals in 2015.

Purpose of the Dementia Friendly Hospital Charter for Wales

The purpose of the Charter is to enable hospitals to create a dementia friendly care experience and environments that meet the needs of people with dementia, their families, carers and supporters in Wales.

The Charter will...

- Act as a short, clear statement of the key principles that contribute to a dementia friendly hospital.

- Provide a set of principles and indicators that focus on the needs of people with dementia and their families, carers and supporters.

- Inform people of what to expect when they receive care and visit a dementia friendly hospital.

- Build on the foundation offered by the Royal College of Nursing's Staffing, Partnership, Assessment, Care and Environment (SPACE) principles. This includes the latest developments and resources that hospitals can use to provide dementia care and support.

- Offer an improvement guide to assist hospitals in their self-assessment against the dementia friendly principles.

These points will be discussed in more depth later in this document.

The Dementia Statements

The Dementia Statements, published in 2017, reflect what people with dementia and carers say are essential to their quality of life. These statements were developed by people living with dementia and their carers and these rights are enshrined in the Equality Act, Mental Capacity legislation, health and care legislation and international human rights law. The statements are fully supported by the Wales Dementia Action Plan 2018-22 and include:

- We have the right to be recognised as who we are, to make choices about our lives including taking risks and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.

- We have the right to continue with day-to-day and family life, without discrimination or unfair cost. We also have the right to be accepted and included in our communities and not live in isolation or loneliness.

- We have the right to an early and accurate diagnosis.

- We have the right to receive evidence-based, appropriate compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.

- We have the right to be respected and recognised as partners in care, provided with education, support, services and training which enable us to plan and make decisions about the future.

- We have the right to know about and decide if we want to be involved in research that looks at cause, cure and care for dementia and be supported to take part.

- We have a right to be treated in a non-discriminatory way and to be shown respect and recognition of us as individuals and our cultures.

And in Wales:

- We have the right to receive assessment, care and support in Welsh without having to ask for it (in accordance with the principle of the active offer) if that is what we need and prefer.

The Charter supports key documents and legislation within Wales:

Wales Dementia Action Plan

The Action Plan sets out a clear strategy for Wales to become a dementia friendly nation that values the rights of people with dementia to live as independently as possible in their communities. It pledges to consider the rights, wishes and preferences of people with dementia in the implementation of the plan.

All-Wales Dementia Pathway of Standards

The All-Wales Dementia Pathway of Standards are statements that reflect what people believe will make a positive difference to dementia care in Wales. They were developed over two years and involved over 1800 people ranging from people living with dementia to voluntary sector organisations to practitioners across Wales and the UK. After a list of over one hundred potential standards were identified they have been narrowed down to 20 which are seen as being key to the promotion of dementia-friendly care across Wales.

Health and Care Standards Framework

The Health and Care Standards Framework supports the NHS and partner organisations in providing effective, timely, accessible and quality services across all healthcare settings. Seven themes were developed through engagement with patients, clinicians, stakeholders and identified as the priority areas for the NHS to be measured against. The framework standards underline the importance of providing services in Welsh.

The Charter aligns with other key documents:

- Well-being of Future Generations (Wales) Act 2015

- Older People's Commissioner for Wales' overarching priorities

- Impact of the COVID-19 pandemic on hospital care for people with dementia. Royal College of Psychiatry 2020

- The Good Work Dementia Learning and Development Framework 2016

- Home First: The Discharge to Recover then Assess model (Wales) 2021

- Creating healthier places and spaces for our present and future generations

- A healthier Wales: our plan for Health and Social Care 2018
- Social Services and Well-being (Wales) Act 2014
- Mental Health (Wales) Measure 2010
- Mwy na geiriau/More than just words 2016
- Dementia Action Plan: Strengthening provision in response to COVID-19 2021.

SPACE principles

SPACE is a set of five principles that form a shared commitment to improving care for people with dementia and their families. Based on evidence from people living with dementia, carers and practitioners, each principle is considered essential to the delivery of care. Developed by the Royal College of Nursing and updated in 2019, the principles are designed for use in a wide range of health and social care settings and are used to inform the Charter. During the Wales Charter consultation, stakeholders felt that two extra principles were required, therefore Volunteering and Governance are included (SPACE-VG).

The SPACE-VG principles include:

Why are Improvement Cymru, NDAA and its partners leading this work?

Because of its core role and strategic position, Improvement Cymru can:

- Facilitate and support the readiness and implementation of the dementia friendly principles in hospitals (supported by Welsh Government).
- Build relationships and partnerships, liaising with relevant people and agencies including those who plan, deliver and care within hospitals.
- Share good practice across settings, organisations and regions promoting improvement.

Vision Statement

'Dementia is a priority in all our Welsh hospitals and the Charter outlines the national and regional shared values and principles to achieve this. The values and principles are for all staff in hospital, community and other care settings and shows people with dementia and their carers coming into hospital from their own home what to expect'.

All Wales Shared Values

- Organisations and hospital staff are committed to listening, learning, enabling, being kind and caring. Staff at all levels alongside people living with dementia and carers can make a positive difference together in achieving good care.

- There is strong partnership working between the person, hospital staff, the person's carers, family and supporters. This also should include community settings such as care homes and other organisations involved in the person's care.

- People living with dementia, their carers, family and supporters are given appropriate and timely information for them to make choices about care, to further increase their independence and decision making.

- Hospitals and healthcare settings take active steps to provide what each person living with dementia needs during their hospital stay. People are made to feel welcome and heard, with the diverse cultures, experiences and needs of people from groups such as BAME, LGBTQIA+, Welsh speakers and people with learning disabilities being recognised and valued.

We will...

- Understand you may prefer to speak to us and be cared for in Welsh. We will make sure that you can do so.

- Ensure people with communication and language needs have access to appropriate services including translation services to support their care needs.

- Ensure people with sensory impairment such as poor sight or hearing have access to their glasses and hearing aids. When they are not in a good state of repair, steps should be taken to fix them as soon as possible. In the case of full sensory loss such as blindness or deafness, information should be provided in a way that it can be understood by the person. This may involve getting written resources translated into braille or the use of an interpreter for sign language.

- Offer people from different ethnic communities' culturally appropriate and understandable information about dementia. This should include information on existing services and support and make sure that people understand dementia is a medical condition.

- Not judge people from different communities for having a different understanding of dementia to our own. We must ensure that different opinions or beliefs do not result in people with dementia not getting the care and support they might need or benefit from.

- Always maintain people's dignity. Assist people with hygiene and personal care as they require to promote as much independence as possible.

- Never talk about someone in front of them without them being part of the conversation. It is important that we see the person not the dementia. Make sure that when you are talking about a person that the language used is respectful, avoids labels and negative remarks.

- Be careful about when and where we talk about people's private information.

- Communicate with people as they wish to be communicated with, without the use of language that treats the person as a child.

- Not start disagreements with people living with dementia. If there are disagreements or difficulties, we deal with them in a kind way, professionally and away from others.

- Never dismiss or ignore people and ensure their fears and anxieties are always taken seriously. We should take time to understand people's needs and address them.

- Support people when they are distressed, try to understand why they are feeling this way and respond to their needs, supporting them in a safe way.

- Promote and support people's emotional care. This is equally as important as completing practical tasks.

- Work in collaboration with those who know the person best.

- Understand when people are distressed they can behave differently. This can be upsetting for the person, their carer, supporters, family and staff. We should reassure everyone that we are aware that this can happen and talk about it together.

Welsh hospitals are committed to achieving the Dementia Friendly Hospital Charter. The following SPACE-VG Principles outline Welsh hospitals commitment to dementia care.

S - STAFFING

See it, sort it!

Staff at all levels are given permission and encouragement to make a difference to shape good care. The learning and development of staff in dementia care is important and opportunities to undertake training are valued, supported and invested in. Staff are recruited who share the values and beliefs of the Charter.

Charter Principles:

- Staff are valued, are in the habit of sharing good practice and the good work they deliver is celebrated.

- At all levels, there are specific leadership roles identified that have responsibility for putting the Charter into practice and for the safe delivery of dementia care. These roles are visible, easy to access, and staff understand the organisation's structure and who is responsible.

- Specialist dementia care staff are available, routinely offering support and advice where required within inpatient and community settings.

- All aspects of care and care planning involve the person and carers, family members, supporters and care home staff where appropriate.

- All staff are responsive to the needs of the person with a curious and helpful attitude, recognising and responding to the needs of people.

- Staff provide personalised care in a timely way and adjustments are made to enable and support the individual.

- Dementia care learning and development is mandatory for all staff and volunteers working in clinical areas with people living with dementia. The training should be at the appropriate level which is described in the Good Work Framework. This should involve how to assess needs and plan care. Once the care has taken place, we should see whether this has made a difference to the person.

- Observations of the person's experience is examined using tools such as Dementia Care Mapping (Insert link and graphics). This information is then used to develop ways of moving forward and support learning.

- Staff enable people to participate in activities in addition to care. This may be as simple as engaging in a conversation or providing stimulation in the form of things that they enjoy such as leisure activities.

- Staff are aware that people's behaviour is a form of communication, therefore they may need to adjust in order to meet that individual's needs in that moment.

- Staff always properly introduce themselves to patients, carers and families. The 'Hello my name is' campaign is one way of doing this #hellomynameis.

- Staff are aware of the importance of ensuring Welsh speakers are offered services in Welsh and other languages. Staff recruitment and training will support this.

- Staff have a working knowledge and apply the principles of all laws that relate to dementia for example the Mental Capacity Act (2005) and Mental Health Measure (2009).

- Staff are encouraged and assisted to look after their own health. A healthy workforce is connected to achieving better outcomes for people with dementia.

P - PARTNERSHIP

Working together

It is important that people with dementia, families, care agencies, care home facilities and professionals work together for the best outcome. All people should be equally recognised as partners in providing care and supporting transitions between care settings and home. Partnership includes choice and control in decisions reflecting everyone's needs and opinions about the support required.

Charter Principles:

- The organisation uses the 'Triangle of Care' principles between the person with dementia, health professionals and their family/carers. The implementation of John's Campaign or other carer focussed projects give the family, carers and supporters a voice and allows their needs to be considered.

- Seamless transition between care settings and home is seen as vital. Discharge planning starts on the day of arrival into hospital. Either the person with dementia or someone who can represent their needs should be involved in co-ordinating their care.

- People's language preference and cultural needs should be recorded and acted upon to form part of their plan of care. This should always be communicated between the staff involved.

- When people who live alone and have dementia are discharged from hospital, they are followed up with a wellbeing check within 24 hours. This may be provided by a staff member from health, social care services or a charitable organisation.

- The person has a document that tells you useful information about them and their life such as a 'This Is Me' document. This document is always kept with them and updated by care partners and health professionals. This ensures that everyone can engage on a personal level and are aware of the needs and preferences of the person.

- People living with dementia and their carers or families are offered opportunities to say how they have been cared for and what their experience has felt like.

- Good communication and access to clear information is essential in discharge planning. This will help the discharge be understandable to people involved, give opportunities to raise any questions or concerns and lead to safe discharges either home or to other care settings.

- Staff should help people with dementia and their families, carers and supporters to develop plans to support them at home after discharge. This may involve finding and contacting services and activities in the local area.

- Topics such as Lasting Power of Attorney, Advanced Care Planning (making decisions about treatment prior to being unwell) and end of life discussions should be explored and revisited. This should be done sensitively and take into consideration the needs and situation of all people involved.

- Bereavement support may be helpful for families and carers and this support is offered in advance of a person dying.

A - ASSESSMENT

Knowing the person

Assessments are always centered around the person and seek to identify strengths to enable care and support to be built around their needs. Assessment includes identification and treatment of a range of conditions and symptoms, such as delirium, depression, continence care and pain. 'This Is Me' or an equivalent document is used to get to know the person and information is accessible for all staff.

Charter Principles:

- Assessments should include:
    - » the person living with dementia
    - » the carer / family
    - » care home staff
    - » person's representative or advocate
    - » other care agency if appropriate

- Assessment encompasses people's social, emotional and spiritual needs, including their ambitions and individual goals, as well as their physical and mental health needs.

- Assessment includes what language and communication people with dementia and their families say they prefer and need. This is regularly reviewed as the person's circumstances change. This will include Welsh and/or other languages.

- Assessment of spiritual or religious beliefs. This should include whether they would like any support to continue worshipping or be part of a spiritual or religious community whilst in hospital.

- Hospitals work with organisations such as Diverse Cymru to ensure reasonable adjustments are made in supporting cultural and ethnic diversity.

- Pain is assessed regularly whilst in hospital. When medication is prescribed, staff should assess whether the painkillers have any effect so that adjustments can be made. Similar assessment should take place when considering other methods of pain reduction.

- People are not 'labelled', and staff understand and explore the person's regular routines, preferences and responses. Changes in a person's behaviour should not be ignored.

- An assessment of a person's everyday functioning takes place in their own home (where possible) as it is a familiar environment. This will enable a better understanding of the person's abilities and routines.

- Discussion around loneliness takes place during a hospital stay. Where needed, a support plan is agreed with the person to reduce loneliness when they are discharged from hospital.

- There are clear discharge plans around medication, to ensure safety. This should involve assessments of the person prior to being discharged from hospital (where possible) and may involve further monitoring in the community.

- Whilst a diagnosis of dementia is generally made outside of a hospital setting, however when it is made in hospital, the Welsh Government READ code circular and guidance is followed. This will enable the person to be referred and connected to their local memory assessment service and GP, which will ensure access to post-diagnostic treatment, information and support.

- A person with dementia will be supported in making decisions about their care for as long as possible. Where the person lacks capacity for a particular decision, any appropriate Lasting Power of Attorney should be used. Where there is no Lasting Power of Attorney, a family member or carer can communicate the person's views, or an Independent Mental Capacity Advocate will help make decisions on their behalf. The person with dementia should be helped to be part of these decisions throughout the process.

- Discussions around future care and the use of 'Advance Care Planning' should be encouraged as early as possible to establish end of life wishes and care preferences.

- When a person is approaching the end of their life, timely communications take place with the person, their carer and family or advocate.

- For people that speak Welsh, care is delivered by Welsh speaking practitioners avoiding the use of translation services and where there is a language barrier, interpreters will be used.

- To identify physical deterioration at an early stage, staff should make every effort to understand what the person is like normally (when not unwell) and pay particular attention to new or worsening confusion. If the person's function and behaviours are unknown, then the confusion should be treated as new.

C - CARE

With and around the person

Care is kind, enabling, responsive and where possible, promotes self-care and individual strengths, skills and abilities. Care supports and enables the person to maintain their sense of self and relationships with loved ones.

Charter Principles:

- Human rights and equality legislation is essential when developing care for people with dementia in hospital settings.

- The views, opinions and preferences of the person with dementia, their carer, family or advocate are actively sought out. These views should help form their plan and delivery of care.

- The use of documents such as 'This is Me' are used to make connections with people living with dementia. They should be read, reviewed and updated regularly.

- Information is provided in a way that is accessible and suitable to the person. This may include adaptations for hearing and sight loss and changes in language skills.

- Care, information and support will be provided in the language of preference if that is the person's need or requirement.

- Staff ensure that people with dementia can maintain physical contact and relationships with their loved ones and significant people in their lives.

- Care is delivered by a team of staff providing advice and intervention to address needs.

- Where possible, adjustments are made to ensure that care is sensitive to cultural needs. If this cannot always be accommodated, then discussions between the person, family and carers or advocate should take place to see if there are other ways that care can be delivered.

- Care enables people to be physically and cognitively active. This can include engaging in activities important to them or maintaining existing skills such as personal care for example, washing and dressing, brushing their hair and encouraging independence.

- Care includes conversations and information to support physical and mental health and healthy lifestyle choices for people when they return home. This is an important message to help people stay healthier for longer.

- People with dementia have the right to equal access to palliative care when approaching the end of their life. This should include medication for pain and symptom control and plans to keep them comfortable.

- Staff are aware of the person's preferred place of care at the end of life such as going home or into a hospice. Staff should know how to access this for the person and their families.

- Clothing and equipment required for therapeutic activities are available to all people free of charge.

- Care can include technology. There should be access to free Wi-Fi and technological devices
- People with dementia are supported to take positive risks that will continue to promote their independence and happiness, such as engaging in leisure activities if it is safe to do so.
- People will have access to an independent advocate where needed.
- The person or family and carers can opt in or out of hospital dementia care schemes.

E - ENVIRONMENT

Enabling the person

The environment is comfortable, empowering and promotes independence. The environment encourages usual mobility, activity and social interaction. Hospital planning and maintenance incorporates dementia friendly areas and there is support from all departments to design, achieve and upkeep them.

Charter Principles:

- People living with dementia and staff work together to ensure that the environment is appropriate, aided by The King's Fund Dementia Friendly Environmental Assessment tool. Areas of interest include wards, outpatient clinics, dementia friendly parking places, toilet facilities, including those for carers, family members and supporters within wards and treatment areas with A&E (Emergency departments) and minor injuries departments.

- Signage, symbols and markers support navigation throughout buildings and are consistent throughout the region's hospitals.

- Adaptations are made to support the person in moving around the environment safely rather than restricting movement.

- A document or 'welcome pack' should be provided and can be translated in the person's preferred language. This explains what resources, equipment and facilities are available in the hospital. This should include a carer and family room, key contact information and how carers and family can assist the person's care (if they would like to) whilst in hospital.

- People have opportunities to explore the layout of the ward as part of the admission process. Staff should take time to show people where things are and assist people whenever they appear unsure. This could include the use of fixtures and fittings that may be different to home such as taps and handles.

- Where possible, there is a supported dementia friendly outside space or garden that people with dementia, carers and family can access and enjoy.

- The area offers quiet spaces designed for people to ensure that noise and distractions are minimised.

- The environment helps people to see, hear and communicate better and promote independence.

- The use of technology, for example, call bells and radios available within the environment will be discussed as will fixtures, fittings and the use of appropriate furniture and equipment.

- Staff are vigilant about changes in temperature and lighting, and they manage this for the comfort of the person.

- Moving beds and changing wards within the hospital are minimised where possible. Sometimes a move to another setting is unavoidable so every effort must be made to

support the person and that the carer and family are informed. This includes where the person has moved to, the reasons for the move and steps to support them to adapt to the new environment.

- People receive the support and care to die with dignity. Considerations are made such as single room access or adaptations to the environment for the dying person and their families and carers to support privacy.

- The person will have an accessible space to keep their personal and comforting belongings. Staff will help the person to use and enjoy them.

- People have access to fundamental items such as dentures, glasses, hearing aids and other aids and adaptations that make them feel reassured and safe. Staff ensure these are clean and in working order.

V - VOLUNTEERING

Opportunities

Volunteers have learning and development opportunities to support people with dementia and their families. This should include providing person-centred support for meaningful activities and pastoral care with safety and dignity. Volunteers complement paid staff and are not a substitute for them.

Volunteers Charter Principles:

- Undertake an Alzheimer's Society Dementia Friend awareness session.

- To be aware of the language needs of people with dementia, their carers, supporters and family. Where there is a language need, support should be available in Welsh or other languages, including sign language.

- Volunteers are regularly supervised and supported in their role. They are encouraged to take part in learning and development opportunities provided by Welsh health boards.

- Ensure that the person is comfortable and willing to engage in activities. Essential communication items such as teeth, glasses and hearing aids should be used. In cases of sensory loss, volunteers should be supported to expand their knowledge and skills

- Volunteer roles are clearly defined in the health board's policies. This is communicated to and understood by the volunteers and staff members working with them.

- There are a range of volunteering experiences available throughout the hospital. These involve intergenerational work, people with dementia being experts by experience and staff members volunteering. Regions actively recruit and welcome applications from volunteers with diverse backgrounds and abilities.

G - GOVERNANCE

Right time, right place, right person

Governance means that we make sure that we are doing what we say we are going to do. This involves audits, surveys and speaking to people to establish how we are doing. Where things are not as they should be, steps are taken to improve. Systems are in place to support continuous improvement in the quality of care for people with dementia and their carers whilst in hospital. This should include information given to people in a dementia friendly way and that the hospital adopts ways of working that support staff to deliver care that is dementia friendly.

Charter Principles:

a. Governance structures:

- The health board is signed up to the Dementia Friendly Hospital Charter for Wales and the Dementia Statements are used to inform approaches to care.

- There is a senior member of staff within each region who guides and monitors delivery of the regional dementia strategy.

- The health board has an Executive Board member designated with responsibility for dementia care.

- Clinical dementia specialist leads have access to dementia champions / link workers and volunteers that can work with each area to support the delivery of dementia care.

- There is a Dementia Friendly Hospital Charter Workstream Group that connects to the regional dementia board. It is inclusive of all staff groups, third sector and members of the public that monitor the delivery of care and includes perspectives of people with dementia, their carers and family members.

- The quality of care is monitored both internally and externally via the Charter Regional Partners Review Task Group.

- The Dementia Friendly Hospital Charter Steering Group provides regular dementia care updates to the regional dementia board and the regional partnership board.

- The contracts with agency staff and contractors specify how they will uphold the principles of the Charter and are involved in the implementation.

- The organisation is supportive of the Alzheimer's Society's Dementia Friends initiative.

- The organisations have good quality, robust and accessible practices to ensure safeguarding and whistleblowing.

- The organisation upholds a "see it, sort it" principle to address themes relating to the care and needs of people living with a dementia.

b. Human Resources:

- Support is provided for staff to work flexibly when they care for a person with dementia.

- Policies and procedures help combat stigma towards employees affected by dementia and reasonable adjustments are made to enable them to continue working.

c. Feedback:

- There is a robust system for routinely gathering timely meaningful feedback, capturing the experiences from people with dementia, their carers and staff. Where feedback highlights areas for improvement, time should be taken to explore the issue and respond if requested. The responses should address the issue and highlight any steps to be taken to change and improve the experience of people living with dementia.

- This system for feedback is clearly visible and readily available when required.

Communication Principles:

- There is a communication strategy for the Dementia Friendly Hospital Charter.

- A compliments and complaints policy are accessible in an appropriate format for people with dementia and their family.

- Regular focus groups and other engagement mechanisms are organised with people with dementia and their carers, plus outside partners, where appropriate.

- The hospital participates in the National Audit for Dementia Care using a multi-disciplinary approach.

- Patient Advice and Liaison Service (PALS) is available, clearly signposted and provides dementia-specific information, care and support. They are trained to understand the needs of people with dementia and their carers, supporters and family members.

- Advocacy services for people living with dementia and carers are readily accessible.

- Religious and spiritual advice is readily accessible on a 24-hour basis for people living with a dementia.

- Services provide an active offer in Welsh where it is the person's primary language. Staff are supported to deliver care in Welsh. Services and care will be provided in Welsh and other languages where needed. Staff are encouraged to improve their Welsh language skills.

- Services provide translation in the person's primary language to support communication and care. This would also include the use of British Sign Language (BSL) interpreters.

- People living with dementia and their carers are informed about the opportunities and right to decide if they wish to be involved in research.

In addition to this Charter, there is:

- A readiness pre-assessment form to complete based on how ready a health board is in working towards adopting the Charter.

- A self-assessment online tool – Care Fit For VIPS that will be helpful for all partners to determine the health boards position in meeting the principles and to review progress in implementing the Charter.

- A growth (implementation) plan to assist all partners in meeting the Charter principles.

Providing care centred around the person, building relationships and partnerships runs throughout this document and should be considered within each principle.

WITH THANKS TO

The partners that have worked with Improvement Cymru and the Alzheimer's Society Cymru in coproducing the Dementia Friendly Hospital Charter for Wales:

- Age Cymru
- Bangor University
- British Deaf Association
- Cardiff University
- Care and Repair
- Care Inspectorate Wales
- Carers
- Cardiff University
- Crystal Creative Digital Agency
- Dementia Matters Powys
- Diverse Cymru
- Health Inspectorate Wales
- Improvement Cymru
- NHS Wales Delivery Unit
- NHS Wales Health Collaborative
- NHS Wales Hospitals
- National Institute for Health Research[1]
- People living with dementia
- Royal College of Psychiatrists

- Social Care Wales
- Swansea University
- TIDE
- University of South Wales
- University of Worcester
- WCVA (Wales Council for Voluntary Action)
- Welsh Ambulance Service
- Welsh Government
- Welsh Language Commissioner
- Welsh Regional Partnership Boards

With a special mention to:

- 3 Nations Dementia Working Group
- Alzheimer's Society Cymru
- Improvement Cymru
- Lleisiau DEMENTIA
- National Dementia Action Alliance
- Practitioners, volunteers and staff from across all settings

[1]https://fundingawards.nihr.ac.uk/award/13/10/80

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Cyfarfod a dyddiad: Meeting and date:	Quality Safety and Experience
Cyhoeddus neu Breifat: Public or Private:	
Teitl yr Adroddiad Report Title:	Gold and Silver Command Structure Stepdown
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris Deputy Chief Executive/Executive Director Integrated Clinical Delivery
Awdur yr Adroddiad Report Authors:	Debbie Lewis Interim Emergency Preparedness Resilience and Response Lead Mark Andrews, Directorate General Manager Medicine
Craffu blaenorol: Prior Scrutiny:	
Atodiadau Appendices:	Appendix 1 – Surge Capacity Table
Argymhelliad / Recommendation:	

The Board/Committee is asked to approve the following six recommendations:

1. The Outbreak Reporting and Control Procedure, including Major Outbreaks should be activated in the response to Covid Level 2 and 3 declared outbreaks.

2. Should the situation change and any of the previously agreed triggers be met Gold will be reconvened

3. The 'pseudo' Silver role will be undertaken by the Interim EPRR Lead along with the Head of Tactical Control Centre to support the impact on the operational delivery across the system.

4. The PRAID logs will continue to be utilised in order to capture actions and to ensure decision making is recorded.

5. Any decisions that need to be made, requiring Gold sign off, will be taken through the Executive Team.

6. The above recommendations remain in place until the new BCU HB Operating System is in place, when there will be an opportunity to reflect on a suitable model for a Gold and Silver command structure that would provide the necessary governance and assurance for command and control in any all-hazards emergency response situation.

Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer		√	Ar gyfer Trafodaeth		Ar gyfer sicrwydd		Er gwybodaeth

penderfyniad /cymeradwyaeth For Decision/ Approval		For Discussion		For Assurance		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:

On 28 March 2022 the majority of the Covid restrictions were lifted. From the 31 March 2022 Public Health Wales surveillance data ceased to be provided and on 1 April 2022 the Covid testing policy in Wales for the public (and staff) changed. This has had a direct impact on the reporting of case rates.

Free NHS lateral flow tests (LFTs) are no longer available for the general public to access if they do not have symptoms. Those who are symptomatic are still able to order tests online for home delivery, and tests are still available to order, for free, in certain situations. However it is possible to purchase LFTs from various retailers, for those who do not have symptoms.

Public Health Wales has made the transition to integrated surveillance, from a pandemic response to an endemic one, and "living with Covid in Wales". Consequently, rather than continuing to hold Gold and Silver meetings, it would be more beneficial for the Outbreak Reporting and Control Procedure, including Major Outbreaks to be activated as opposed to the strategic response to major incidents.

The changes that have been made to the Test, Trace and Protect programme (TTP) have affected our incidence reporting which no longer supports our ability to obtain an accurate assessment of community and hospital cases. As such we are reliant upon medium term projections (MTPs), which are produced regularly by Swansea University, for decision making and determining the arrangements that will be required for future outbreaks.

As national guidance is no longer as prolific, future outbreaks will need to be managed via more normalised channels and the activation of existing pandemic and outbreak plans.

The three acute sites, Ysbyty Gwynedd, Ysbyty Glan Clwyd and Wrexham Maelor have all declared Level 3 Covid outbreaks. As a result of these declarations, along with the situation reports, this informed the decision to activate the Outbreak procedure along with the Strategic Outbreak Control Team. Regular (OCT) meetings in the East, Central and West areas have been convened, which escalated to the activation of the Pan BCU Outbreak Control Team with two meetings taking place on 30 March 2022 and 5 April 2022.

The Pan BCU OCT meeting was requested by the Director of Nursing Infection Prevention and Decontamination and chaired by the Deputy Chief Executive/Executive Director Integrated Clinical Delivery. This meeting was in addition to the Extraordinary Gold Meeting which was held on 28 March 2022, also chaired by the Deputy Chief Executive/Executive Director Integrated Clinical Delivery.

It is recognised that as a result of the on-going inquiry requirements the Health Board needs to ensure communications are consistent and archived against a time line and so the role of pseudo silver has been established and implemented.

Cefndir / Background:

In order to support the strategic and tactical responses to the pandemic, the Health Board established several specific Workstreams and Cells along with the critical planning, decision making and reporting to the Silver command structure. These workstreams are as follows:

- Resources
- Vaccination
- Test Trace Programme
- Clinical Pathways
- Epidemiology/Intelligence
- Modelling update and projected activity
- PPE (Personal Protective Equipment)
- Communications
- Operational Delivery
- Mental Health
- Women's
- Planned Care Forward Look
- Infection, Prevention and Control
- Care Homes
- Risk Log

While the Health Board is still supporting the COVID-19 pandemic the EPRR Lead has the responsibility for maintaining oversight of all the Workstreams and Cells. This will ensure continuity of reporting and senior monitoring pending any future structure changes.

Since Monday 14th February an 'enhanced' Emergency Preparedness, Resilience and Response Team has provided operational updates to the Executive Team on the SARS-CoV2 local, national, and internal increasing threats or risks. The following enhanced structure was also convened:

- Gold-Silver Support Lead: Directorate General Manager Medicine
- Interim EPRR Lead (end of February 2022)
- Head of Tactical Control Centre
- Head of Informatics to support Surveillance functions from Warning and Informing
- Management support for PRAID, reports etcetera
-

As part of these arrangements, the surveillance function for Variants of Interest / Concerns continued to be reported by the COVID-19 Intelligence Cell from the Business Intelligence Unit to the EPRR Team with critical issues for escalation through to the weekly Executive meeting to provide critical horizon scanning of future Variants of Interest / Concern.

The EPRR Team also supported the following key documents and inboxes to maintain continuity with surveillance and reporting:

- Reviewing the Prevention and Response Plan / Outbreak Control Plan
- Monitoring the HECC Silver and Coronavirus C U inboxes
- Pandemic Influenza Framework
- Gold Command Operating Arrangements and Guidance on Decision Making
- Reviewing the Outbreak Reporting and Control Procedure, including Major Outbreaks

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications
Situational Awareness

It is crucial that, given the uncertainties with SARS-CoV2, and how the virus may behave in the future, the Health Board retains a strong Warning and Informing function through its Emergency Preparedness, Resilience and Response (EPRR) structure.

This will ensure that any future operational impact of known or new Variants of Interest / Concern is escalated for consideration to the Executive Team in a timely manner. This would allow a proportional incident management response.

In order to facilitate this approach from 28 March 2022 the EPRR Lead has continued to provide weekly situational awareness reports to the Executive Team and attend the Strategic OCT and any pan BCU OCT meetings.

The notification of any changes will be coordinated by the 'pseudo' Silver for dissemination from a single source.

Gold Role

Gold remains the Deputy CEO, and any issues from the pan BCU OCT will be escalated via the 'pseudo' Silver. Any decisions which require Gold endorsement will be taken via EMT.

'Pseudo' Silver Role

The Silver role will be undertaken by the Interim EPRR Lead along with the Head of Tactical Control Centre to continue to support the impact on the operational delivery across the system.

Decision Making

The PRAID logs, which included the Risk Logs, Action Logs, Issue Logs and Decision Logs, will still need to continue to be completed, by Gold and 'pseudo' Silver, in order to provide an audit trail for decision making, which is required as evidence to be submitted to the Covid Inquiry.

Triggers for Establishing To SARS-CoV2 Gold and Silver Command

There are nationally agreed triggers in place to highlight increased cases, positivity, and admissions. The Health Community Plans also include operational triggers to support local decision making to meet winter and COVID-19 surge capacity and have informed the Gold and Silver Command structures of operational trends that might require further internal and external support. There are also specific Divisional Plans for Women's, Paediatrics and Mental Health.

The triggers below can and have been monitored by local teams to make operational plans including resources and surge capacity in critical areas that might be impacted by increasing staff absence or hospital admissions. They are reported by each Health Community at the daily Tactical Control Centre (TCC) meetings to determine if further pan-secondary care / community support is required to address any critical shortfall in core service provision. At all times aiming to reduce risk and harm within the wider health community and with critical partners.

Local plans in acute and community hospital settings to maintain operational effectiveness with admission avoidance and discharge planning will have already taken place following SAFER, R2G and SORT principles.

Each Health Community will continue to report a common suite of triggers at the daily TCC meetings and could also report the following additional triggers to indicate additional operational pressures from SARS-CoV2:

1. Daily Covid admissions
2. Wards Covid Patients
3. Covid in ITU/HDU
4. Paediatric Covid and Non Covid
5. Covid CPAP demand
6. NIV demand
7. Total bed gap
8. Front line staffing gaps

Further work to develop an agreed suite of SARS-CoV2 triggers will be taken forward by the EPRR team and COVID-19 Intelligence Cell referencing any Welsh Government guidance and benchmarking with other Health Boards / NHS Trusts.

Trends indicating operational concern from SARS-CoV2 will be part of the Executive Highlight Report from the EPRR, PHW Health Protection and Informatics teams. The membership of the COVID-19 Intelligence cell will also be revised to include representation from Scheduled and Unscheduled Care Teams as well as Local Authority partners to ensure a pan-organisational review of SARS-CoV-2 on health and social care provision.

The SBAR Proposals for Future Surveillance and Horizon Scanning to support COVID-19 and Future Strategic and Operational Shocks, contain more detailed information on these processes.

In addition the EPRR Lead along with the Assistant Directors of Scheduled and Unscheduled Care should be the lead SROs to maintain the integrity of the Inpatient Surge Capacity for Acute and Community Hospital Facilities: Potential and Open, which is included as Appendix 1. The surge capacity table should be updated on a monthly basis and reported to the Deputy Director Integrated Services Clinical Regional Delivery Director, Health Community Directors and the Unscheduled Care Flow Oversight and Support Team.

Opsiynau a ystyriwyd / Options considered

Goblygiadau Ariannol / Financial Implications
Dadansoddiad Risk / Risk Analysis
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
Asesiad Effaith / Impact Assessment

Appendix 1 – Surge Capacity Table

MONTHLY SUMMARY OF INPATIENT SURGE CAPACITY FOR ACUTE AND COMMUNITY HOSPITAL FACILITIES: POTENTIAL AND OPEN				

Month: February 2022

Location	Opened surge beds	Surge reserve available to open: *Subject to staffing, IPT, Estates works*	Surge In Extremis *Impacts on planned care[1]*	Surge beds at Business Continuity: *Subject to Gold approval and additional resources*
Critical Care				
East Area				
Wrexham Maelor Hospital				
Central Area				
Glan Clwyd Hospital				
West Area				
Bangor Hospital				
Women's Services				
Mental Health and Learning Disabilities				
Paediatrics				
	Surge in Open =	Surge in Reserve =	Surge in Extremis = +[2]	Surge in Business Continuity =

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Patient Safety Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Sarah Musgrave, Patient Safety Lead Manager Shan Kennedy, Redress and Claims Lead Manager Debbie Kumwenda, Inquests Lead Manager
Craffu blaenorol: Prior Scrutiny:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO Matthew Joyes, Acting Associate Director of Quality
Atodiadau Appendices:	1. Patient Safety Report – February-March 2022

Argymhelliad / Recommendation:

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

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

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

Cefndir / Background:

This report is designed to offer improved information and analysis in relation to patient safety, in order to improve the assurance received by the Committee. The period under review is primarily February and March 2022 (inclusive); however, longer-term data (allowing month on month comparison) has been included in the graphs to provide a better longitudinal view and to enable the use of statistical process control (SPC) charts.

Asesiad / Assessment & Analysis

Assessment and analysis are 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 – This is contained within the report.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – This is contained within the report.

Asesiad Effaith / Impact Assessment – Impact assessments are not required for this report.

Patient Safety Report February and March 2022

Produced by the Patient Safety Team, Quality Directorate

INTRODUCTION

Patient safety is focused on the prevention of harm to patients by improving the way in which care is delivered so that errors are reduced, learning occurs from the errors that do occur, and a culture of safety is fostered that involves health care professionals, partner organisations, patients and their carers/families.

The Patient Safety Team, part of the Quality Directorate, is responsible for facilitating and overseeing the incident process, the safety alert process, the collection of patent safety data and reporting, and patent safety culture, learning and improvement (working with clinical leaders and specialists such as the Transformation and Improvement Directorate). The Legal Services Team, also part of the Quality Directorate, facilitate and manage claims and inquests.

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

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

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

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

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

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

NATIONALLY REPORTABLE INCIDENTS

In October 2020, the NHS Wales Delivery Unit (DU) took on the responsibility for oversight of serious incidents on behalf of Welsh Government in anticipation of the NHS Wales Executive being formed. The Quality Directorate has regularly met with the NHS Wales Delivery Unit and will continue its strong working relationship with them.

As of the 14 June 2021, NHS Wales' responsible bodies were required to implement Phase 1 of the Welsh Government's National Incident Reporting Policy. The most obvious change in policy direction is a change in terminology with the removal of the word "serious" from the term serious incident. The intention here in removing the word "serious" is to support a more just and learning culture where reporting incidents does not feel punitive.

From 14 June 2021, the following definition of a nationally reportable patient safety incident applies:

"A patient safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare."

The timescale for reporting such incidents has increased from 24 hours to within seven working days.

The Delivery Unit lifted any reporting restrictions that were put in place because of Covid-19 as of the 14 of June 2021.

Further details around changes to National Incident Reporting in NHS Wales can be found on the Delivery Unit website Patient Safety Incidents - Delivery Unit (nhs.wales).

Never Events are defined as patient safety incidents that are 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 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 National Incident Reporting Policy.

During February and March 2022, 42 nationally reportable incidents were reported, up from 34 in December 2021 and January 2022

The table below shows the Health Board position in terms of reportable incidents per 100,000 population in relation to the All-Wales position per 100,000 population.

| Period	BCUHB Incidents/100,000	All Wales Incidents/100,000
Jun/July 2021	1.0	1.8
Aug/Sept 2021	1.8	2.3
Oct/Nov 2021	3.8	3.0
Dec /Jan 2022	4.3	3.2
Feb/March 2022	6.2	3.8
Average	3.4	2.8

Given the small numbers involved, and the particular reporting requirements for certain incidents which can fluctuate, the average should be considered a more useful comparison than an individual two month period. However, it is clear from the data that an increase in nationally reportable incidents has occurred in the last 4 months.

In addition to the above mentioned nationally reportable incidents, there were five Early Warning Notifications (EWN) reported, two of which were Procedural Response to the Unexpected Death in Childhood (PRUDiC) related. These notifications are not investigations but rather alerts of potential stakeholder interest.

At the time of writing, the total number of national reportable incidents open is 68 of which 16 are overdue. The total number of open incidents has decreased from 76 from the previous time period; the number that are overdue has significantly decreased by 20.

Much work has been undertaken in March to enable closure of historic incidents (i.e. those reported under the previous reporting policy). These account for 8 of the total open reportable incidents. This is a decrease from 23 in the last reporting period.

Overall closure rate within timeframe was 87.5% in February, falling slightly to 75% in March. Although this is a much-improved position from June 2021 the impact on services from clinical pressures, staff sickness, vacancies, and staff re-deployment has impacted on the ability of services to respond in a timelier manner to incident investigations in March. However, this is the best position seen for some time (with February the best ever).

% of DU Reportable Incidents Completed within timescale (90%)-BCUHB starting 01/12/19
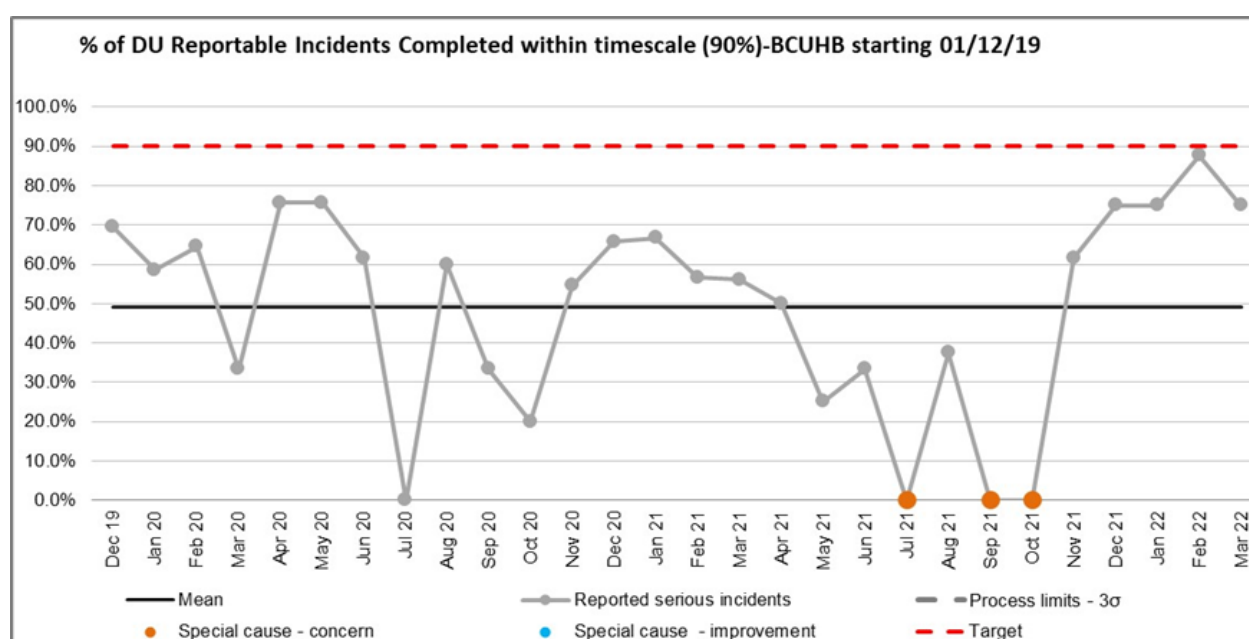
NATIONALLY REPORTED INCIDENTS (NRI)

There were 42 NRIs, including three Never Events (one reported retrospectively) for the two-month time. Never Events are detailed in a separate specific section.

As part of the new incident process, "Rapid Learning Panels" (RLP) take place between the senior service team and clinical executives around 24 hours following a Never Event and/or when an adverse incident where significant harm or death of a patient has occurred. The role of these meetings is to review immediate learning and actions being taken (including any cross-Health Board immediate learning), identify key risks and provide support where required. These compliment the Make it Safe (MIS) Rapid Review completed within 72 hours and the investigation completed within a specific proportionate timeframe (30, 60 or 90 working days).

During February and March 2022, 16 RLP meetings took place into the most serious incidents.

The forty-two NRIs recorded during this time period can be broken down as follows

- Never Event (n=2) – wrong site surgery
- Never Event (n=1) – retained swab (reported retrospectively)
- Fall with severe harm (n=17)
- Grade 3 or above healthcare associated pressure ulcer develops (n=7)
- Delay or failure to monitor patient (n=4)
- Failure to act on adverse symptoms (n=1)
- Implementation & ongoing monitoring/review (n=2)
- Ambulance delays resulting in harm/death to patient (n=3)
- PRUDIC (n=1)
- Delay in treatment - ophthalmology (n=3)
- Delay in diagnosis (n=1)
- Other type of incident (n=1)

Themes identified from Nationally Reported Incidents

The Patient Safety Team monitor incidents to identify themes and where these need to inform organisational priorities (recognising full investigations are underway). The following section provides a summary of some of these themes and the actions underway.

Recognition and escalation of deteriorating patient (to include delay/failure to monitor patient, failure to act on adverse symptoms, implementation and ongoing monitoring/review) (n=7)

This is a recurring theme. There have been seven incidents that were nationally reported during this period whereby recognition, escalation and treatment of a deteriorating patient has been delayed and subsequently resulted in severe harm or death. Four of the incidents occurred in Ysbyty Glan Clwyd, two in Ysbyty Gwynedd, and one in Wrexham Maelor. In addition, it is recognised that a lack of a clear management plan and timely discussions with patients and families about ceilings of care can result in inappropriate escalation.

An audit is taking place of medical emergency calls, being led by one of the acute site Hospital Medical Directors. This work will provide information to enable targeted areas where required with an aim that calls will be reduced and that ceilings of care are discussed

proactively and appropriately with patients, families and clinical teams. This will inform future improvement plans. In the interim, a safety alert setting out actions to take (with reference to policy and procedure) has been issued across the Health Board. A review of the Acute Intervention Team (AIT), led by the Deputy Director of Nursing, is ongoing. To date, a baseline assessment has been completed and the priorities for the AIT service delivery group identified, this includes operational standards and a competency framework.

In addition, the Health Board has re-formed an improvement group to look at one aspect of this area. The Sepsis Trigger, Escalation and Antibiotic Stewardship Review (STEAR) Group met in March 2022 for the first time. This group has been formed to provide Health Board-wide best practice guidance to health care professionals in determine how to trigger, respond, escalate, and review the response to the deteriorating patient. The key focus will be on:

- Approving triggers for SEPSIS (e.g., NEWS-2)
- Mapping observations charts to emphasise triggers
- Agreeing the escalation process
  - Care Bundles
  - Outreach
  - Medical Emergency Teams (MET)
- An education program to support outcomes of the group
- Agree how outcomes will be benchmarked and frequency of the auditing process
- The framework of shared learning of outcomes and embedding the escalation process to strive for continued improvement.

Falls (n=17)

Within the reporting period there were a total of 17 patient falls that resulted in severe/permanent harm and therefore met the criteria for national reporting. This is broken down as follows:

East Acute (2), West Acute (2), West Area (4), Central Acute (6), Central Area (3).

On review of initial learning from these incidents, there are several themes that can be identified that contribute to these falls:

- Staff shortages
- Inadequate completion of falls documentation
- Poor handover/communication between staff or with families
- Lack of use of call bells

A number of specific actions have been implemented locally.

- The NMC and GMC are currently working with staff across the Health Board to improve documentation standards. A letter has recently been sent to all nurse registrants reminding them of the standards required.
- New SBAR handover documentation has been instigated to ensure that there is effective communication between nursing staff and also permit the timely and accurate communication with the families of patients.
- Safety briefs and team huddles to re-enforce the importance of completion of risk assessments; compliance of which will be monitored via Matron audits and spot-checks.

- Staff are to ensure that all patients are actively encouraged to use the call bells as appropriate and 'at a glance' boards will be visible for staff to instantly recognise those patients who are a falls risk.

Grade 3 or above healthcare associated pressure ulcer

Within the reporting period there were a total of 17 grade 3, grade 4 or ungradable healthcare associated pressure ulcers. The recurring themes are:

- No evidence of increasing intentional rounding as/when needed.
- A delay in completing documentation on admission i.e., pressure ulcer management plans and Purpose T documentation

All investigations from pressure ulcer investigations are reviewed weekly at local harms' meetings. The Tissue Viability Nurse attends. Improvement work is ongoing and is targeted based on local findings and areas of interest.

Ophthalmology incidents (n=3)

In the last two reports, the issue of patients who have suffered harm (irreversible sight loss) as a result of delays in accessing treatment was highlighted. Three further incidents have been reported in the February to March 2022 period. The issue of service capacity remains on the corporate risk register. Work is ongoing to review national registry data to provide further insight into the service compared to other service providers, and to explore a buddy relationship with another tertiary service provider. The individual cases will be subject to investigation including consideration of Redress under PTR Regulations. An updated version of the thematic review has also been commissioned and will be presented at the Patient Safety and Quality Group in April 2022.

Ambulance delays resulting in harm/death to patient (n=3)

Ambulance delays continue to contribute to harm caused to patients. The three NRIs reported in this time period are:

- Delays in patients being brought into emergency department, contributed to ambulances being held outside the emergency department.
- Delays in transfer to Ysbyty Glan Clwyd for treatment from vascular services.
- Delay in transfer of patient to tertiary centre for time critical treatment for thombectomy (window of opportunity missed).

There is ongoing work between the Emergency Departments and WAST to review the intra/inter hospital transfer process to develop pathways for the transfer of patients who require time critical treatment.

LEARNING FROM NATIONALLY REPORTABLE INCIDENTS

As outlined above, all NRIs are subject to a Make it Safe Rapid Review, potentially a Rapid Learning Panel and a proportionate investigation. The learning and actions from each is recorded on the Datix safety management system.

The Incident Learning Panel (ILP) was introduced as part of the new Incident Management Process in April 2021. The role of the panel is to moderate and ensure that we are constantly improving the quality of investigations and reports. All investigations into serious incidents that have occurred since April 2021 have been reviewed at the ILP. There has been an initial focus on the quality of reports by the panel and services have taken on feedback provided with a subsequent marked improvement noted.

Plans are in place to strengthen the extracting and sharing of learning from the Incident Learning Panel to include:

- Learning on a page to replace the "lessons learned "template re-named Insight
- Monthly ILP Bulletin serving as a compendium of all the Insight reports
- A central Patient Safety Learning Library as part of the new Intranet site
- Mandated Learning Events (using the Oxford Model Event concept) following each completed investigation
- Updating the Safety Alerts Policy and process

During the months of February and March 2022, 72 investigation reports were presented to the ILP. This included those investigations commissioned that do not meet the national reporting threshold. 55 reports were approved by the panel, 17 were deferred and needed further work for reasons such as the quality of the report writing or weak action plans.

In total there are 177 investigations in progress that have been commissioned by the Patient Safety Team. In total, 39% of these are over overdue. West Acute hold the largest proportion of overdue incidents, followed by Central Acute. Overdue reports are highlighted on the Weekly Quality Bulletin in order that these figures are visible to management teams. In addition, to ensure that learning is captured at the earliest stage possible, all incidents graded moderate and above are reviewed daily; and where a Make it Safe Plus review is commissioned these are reviewed at corporate level to ensure learning is captured and appropriate to promote patient safety.

During February and March 2022, 25 nationally reportable incident reviews were approved at the Incident Learning Panel and closures submitted to the DU. The learning and actions taken from the incidents are detailed below. The learning from completed falls and pressure ulcer investigations has been grouped together. The learning from completed Never Event investigations is detailed within that section.

<u>Spinal haematoma following removal of epidural</u>

A patient was diagnosed with an extradural spinal haematoma resulting in cauda equina and cord compression which resulted in the following learning and improvement actions being taken.

Learning:

- At present practice the spinal epidural observation chart is discontinued following the removal of the spinal epidural; this incident has highlighted the need to change practice and continue observations up a minimum to 48 hours post removal of the epidural.
- There was no evidence of a LocSSIP being completed as evidence the epidural was inserted aseptically. LocSSIP should be added to the spinal epidural observation chart and needs to be considered if it should be incorporated in the spinal epidural observation chart.

- There was a delay in recognising the patient had developed a spinal haematoma and a further delay in diagnosing the spinal haematoma. A spinal haematoma following a spinal epidural for analgesia is an anaesthetic medical emergency according to the Association to the Royal College of Anaesthetics and requires urgent escalation to an Anaesthetist so that an urgent Magnetic resonance imaging (MRI) can be performed to diagnose the spinal haematoma.
- At present, there is no BCUHB Epidural Infusion Analgesia Policy, the only guidance found was a 2005 version for Bangor (C157 – Epidural Analgesia in Adult Acute Pain Management: Best practice guidance).

Improvement Actions:

- Learning has been disseminated through the Putting Things Right meetings, Local Critical Care/Surgical Patient Safety Quality Group & Site Patient Safety Quality Group.
- The case has been presented to the Royal College of Anaesthetists and the Critical Care network.
- Review of the spinal epidural observation chart and incorporating the LocSSIP within the document
- Develop a Epidural Infusion Analgesia Policy for the Health Board.
- Amending the Epidural Infusion Chart so staff observe the patient for a further 48 hours post removal of the epidural line.
- Reinforce with all prescribers' anticoagulant therapy doses must not be administered in patient with an epidural in place.
- Reinforce with CCU/ITU staff to complete epidural observations in line with the prescribed monitoring group.

Escalation of deteriorating patient

The patient attended ED having become generally unwell, experiencing a rapid decline in mobility, confusion and increasing drowsiness. A differential diagnosis of deep hypoactive delirium and decompensated liver disease with hepatic encephalopathy and severe hyponatraemia was made. The patient was hypotensive. Nursing staff bleeped the on-call doctor four times with no response. The patient was reviewed by the doctor. BP remained low over the night shift. Concerns escalated to the medical team and advice was given that the patient was not for IV fluids or albumin. The patient remained hypotensive on the morning. During the ward round, the patient was found to have developed Hepatorenal syndrome. A blood transfusion was requested and Terlipressin prescribed. The patient, sadly, later died.

Learning:

- The investigation highlighted nursing staff should be made aware of the importance of escalating the sickest patient to consultants when ward rounds start, in order to ensure that the patients of highest clinical priority get reviewed first.
- It was recommended that in situations where there were failures in review of patient when escalated, more senior support to review a patient of concern should be looked for. Clear procedures and routes for escalation need to be highlighted.
- For patients that do not have a 'do not resuscitate/not for Medical Emergency Calls (MET) order', a MET call can be placed which an acute intervention team will then respond to. For patients not for MET calls or resuscitation this incident has been

highlighted as a learning point and a request will be raised for extra medical staffing for out of hours cover with the medical programme manager. In the immediacy, nursing staff are aware to escalate concerns to senior members of the medical team.

Actions:

- Out of hours medical staffing level to be raised with Medicine programme manager.
- Patients identified as priority to be reviewed on the consultant ward round will be identified and highlighted in the safety briefing.
- Nursing staff to be made aware to escalate concerns for patients to senior medical staff i.e., Registrar and Consultant if not satisfied with review. This will be communicated daily at the ward safety briefing.

<u>Delay in Intra- hospital transfer</u>

The patient arrived at the ED in Ysbyty Gwynedd and was diagnosed with an extensive thrombus in their aorta. The patient required rapid transfer to Ysbyty Glan Clwyd for care under the vascular team. Transport was booked at 22:06 hours and after initial grading as an Amber 2, was upgraded to an Amber 1. By the time a crew arrived at 05.10 hours on the, the patient had deteriorated to end of life care and sadly died a brief time later.

Learning:

- The investigation highlighted the importance of rapid results to help patient flow. There is a need to ensure there is a backup plan available to cover any short notice sickness eventuality. There are substantial delays on each site, which result in an inability for the ambulance service to respond to emergency calls across North Wales. Communication between the Operational Delivery Unit and BCUHB Silver, need to include ambulance control on completing agreed actions and escalation. Delays in a time critical transfer can change the outcome for the patient. However, all factors need to be assessed before judgement can be made.

Actions:
- Review of the intra hospital criteria for critical care transfers to include use of EMRTS and ATACCT (critical care transfer service).
- Development of a formal ambulance divert process for BCUHB and WAST.
- Communication with all clinical staff in relation to clinical assessment and documentation and the importance to document the time of event if writing retrospective records.
- Review of current vascular pathway to consider vascular emergency transfers have direct admission.
- Development of a flow process when requesting intra hospital transfers for time critical patients.
- Review of site escalation policy to include reverse boarding to support rapid moving of patients awaiting beds when demand and capacity in ED hits gridlock.
- ED staff training in relation to booking of critical care transfers via the 999 route.
- Increasing of working hours of SDEC to support pulling those requiring a speciality in reach to reduce the gridlock within the Emergency Department.

Delay to treatment (mental health)

A patient was referred to local primary mental health support service (LPMHSS) in March 2021. During this time, the patient was seen by a consultant psychiatrist and accessed support from the CMHT Duty team on two occasions, the last contact being on 26th July 2021. Patient sadly died on 4th September 2021, with a provisional cause of death as Morphine overdose and occlusive coronary artery atherosclerosis.

Learning:

- The review into the patients care and treatment identified that there were risk indicators that should have been identified by practitioners and during the many contacts in crisis which could have been linked to inform the escalation of the patient's presentation. No recorded assessment or risk formulation was documented on Mental Health Measure paperwork.

Actions:

- Single Point of Access (SPOAA) minutes will include a documented rational for each decision made with signature and date of chair.
- LPMHSS to provide all initial assessment within designated timescales of 28 days and face to face to be standard practice.
- Individual duty officers to be supported through a supervision process given opportunity to reflect on practice.
- Any onward referral within Part 1 or Part 2 of the CMHT to remain open to the referring service until a formal discharge has taken place.
- LPMHSS to liaise with the patient's GP in the first instance for any medication requirements.

Delay to follow up (ophthalmology)

The patient was last seen in June 2021 in the Intravitreal Injection (IVT) clinic. The plan was for an outpatient follow-up appointment to take place in three months' time in the Medical Retina Clinic . in January 2022, the patient telephoned the Department to state that his vision had deteriorated and was seen in clinic. Subsequently, the patient was listed for urgent IVT treatment.

Learning:

- Capacity issue and waiting times appointments for IVT are a risk to patient safety

Actions:

- Develop a Standard Operating Procedure to address the recording of the patients on the waiting list - ensure utilising WPAS as the predominant method of managing patients on the waiting list and attendance.
- Risk Assessment of Outpatient areas in Abergele Hospital in order to increase face to face clinic appointment activity.
- Reminder to the Ophthalmology Team to always inform patients of the importance of notifying the department should their eyesight begin to deteriorate.

Issue with administration governance of school immunisation programme

Dwyfor School Nurse Team identified a concern around the administration governance of the school immunisation programme possibly as far back as 2010. The concern centred on either a delay in inputting data or an omission of the school immunisation data onto the All-Wales Child Health System.

It was noted two bags full of what was reported as "mixed paperwork" which included immunisation consent forms. These forms appeared to have not been stamped as inputted into the system.

There was also an error with all the Year 9 consent forms prepared and printed off ready for January 2022 school immunisation events / programme. The consent forms showed that they had been inputted into the system wrongly as an HPV (Human Papillomavirus) second dose, this was an error as it was the first dose.

The system therefore would not have alerted for a 2nd dose. The Team Leader was also informed that these consent forms (wrongly noted as the 2nd dose and therefore a completed course) had also been "filed" in the child's records and therefore was not prompting the system to trigger a recall. The team were concerned that there may be an unknown child that had been missed.

On 30th November 2021, an immediate investigation was set up led jointly by the Deputy Operations Manager and Team and Health Visitors (HV) and School Nurse (SN) Service Manager and management team and included the Child Health System management team.

Learning:

- There was a number of contributing factors to this incident however the main concern has been historic vacancies and recruitment concerns within children's administration services. Evidence demonstrates that funding for increased admin support for immunisation services has not kept pace with the increase in the school immunisation service workload and demands / profile.

Actions:

- Operational Manager to review administrative resources to match the school immunisation demands and growth in Regional Children's Services Meeting.
- Concerns regarding recruitment and retention of staff and increasing demands to be added onto the Risk Register.
- Develop a long term (3 year) admin workforce plan.
- Admin Manager to be represented at Health Visitor part of the Nurse Staffing Act implementation work stream.
- Development of an audit tool, walkabout proforma for reporting to Admin Standards meeting.
- To add filing times to Admin monthly performance report.
- To add Healthy Child Programme and Immunisation data inputting times to Admin Monthly performance report.
- Induction and training packages to be reviewed and updated / adapted.
- Admin Manager and Health Visitor School Nurse Service Manager to ensure community teams are aware of filing duties (not all filing is a Child Health System).

- Pilot to test real time immunisation data collection – admin on site with School Nurse teams to input as immunisations are delivered.

Avoidable Grade 3, 4 ungradable pressure ulcers

There were 7 investigation reports approved at ILP relating to reportable, avoidable pressure ulcers during this period. Themes and trends have been identified, which are as follows:

- No evidence of increasing intentional rounding as/when needed
- A delay in completing documentation on admission i.e., pressure ulcer management plans and Purpose T documentation
- Lack of communication with the Orthopaedic department about management plans/documentation for patients with orthopaedic devices i.e., fixation braces
- Lack of reviewing and updating risk assessment documentation for patients throughout their care.

A specific paper was provided to the last QSE Committee on the improvement work being done. This included re-commencing the improvement collaboratives.

Falls

There were 11 investigation reports relating to falls during this period that were approved following a review at the Incident Learning Panel.

Themes and trends have been identified as:

- Lack of prompt and fully completed risk assessments which may have identified a requirement for greater enhanced observation.
- A lack of completed bed rails risk assessments
- Failure to ensure correct non-slip footwear is in place
- Call bell not utilised or not to hand
- Lack of updated risk assessments following a change to a patient's clinical presentation
- Lack of communication during patient handover.

A specific paper was provided to the last QSE Committee on the improvement work being done. This included re-commencing the improvement collaboratives, new e-learning and updating the policy.

NEVER EVENTS

In total, twelve Never Events have been reported in 2021/22 (compared to five in 2020/21 and six in the full year of 2019/20).

Within the current reporting period three Never Events were reported, detailed immediately below (one of which is a retrospective incident from May 2021). Investigations into all three are ongoing.

New Never Events

Retention of a foreign object – a surgical swab found within the patient's throat following a theatre visit.

Immediate Learning: A swab, sharps and instrument check must be completed followed by the World Health Organisation "Sign Out" element of the checklist at the end of the procedure. Communication with the theatre and circulating team about the swab location must take place at timely intervals. Any intentionally retained swabs should be written down on the theatre white boards at the time of insertion and be fully documented within the Integrated Care Pathway. This learning has been shared with theatre teams.

Wrong site surgery – The patient was taken to theatre for a femoral - popliteal bypass but received a femoral - femoral bypass only.

Immediate Learning - In this case the surgeon was new to the Health Board, initial enquiries suggest that the surgeon had not received training to enable him to view the images and acted purely on the report (which was incorrect) which contributed to the incident. A range of immediate safety measures have been implemented in vascular services including dual working of surgeons on-call, which have been reported to the Committee in separate papers.

Wrong site surgery – Patient taken to theatre for laparotomy and litigation of right iliac artery. Further exploratory laparotomy undertaken where the surgeon removed vicryl tie around left common iliac artery.

Immediate Learning: Consideration will be given to the decision making process for emergency transfers to Stoke. A safety alert on safe travel has been issued covering staff responding across sites.

Surgical safety, human factors and quality improvement

In response to the number of Never Events, and the learning identified, the Health Board recognised the role of human factors in the prevention and mitigation of systemic failure on patients, families and clinical staff. The Health Board aims to mainstream human factors knowledge, understanding and practice in order to ensure the consistent, sustainable delivery of safer care for patients, whilst supporting our staff in that delivery: *making it easy for them to do the right thing.*

To do this, the Health Board has (1) commissioned an external company with human factors expertise, AQuA, to build capacity and capability in human factors and its application to healthcare, (2) commenced the development of an organisational wide faculty dedicated to human factors, and (3) commenced a targeted programme into the surgical safety checklist.

To support (3) the Transformation and Improvement Directorate has recruited a Quality Improvement Fellow. This fellow will combine the teachings of improvement methodology with its application to a specific programme of work i.e. the reduction of Never Events within the context of theatres, and improved compliance (and quality) of the WHO surgical safety checklist. The inaugural fellow is an experienced Operating Department Practitioner, who has recently been working as the Deputy Lead Manager for the Patient Safety Team.

As well as focussing on service improvements, the application of human factors can also enhance and supplement traditional investigation techniques. The human factors programme supported by AQuA will develop our staff in the use of human factors at both an

expert and practitioner level, and it is planned that staff who attend will also contribute to patient safety incident investigation teams.

Completed Never Event Investigations (Aug 2021/March 2022)

Incident date	Incident Description	Learning	Actions
17/08/2021	Email received from the National Joint Register highlighting a 32mm head and 36mm liner were used for a Primary Hip procedure.	More robust implant checks are needed for implant compatibility. Staff who have had periods of cessation of surgical activity due to Covid-19 to be made familiar with checking procedures. Awareness and recognition of the impact that Human Factors contribute to decision-making processes and their later consequences in clinical practice.	Introduction of white boards within theatres to identify implant sizes Trauma & Orthopaedic Surgeons to template patients pre-operatively for elective surgery and discuss implant size in PAUSE step of the WHO Checklist Documentation to be reviewed emphasising what size implants used on Theatre care plan. Local Standards for Invasive Procedures reviewed and updated with new protocols for implant checking.
23/10/2021	Surgical trocar left in eye.	An immediate requirement to ensure there is a process of which to check swabs and sharps in/out within the ABH ophthalmology theatres Formal checklist, counting in and out must be routinely used. Documentation within the Integrated Care Pathway (ICP) documentation must be shared immediately. The WHO Safer Surgery Checklist must be undertaken with full engagement of staff. Patient identifiable labels must be available within the patient's notes.	Temporary laminated sheets put in place to act as white board in the interim. New white boards have been ordered. Paper documentation for swabs and sharps are recorded within the patient's notes. To introduce an ICP for Theatres within Abergele. WHO compliance to be audited and quality audits completed.
09/10/2021	Retained swab discovered – Identified 6 weeks post delivery	Swab counts must be undertaken by two health care professional and signed by both.	Communication with all obstetric and midwifery staff the importance of two healthcare professionals

Incident date	Incident Description	Learning	Actions
			undertaking and confirming all swab counts.

Spot check audits to be undertaken weekly on post-partum documentation to monitor compliance.

Retrospective review of post-natal records where there has been an episiotomy or tear repaired to assess the number of women that decline perineum/episiotomy/intimate areas examination during the post-partum period and establish if further work is needed. |
| 7/05/2021 | Chest drain placed wrong side | Failure to utilise LocSIPP prevents clinicians/teams from questioning and confirming that the correct side of the patient's chest was being prepared | Publish lessons learnt Health Board wide to highlight requirement for LocSSIP for ICD insertions to be utilised on all occasions.

Undertake an audit of ICD insertions in reference to completion of LocSSIPs within Respiratory wards and Critical care across all acute sites (sample of 10 each site)

Review all LocSSIP for ICD insertions to include ultrasound of both sides of chest

Review of pleural thrombolysis guidance – to consider drafting of SOP for inclusion of CXR pre administration

Share Investigation findings and lessons learnt across BCUHB at WM/Matron meetings PTRs, Directorate and Site PQSGs for lessons learnt |

Incident date	Incident Description	Learning	Actions
19/5/2021	Wrong side nerve block	The importance of verbalising the "Stop before you block" command prior to administration of injection.	Patient Safety Alert to be created and distributed to each site Anaesthetists and Anaesthetic Practitioners to sign to confirm that they have read and understood the patient safety alert Ensure that stop before you block posters are clear in each Anaesthetic room. Also, labelling of equipment as 'Aide memoir' to STOP before you BLOCK Anaesthetic audit of the compliance of Stop Before You Block interventions for a period of 3 months.
6/5/2021	The patient was prescribed/ given a second dose of methotrexate within 2 days of her previous dose.	It is safer not to prescribe Methotrexate until all checks have been completed Methotrexate should be prescribed on the specific BCUHB Methotrexate chart and the day of the week clearly stated. The date of the last administration must be checked before prescribing Methotrexate should not be given by the nurse until the prescription has been clinically checked and endorsed by a pharmacist Only Methotrexate dispensed by the hospital pharmacy should be administered in hospital.	Clinical alert circulated across BCUHB Include Methotrexate in Back to Basics Medicines Management training, medical staff undergraduate training and Doctor's induction presentation in August and induction book. Once approved, disseminate the revised Methotrexate guideline MM31, to all medical staff, nurses and pharmacy staff.

The Committee received an action plan update during the year on a Never Event in urology services from November 2019. At the time, one action was outstanding – the provision of a human factors debrief. This has taken place and feedback provided to the Office of the Medical Director. This completes all actions from the serious incident review. However, it is recognised that underlying factors in the service remain and these are to be addressed by the Urology Improvement Plan, to be overseen by the Urology Steering Group. This will be chaired by the Executive Director of Integrated Clinical Services and will report into the

Committee. The Committee approved an external review by the Royal College of Surgeons which will provide a further detailed analysis of safety and clinical governance in the service. Additionally, wider issues regarding the YGC site and surgical safety are relevant and a separate improvement plan for the site is being developed and will be reported to the Committee.

Open Never Event Investigations

The following Never Event investigations remain underway (in addition to the new Never Events detailed above):

Incident date	Incident Description	Current status
20/08/2021	Ascetic drain inserted inappropriately. Consent taken from patient as intended to relieve respiratory symptoms.	Awaiting Investigation Report
13/10/2021	During laparoscopy for ectopic pregnancy, healthy tube removed prior to visualisation of rupture tube containing pregnancy.	Awaiting Investigation Report
22/08/2021	Patient underwent surgery to fix left proximal humerus fracture, during surgery the small guide for philos plate used was left in situ. The day after surgery, a check x-ray revealed the issue after being also alerted by HSDU to the absence of the small block.	Awaiting Investigation Report

INDEPENDENT INVESTIGATIONS

There is currently one independent external investigation ongoing as commissioned by the Health Board

Location	Incident	Update
CMHT (East) MHLD	Patient known to Community mental health team arrested on suspicion of murder	Draft report received - currently being reviewed for accuracy

VASCULAR QUALITY REVIEW

To support the Chair of the Vascular Quality and Harms Review Panel, a Vascular Quality Team has been formed including three senior members of the Quality Directorate with dedicated administrative support. It is the role of this team to review and further investigate, where necessary, the cases that have been reported upon as part of the case record review by the Royal College of Surgeons in England. In addition, they will manage all vascular complaints where harm is alleged. The Acting Assistant Director of Patient Safety is managing this team and is a member of the panel. The panel meets for the first time on 06 April 2022.

PATIENT SAFETY IMPROVEMENT PROGRAMME

The Quality Directorate are currently working closely with the Transformation and Improvement Directorate to develop a **Patient Safety Improvement Programme**. A workshop was held on 07 February 2022 led by the Associate Director of Quality. All medical, therapy and nursing directors were invited and the aim of the workshop was to work through priorities for the projects (approximately 4/5 per year) focused on preventing or reducing harm. The recommendations are being prepared for a meeting with the Executive Clinical Directors.

PATIENT SAFETY ALERTS AND NOTICES

The Welsh Government (WG), supported by the NHS Wales Delivery Unit, leads on the vital role in identifying significant national safety risks and concerns that would require a Patient Safety Solution at a national level for issue to the NHS in Wales. There are two types of solutions issued:

- ALERT (PSA): This requires prompt action with a specified implementation date to address high risks/significant safety problems.
- NOTICE (PSN): This is issued to ensure that organisations and all relevant healthcare staff are made aware of the potential patient safety issues at the earliest opportunity. A Notice allows organisations to assess the potential for similar patient safety risks in their own areas, and take immediate action. This stage 'warns' organisations of emerging risk. It can be issued in a timely manner, once a new risk has been identified to allow rapid dissemination of information for action.

Organisations are required to confirm that they have achieved compliance by the date stated.

Open Alerts

Reference	Title	Applicable To?	Type	Date action underway	Deadline	Notes
PSN057	Emergency Steroid Therapy Cards: Supporting Early Recognition & Management of Adrenal Crisis in Adults and Children	BCU WIDE	Patient Safety Solution - Notice	27/05/2021	31/12/2021	West Acute site have process in place which has been shared with Central and East Acute. Once agreed will be rolled out across BCU.
PSN058	Urgent assessment/ treatment following ingestion of super strong' magnets	Area - Central Region, Area - East Region, Area - West Region, Children's Services, Division of Mental Health,	Patient Safety Solution - Notice	13/07/2021	05/10/2021	Underway - Child pathway in place but does not refer to adults. Awaiting feedback from clinical leads to confirm if child

		Secondary Care, Women's Services				pathway suitable for adults.

Closed Alerts

Reference	Type	Title	Date issued	Deadline (action complete)	Closed
COVID	Welsh Health Circular	Interim Clinical Commissioning Policy: Antivirals or neutralising monoclonal antibodies in the treatment of COVID-19 in hospitalised patients (Version 5) in hospitalised patients (Version 5)	27/01/2022	03/02/2022	04/02/2022
PSN064	Patient Safety Solution - Notice	Patient Safety Notice PSN064 / January 2022 - Handlebar injuries in the paediatric abdomen	07/01/2022	28/02/2022	02/03/2022
PSN059	Patient Safety Solution - Notice	PSN059 - Eliminating the risk of inadvertent connection to medical air via a flowmeter	10/09/2021	16/12/2021	01/02/2022
COVID	Patient Safety Solutions - Alert	CEM/CMO/2022/02 - Neutralising monoclonal antibody and intravenous antiviral treatments for patients in hospital with COVID-19 infection	02/03/2022	02/03/2022	02/03/2022
PSN060	Patient Safety Solution - Notice	Patient Safety Notice PSN060 / Reducing the Risk of Inadvertent Administration of Oral Medication by the Wrong Route	07/10/2021	21/12/2021	30/3/2022

LITIGATION

During the period of February and March 2022, 64 claims or potential claims were received against the Health Board. Of these, 53 related to clinical negligence and 11 related to personal injury. These figures are slightly higher than recent months.

Whilst the numbers have fluctuated a little throughout the bi-monthly periods, it is anticipated by Legal and Risk Services (Health Board's solicitors) that claims will rise significantly due to the direct and indirect effects of the Covid-19 pandemic. The number of new claims received has increased over the last two months, which has been as expected and it is believed this figure will continue to rise as the Health Board begins to deal with the effects of cancelled procedures and appointments.

Clinical Negligence-BCUHB starting 01/01/19

Personal Injury Claims-BCUHB starting 01/01/19
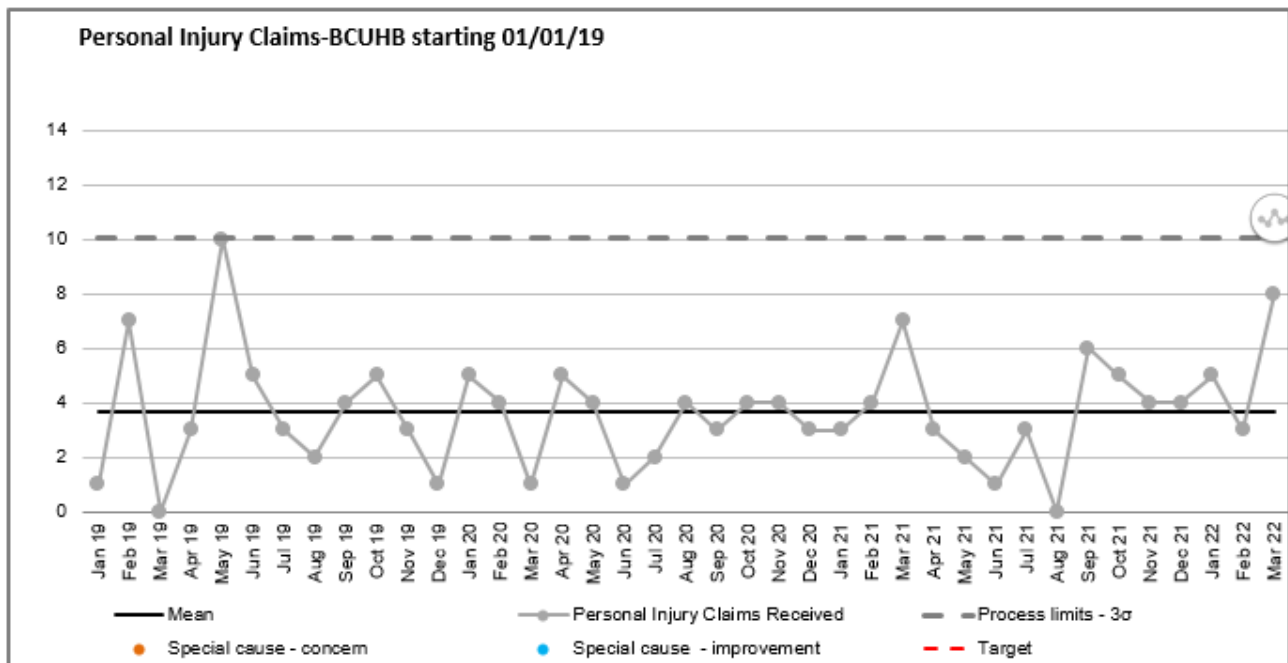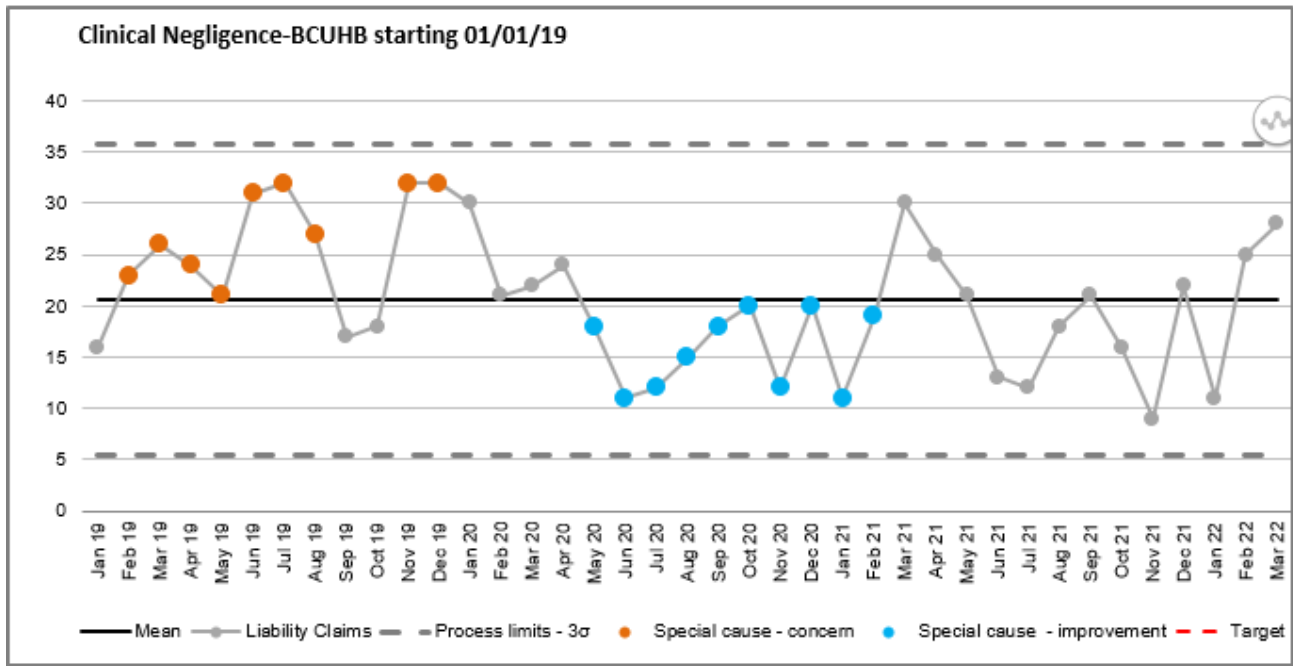
During the bi monthly period, 44 claims were closed. Of these, 30 related to clinical negligence and 14 related to personal injury. The total costs for these closed claims amounted to £1,820,633.6 before reimbursement from the Welsh Risk Pool. The most significant claims related to:

Failure to diagnose fracture in the ED and appropriately refer to Manchester Royal Infirmary and failure to communicate to the Claimant that she had suffered a fracture to the humeral head. (£108,011.30)

Learning:

- Discussion of this case took place at the time of the event and more recently at an M&M meeting within the ED Department. An advice sheet is also now given to patient's regarding arranging follow-up appointments at their local hospital.

Bowel Injury caused during laparoscopy and failure to recognise bowel injury during initial laparoscopy. (£62,750.00)

Learning:

- Individual consultants and clinical teams (& risk management team) are to monitor complication rates at laparoscopy. Maintaining clinical competence and training as standard practice.

- All surgeons performing laparoscopy must check for any potential organ injury. Once the laparoscope has been introduced through the primary cannula, it should be rotated through 360 degrees to check visually for any adherent bowel. The bowel should be closely inspected for any evidence of haemorrhage, damage or retroperitoneal haematoma. If there is concern that the bowel may be adherent under the umbilicus, the primary trocar site should be visualised from a secondary port site, preferably with a 5-mm laparoscope. On completion of the procedure, the laparoscope should be used to check that there has not been a through-and-through injury of bowel adherent under the umbilicus by visual control during removal.

- Colorectal or general surgeon should be called in the event of suspected or confirmed bowel injury.

Failure to diagnose pneumococcal meningitis in 2013. The blood tests, which were ordered by the ED Doctor, ought to have been reviewed upon their receipt. (£705,806.55)

Learning:

- Blood tests from the ED are now exclusively ordered and reviewed electronically through the Welsh Clinical Portal. This provides a full audit trail of who ordered, and who reviewed the results. The ED issues guidance that no patient should be discharged pending investigation results, instead patients can be admitted onto the ED Observation unit if discharge is anticipated whilst thy await results.
- Additionally every day Mon-Fri, an ED consultant undertakes in direct clinical time a review of the previous 24hrs (or 48hr over weekends) investigation results. These are paper based printouts of all the blood tests, microbiology

and radiology investigations ordered under ED. Any grossly abnormal results can be flagged with case notes reviewed and patients returned to ED if necessary.

Delay in diagnosis of advanced oesophageal cancer. The referral document was incorrectly filed by a Gastroenterology locum secretary rather than being sent to the Endoscopy Unit. (£181,041)

Learning:

- In the future, should agency staff be employed, they will be allocated a mentor who provides an induction, training and support during their time at the Health Board.
- A competency checklist is issued to all new starters in the secretarial team, which includes competency in relation to processing of clinical request. There is also a process guidance sheet for all staff.

The claim relates to care and treatment provided to the patient prior to his death in November 2012. There was a failure to provide out of hours cover at YGC on 8 and 9 November 2012; and had it been available, the patient's symptoms would have been investigated and treated by way of endoscopy, open surgery or interventional CT. (£162,000)

Learning:

- Since April 2019 the major arterial and emergency vascular service was centralised to Glan Clwyd Hospital. The Vascular service runs a 24 hour service including out of hours. The consultant led service is supported by the general surgery on-call team.

The following themes have been identified for this period for clinical negligence:

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

As expected the largest number of open claims relate to Surgery, Specialist Medicine and Women and Maternal Care. This is not an unusual profile of specialities within the NHS. The themes remain similar. The Health Board also continues to comply with the Early Reporting Scheme adopted in Wales in relating to potential birth injury claims.

The following themes have been identified for personal injury:

1. Slips/trips
2. Violence & Aggression (patient to staff)

Personal injury claim savings due to discontinued or favourable settlements for this period totalled £20,481.50. The total savings from 01 April 2021 to 31 March 2022 were £1,078,040.29.

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

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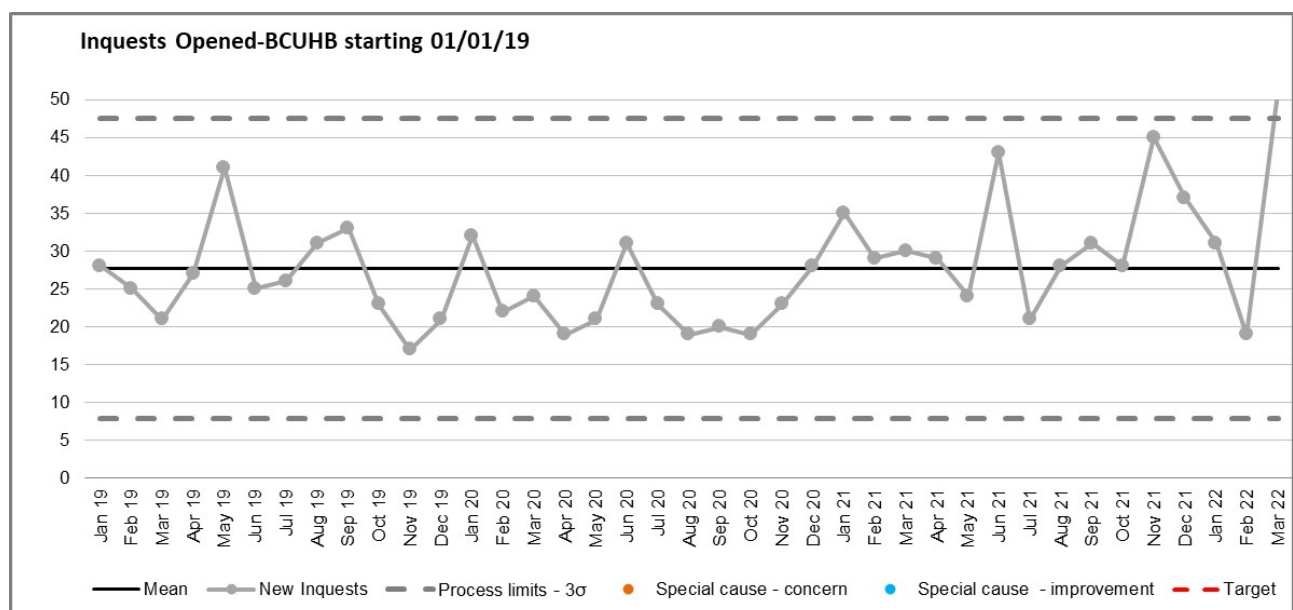
INQUESTS

"An inquest is an inquiry into the circumstances surrounding a death. The purpose of the inquest is to find out who the deceased person was and how, when and where they died and to provide the details needed for their death to be registered. It is not a trial." (Gov.UK)
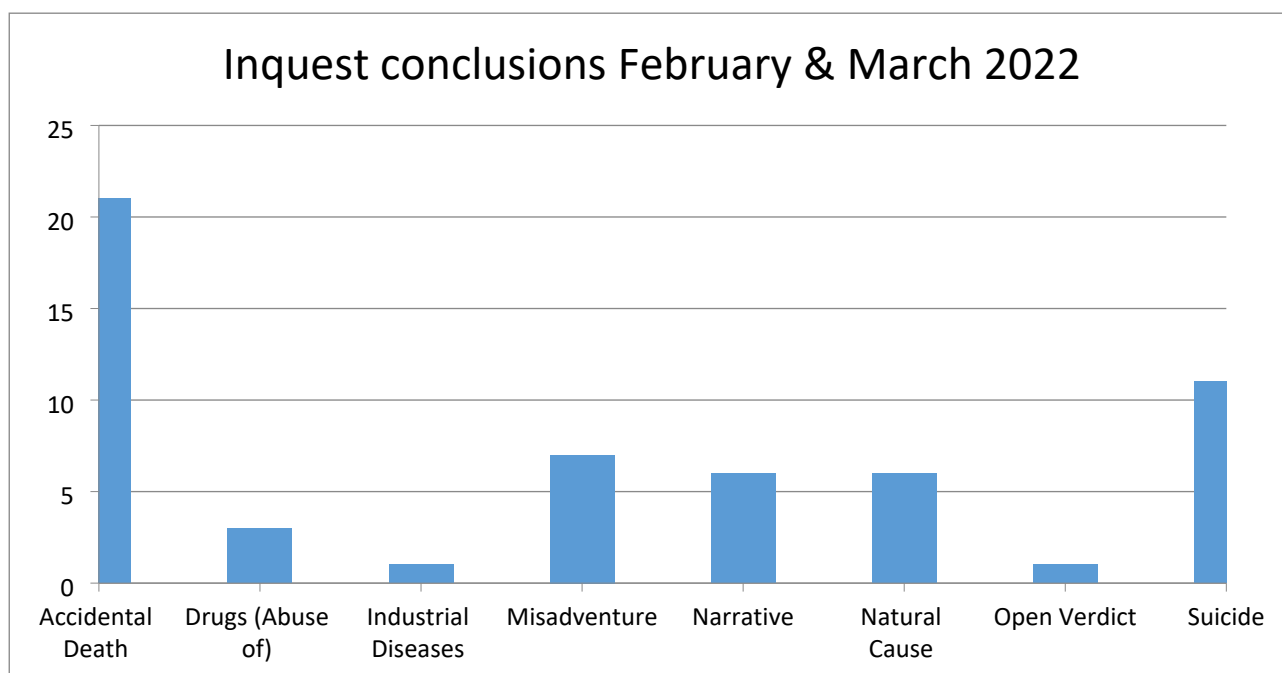
Inquests opened:

HM Coroner notifies the Health Board when they have opened an inquest into the death of a patient and they require further information from the Health Board.

During the relevant time period, February and March 2022, 75 new inquests or requests for information from the Coroner were received from the Coroners in North Wales, 48 of these were received in March. This is reflects an increase in workload when compared to the same period last year.

Inquests Concluded:

61 inquests were concluded between February and March 2022 with the inquest conclusions (where they have been shared with the Health Board by the Coroner) shown below.

Inquest conclusions February & March 2022

A bar chart titled "Inquest conclusions February & March 2022" with the y-axis ranging from 0 to 25. The categories and approximate values are: Accidental Death = 21, Drugs (Abuse of) = 3, Industrial Diseases = 1, Misadventure = 7, Narrative = 6, Natural Cause = 6, Open Verdict = 1, Suicide = 11.

The distribution of these inquest conclusions is in line with previous findings, and there are no unusual or unexpected findings to be taken from this.

Regulation 28 (Prevention of Future Deaths):

In the period of this report, no new Regulation 28 (PFD) reports were received by the Health Board, although at an inquest in February 2022, the Coroner indicated that a PFD would be issued regarding the possibility that medication reviews could be undertaken by ANPs during routine care home visits. Due to IT issues at the Coroner's office, at the date of writing, this has not yet been received.

As advised in previous reports, the Health Board has responses to 3 Notices in the last full year (April 2021 to March 2022) addressing the following points:

- The implementation of the SNAP procedure – whereby N Acetylcysteine (NAC – the standard paracetamol antidote) may, from 31/01/2022, be safely given over a shorter period of time than previously. Although this has not yet been officially sanctioned by the MHRA, accelerated approval within the Health Board outside of the normal governance procedure has been given.

- Confirmation that the process for escalation of abnormal Pathology results has been approved and implemented across the Health Board.

- Details on the new Incident Management Process.

- The implementation of a end of day safety huddle in community mental health teams to ensure safety plans are in place for vulnerable patients and handed over to out of hours teams.

Learning:

Whilst it is recognised that the majority of learning will come from incidents associated with inquest cases, there may be incidental learning, or comments raised by the Coroner during an inquest.

Example 1 - Communication
The Inquest conclusion was Accidental Death and no Regulation 28 report was issued, however the Coroner asked that comments from the family regarding communication with them at the time the patient was admitted to ED should be escalated. The family members present said that they didn't feel heard when they tried to advocate for the patient at admission, and that they would have been able to share important details regarding the patient's condition. The witness present (ED clinical director) assured the Coroner and family that this would be shared and was raised at a following Governance Meeting. Communication with family members is an on-going theme and has been noted in several Medical Examiner reports associated with ongoing incidents.

Example 2 - Mental Capacity Assessment, ED
The inquest conclusion was Natural Causes, however at the inquest the Coroner deferred making a decision regarding the issue of a Regulation 28 report pending receipt of further information from the Health Board regarding Mental Capacity training. The importance of assessing and recording capacity for all patients has been emphasised and a training program is in place within the ED at WMH. The consultant for ED, present as a witness at the inquest also, provided evidence of the training place in place in ED and the numbers of staff who had completed the training. This information has also been communicated to the ED leads for Central and West ED to be shared with their teams also. This information was shared with the Coroner on 18 March 2022, and we have received no further communication in relation to this matter from the Coroner's office.

Inquest Workload:

The Inquest Team have an increasing workload. The ongoing collaboration between the patient safety and inquest teams ensures escalation and prioritisation of incidents linked with inquests, enabling a more proactive approach to incident investigations and actions plan formulation, although reduced staffing numbers have impacted this process during the latter part of March 2022.

Compounding this is the marked increase in cases of COVID-19 across North Wales, which is creating additional challenges in relation to increased staff sickness subsequent impact on the timely submission of statements and reports to the Coroners. The Coroners have been updated on this and we are working closely with clinical teams to provide support and assistance to obtain timely statements.

CONCLUSION

This report provides the Quality, Safety and Experience Committee with information and analysis on patient safety including Nationally Reportable incidents and Never Events occurring in the last two months.

The QSE Committee is asked to note the report.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee May 2022
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 CEO
Awdur yr Adroddiad Report Author:	Julie Ward-Jones, Head of Quality Assurance
Craffu blaenorol: Prior Scrutiny:	Mathew Joyes, Associate Director Quality Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO
Atodiadau Appendices:	None
Argymhelliad / Recommendation:	

The Committee is asked to note this report.

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

Sefyllfa / Situation:

This paper provides an outline of quality related awards, achievements and recognitions for the period **February and March 2022** . 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:

Staff Wellbeing Award for BCUHB

BCUHB has won an award for its positive contribution to workforce wellbeing. This recognition was awarded by Case UK Limited who have identified individuals and organisations who they believe have gone above and beyond expectations to ensure Mental Health Support Services were being made accessible to their workforce.

Raising money for the Cancer Unit, Ysbyty Gwynedd, "Running for Mamma Warrior"

The daughter of an Anglesey woman who was diagnosed with 12 secondary tumours, has raised thousands of pounds for the cancer unit at Ysbyty Gwynedd that treated her beloved mum. In 2019, Suzie Roscoe's mum, Judy Tideswell, was diagnosed with something called "Cancer of Unknown Primary" after discovering multiple secondary tumours. Ever since, "Mamma Warrior" as Suzie now calls her has been receiving what she describes as "amazing care", and immunotherapy, via the Alaw Unit, at Ysbyty Gwynedd, more recently undergoing radiotherapy at Ysbyty Glan Clwyd.

Incredible £20,000 raised at the Rainbow Ball in aid of Wrexham Maelor's Children's ward

After being postponed three times because of the pandemic, the Rainbow Ball in aid of Wrexham Maelor's Children's Ward finally went ahead, on Friday 18th March at Carden Park, to huge success. All the profit from the Ball will go to buy medical equipment for the children and young people to enhance the patients' experience on the ward. Staff between them managed to sell 5,000 raffle tickets and the event was supported by principal sponsor SP Energy Networks and reception sponsors SG Estates, alongside other supporters. The energetic four piece outfit Big Beat band donated their performance that got everyone dancing, and they also did a well-received DJ set later in the evening. There was also a silent auction with variety of exciting prizes up for grabs such as sports and football memorabilia, and a live auction on the night with fantastic lots such as two tickets to attend the Queen's Platinum Jubilee Celebrations Concert taking place at the Queen's residence Sandringham in June.

Awarded over £900,000 from NHSCT's national Covid-19 urgent appeal

Two years since Boris Johnson announced the UK's first Covid-19 lockdown, Awyr Las is highlighting the incredible impact of support provided by the British public through NHS Charities Together's Covid-19 Urgent Appeal. Launched the same day lockdown started, Awyr Las in North Wales will ultimately be awarded over £900,000 from NHSCT's national Covid-19 Urgent Appeal. Since the start of the pandemic, Awyr Las has enhanced the well-being of NHS Staff, volunteers and patients impacted by COVID-19, in many ways. Moving forward, as part of the region's recovery from the pandemic, the funds from NHS Charities Together's Covid-19 Appeal can help fund. Additional mental health support for NHS staff, volunteers patients. An example is the Talking Therapies programme provides an early intervention for people experiencing low mood, anxiety and depression. The service is provided in partnership with Mind and Advanced Brighter Futures.

Tales of the Pandemic

An extraordinarily powerful book written by patients, volunteers and NHS staff in North Wales detailing their personal experiences of the pandemic is set to be published in July. 'Tales of the Pandemic' funded by Awyr Las, the North Wales NHS Charity and curated by BAFTA nominated writer Janys Chambers, is an often heart-rending but also ultimately uplifting read. The stories started coming in

after a call-out was sent to patients, former patients, volunteers, doctors, nurses, ambulance crew and other clinical and support staff, cooks, cleaners, families, relatives, friends, children – asking for their memories of the pandemic. The stories and poems clearly reveal how NHS staff responded so magnificently to the pandemic and are continuing to do so, and how patients valued the NHS as never before.

New website launched offering nutrition and education advice

The **Nutrition Skills for Life** Website will provide support and advice for people across Wales. This is supported by the Public Health Dietitians in Wales Network to provide practical support for healthy food choices and training. Cardiff and Vale University Health Board, on behalf of the Public Health Dietitians in Wales network, announced the launch of the Nutrition Skills for Life® website. This provides nutrition education and training for community staff and volunteers; supporting school, childcare and older adults care settings to improve food and drink provision and helping to introduce and facilitate community food and nutrition initiatives to widen access to a varied and balanced diet.

North Wales community pharmacies introduce 24/7 prescription collection service

Community pharmacies in North Wales are embracing modern technology to enable people to collect prescriptions 24 hours a day. Boots Pharmacy in Abergele is among the first in the region to introduce an automated prescription locker service. Patients who register for the service receive a text message with a unique PIN, which can be used to securely collect their prescription from a locker on the outside of the store, 24 hours a day. The machines, funded with support from the Welsh Government, have also been introduced at Fferyllwyr Llyn pharmacies in Dwyfor. They are expected to be introduced at a number of other pharmacies in the near future. The store in Abergele is the first of Boots' UK pharmacies to introduce an external automated prescription locker service.

Children and young people of North Wales to help develop Children's Charter

Betsi Cadwaladr University Health Board, in partnership with organisations and councils across North Wales, is holding a number of events and opportunities for young people to help write a Children's Charter, and create a lasting difference in areas that matter to them. A Children's Charter is a set of standards that organisations work to, to make sure children and young people are treated fairly and have a voice. The health board's Child and Adolescent Mental Health Services (CAHMS) and Neurodevelopment Services will be leading on series of events and engagement sessions across North Wales, in partnership with the National Trust Cymru, for young people and children to attend and be involved in creating the charter's standards.

BCUHB Welsh Learner of the Year 2022

On March the 1st, Betsi Cadwaladr University Health Board celebrated St David's Day with a ceremony to celebrate and congratulate their hard-working staff who have learnt Welsh. The ceremony was held at the Oriel Hotel, St Asaph. The winner of BCUHB Welsh Learner of the Year

2022 is Manuela Niemetscheck from Bethesda, an Art Psychotherapist in Hergest, Ysbyty Gwynedd, with second and third going to Anna Mackenzie and Mark Butler respectively.

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 3rd May 2022
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Vascular Steering Group Update
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Nick Lyons, Executive Medical Director
Awdur yr Adroddiad Report Author:	Neil Rogers, Acute Care Director
Craffu blaenorol: Prior Scrutiny:	None
Atodiadau Appendices:	Appendix 1: Vascular Improvement Plan Appendix 2: Draft Quality Impact Assessments of "Make Safe" models (pending further activity numbers)

Argymhelliad / Recommendation:

The committee is asked to receive the update from the Vascular Steering 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:

In September 2020, the Health Board commissioned the Royal College of Surgeons (RCS) to carry out an invited review of the BCUHB Vascular Service to include a review of clinical records. The reports from the RCS were received in March 2021 and January 2022 and have led to the development of a Vascular Improvement Plan. This plan also includes actions in response to results from national audits and incidents that have arisen within the vascular service.

The improvement plan is monitored through the Vascular Steering Group which meets on a monthly basis.

Clinical incidents within the vascular service are closely monitored and a review of incidents in early March 2022 led to the introduction of a series of "make safes" that were implemented on 11th March 2022.

An altered service model for the delivery of vascular services was then introduced for a period of 28 days from 17th March 2022 and was noted at an Extraordinary meeting of this Committee on 23rd March 2022 and a Public Board meeting on 30th March 2022. This altered service model included increased oversight of multidisciplinary team (MDT) decision making and an increase in consultant cover.

A further review of these arrangements took place on 24th March 2022 and an extension of this model was adopted to continue to 23rd May 2022. This model was noted at a Private Board meeting on 30th March 2022.

Cefndir / Background:

The Health Board implemented a hub and spoke model for delivery of vascular services in north Wales from April 2019.

External reviews continue to support this "consolidated service" model with a hub at Ysbyty Glan Clwyd (YGC) and spoke at Wrexham Maelor (WM) and Ysbyty Gwynedd (YG).

Asesiad / Assessment & Analysis

The improvement plan looks to develop the quality, safety and patient experience for the vascular services as well as ensuring the sustainability of the service, including the recruitment of staff.

Updated actions include:

- The appointment of a Professional Standards Vascular Lead for the Health Board, a widely respected vascular surgeon who has recently retired to the area
- Improvement work, and the support of Improvement Cymru in this, and the adoption of an Institute for Healthcare Improvement (IHI) methodology
- The involvement of the Health Board in the Vascular Community of Practice in Wales being led by Dr Allan Wardaugh
- The receipt of an application for the key role of Clinical Director of vascular services
- Recruitment for a Consultant Vascular Surgeon position being taken forward with an interview panel planned for May 20th 2022
- Closer working with the regional tertiary vascular centre in Liverpool University Hospital Foundation Trust (LUHFT) including the signing of a formal Memorandum of Understanding on 23rd March 2022
- A Patient Safety Culture Survey which will be completed by the end of April 2022
- A series of 1:1 meetings with the vascular consultants to consider the implication of the second RCS report and to review the expectations of the General Medical Council in *Good Medical Practice*
- A series of 1:1 meetings with NHS Locum Consultants to consider their future career options
- The commissioning of AQuA (Advancing Quality Alliance) to support the Human Factors Programme
- The Vascular Quality Panel has now met 3 times with the first meeting on 7th April 2022
- A survey of patient experience which demonstrated ongoing issues with communication with patients. This survey is being shared with staff and will contribute to ongoing work with the Professional Standards Lead.

Future actions include

- A workshop with the vascular team and the General Medical Council will take place on May 5th 2022
- CHKS, a provider of healthcare information, have completed a review of the outcomes for patients in the vascular service looking at the period before as well as after the adoption of the hub and spoke model. This report is now in draft and will be presented formally to the Vascular Steering Group in May

The service model that is in place until 23rd May 2022 remains under close scrutiny and a summary will be brought to the next QSE Committee. A draft Quality Impact Assessment for the service model in place until 23rd May 2022 is included as an appendix to this report and will be finalised when activity numbers have been further considered.

It is hoped that the return to a traditional service can take place on 24th May 2022 and a decision by the executive team will be based on

- A consideration of whether the enhanced MDT process has materially altered the clinical decision making
- A consideration of whether the enhance consultant cover has materially altered the clinical decision making or delivery of clinical care to patients

Opsiynau a ystyriwyd / Options considered

The need to ensure external validation and assurance of the effectiveness of actions within the Vascular Improvement plan remains under review

Goblygiadau Ariannol / Financial Implications

A detailed proposal of additional workforce requirements has been developed for the Integrated Medium Term Plan (IMTP).

Dadansoddiad Risk / Risk Analysis

The risk register remains under review and a contingency plan is under development should any staffing issues lead to a need to reduce the level of service cover

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Any legal implications in relation to the quality of consent are currently being considered. The Health Board is working closely with regulators in relation to professional standards.

Asesiad Effaith / Impact Assessment

Currently under consideration.

Vascular Improvement Plan (Revised October 2021)

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

Contents

Action Plan	Founded upon RCS review part 1 & 2, NVR performance report and internally guided improvement actions
Action Log	Driven by work stream meetings and internal actions
Issue Log	Driven by work stream meetings and internal actions
Risk Log	Relating to risks held on the risk register and their impact

Current Performance for Actions		
Complete	61	39%
In progress	67	43%
Not yet commenced	27	17%

Total	155

Category	Ref	Objective	Action	Lead	Executive Lead	Date 1	Date 2	Date 3	Date 4	Date 5	Status	Steering Group	Issue	Mitigation	Update
Pathways	4.1	Requirement for agreed and clear pathways to ensure timely and effective treatment at Hub and Spoke sites	Repatriation and rehab pathway to be completed, signed off and utilised for admission to spoke sites from the hub	Medical Directors	Executive Medical Director	01/04/2021	31/05/2021		20/04/2022	21/03/2022	In Progress	QSE via Vascular steering group	Further work required	Patients being co-ordinated between bed management teams on an individual basis currently	4 March - Awaiting information for how to proceed to CEG as CAG has been stood down. Pathways can then receive overall sign off and wider dissemination and placing on the intranet. 21 March - Signed off at extraordinary meeting with YCG CDs and Dep MD as CAG has been stood down - awaiting Exec endorsement. Currently being made uniform with all other pathways for addition to the intranet. 4 April Requires SOP from patient flow to support delivery.
Pathways	2 Internal		Create and disseminate Primary Care Pathways / guidance in relation to vascular conditions	Vascular Clinical Lead supported by GP Lead and Clinical Pathway Lead	YGC Medical Director				31/05/2022		in progress	BCU Diabetic foot group	Delay in commencing due to available capacity	Continued contact with GP lead via BCU diabetic foot meetings re vascular development	Clinical Director and or designated Vascular surgeon to work with Bethan to write guidance for primary care starting 2022. 4 March - meeting held with primary care and existing draft pathways shared for their view. Further meeting to be held to determine how their referral pathways feed into secondary care. 5 April - Primary care lead produced a draft pathway and currently in discussion with the newly appointed professional governance lead for development.
Pathways	4.1.5	Management of patients post major arterial vascular surgery (Repatriation) Pathway requires final sign off ensuring communication between hub and spoke regarding discharge and follow up is improved	All relevant clinical services at hub and spoke sites are aware of the pathway and have robust mechanisms in place to ensure discharge plans are communicated to relevant teams	Specialty Leads supported by, Vascular Network and DGMs all sites	Acute Site Directors supported by Medical / Nursing Directors	22/05/2020	27/01/2021		20/04/2022		In progress	QSE via Vascular steering group	Awaiting wider comms and SOP	As above - patients transfer where capacity allows back to spoke sites	Communication of the repatriation pathway once signed off. 5 April - All pathways added to BCU wide-pathways library to be linked to the vascular page (now created) so easily accessible. News story to be created in the vascular news feed for raising of awareness
Pathways	4.1.8	Pathways are required to enable non-complex / low risk peripheral vascular interventions to be undertaken (in line with VSGBI guidelines) mainly as day cases at spoke sites	Details for inpatient responsibility for patients requiring admission following general anaesthesia	Spoke site Medical Directors	Executive Medical Director	01/04/2021	30/06/2021		19/04/2022		In progress	QSE via Vascular steering group	Pending pathway proposal and meeting with Andy Baker and Keeley Twigg	Agreement for the pathway from East and West - simply needs disseminating and CAG approval	30 December 2021 = West have signed off, General Surgery at East in discussion with MD. 13 December - meeting planned for early February with CL for Gen Surg and Operational lead to discuss. 11 February update - as above, the Medical Directors are reviewing the pathways involving vascular input with their respective teams for sign off. Discussion are ongoing. 20 February - wider dissemination has been completed with a 1 week window for all to raise concerns over previously signed off pathways and will then proceed to CAG, 24 march 2022 - pending CEG in April for formal sign off and addition to intranet
Diabetic and Vascular patient management	4.2.15	Develop Non-arterial Diabetic Foot Pathway should be finalised urgently with involvement of all relevant teams	The diabetic foot pathway will be reserved as a live working document with reviews at 3 monthly (or earlier as indicated) reviews for any non-adherence or incidents stemming from pathway implementation. Full implementation can only occur once funding approved and recruitment complete	Medical Directors supported by and Specialty Leads / DGMs	Executive Medical Director			20/02/2022	31/05/2022		In progress			Soft launch of some of the immediate OPD management and primary consultants to manage care appropriately agreed. Need recruitment before full implementation	4 March - Pathways agreed in principle. Methodology of how we can begin implementation ahead of the resource being made available is under discussion with clinicians, DGMs and medical Directors. 21 March - signed off at YGC CD and AMD meeting ahead of CEG. CAG has been stood down. 5 April - added to BCU pathway library with a plan to add to the vascular news story and page for raising awareness
Diabetic and Vascular patient management			Consideration of appointment for a network wide orthopaedic surgeon with special interest in vascular to support the foot salvage service across all sites	Medical Director (Hub)	Executive Medical Director	01/04/2021	30/06/2021	31/03/2022	TBC		In progress		Escalated to Medical Directors	Currently being covered by existing orthopaedic clinicians	Discussed with Gareth Evans 8/10/21 No current progress on this consideration to date. May depend on the outcomes of Orthopaedic surgeon discussions in the first instance at this stage. 25 November update – Unsure that this requirement is necessary - to discuss at Vascular oversight group 10/12/21 30. 30 December - communicated to Medical Directors for review as not yet progressed with no sign of requirement for the post unless allocating to existing staff member. 5 April - Discussions are taking place in relation to appointment of an orthopaedic surgeon to cover West and Centre and provide cross cover as needed.
Governance	4.1.9	Improvements are required in line with improving the effectiveness of clinical governance	Audit of processes to ensure that agreed changes to clinical practice arising from shared learning are effected	Vascular Clinical Governance Lead	Vascular Clinical Lead supported by Interim Deputy Exec Medical Director			30/12/2021	31/05/2022		In Progress		Awaiting audit outcomes		11 Feb update - Collation of learning to be completed and made reference to for governance meetings and datix events in light of similar incidents. Requires resource for governance to ensure robust included in the vascular improvement funding scheme
Governance	4.1.9		Clarify the requirements for the process of root cause analysis for relevant criteria of major amputations	Vascular Clinical Governance Lead	Vascular Clinical Lead	01/04/2021	31/05/2021	31/10/2021	30/04/2022		In progress		Not presented as planned, deferred to March 22 meeting	Recent review of all major amputation mortality by MDT as per NVR section below	10 November update - discussed at the clinical governance meeting on 9 November - Aw SS response. 25th November update: RCA proforma to be presented at the next governance meeting 10/12/21. 13 December update - not completed as yet - deferred to January 18th CG meeting. Requested that the proforma be shared prior to presentation for review. 17 January update - not yet complete - draft version sent to CD for review and input.
Governance	4.2.13	Improve effectiveness of M&M meetings enabling comprehensive MDT discussion and shared learning	Audit to ensure that there is a robust process to discussion of all mortality and morbidity and carry forward of discussion to nest meeting as needed	Vascular Clinical Lead	Medical Director			30/12/2021	30/04/2022		In progress			Mortality tool updated for the vascular dashboard to make easy reference to mortality patients	Review of cases discussed and cases pending discussion prior to and following each CG meeting
Theatres	3	More effective use of the Hybrid Theatre	Review theatre capacity and ensure all pre-covid lists are returned	YGC Surgical DGM	YGC Acute Site Director			01/11/2021	31/05/2022		In progress	QSE via Vascular steering group	Covid 4th wave - currently on hold	DGM to look at reinstating with additional staffing	Alternate Monday all day case list removed during covid. 25th November update - issues with theatre staffing prioritising lists in place due to staffing. 11 February update - meeting with Theatre manager and DGM YGC - to aim to have the all day alternate week Monday list back with additional staffing.
Theatres	5		Increase access to Interventional Radiology sessions - Lack of interventional radiography (IR) sessions making theatre allocation more difficult into appropriate session.	BCU Radiology Lead	Executive Medical Director			10/12/2021	31/08/2022		In progress		Lack of available IR consultants to recruit	BCU Radiology Lead picking up vascular sessions	3 year plan for radiology to support recruitment to this specialist discipline. IR radiographer leaving January 22 seeing depleted IR sessions available.
Theatres	6		Require increased access to emergency theatres to prevent cancellations of elective cases	YGC Surgical DGM	YGC Acute Site Director			10/12/2021	TBC		Not yet commenced	QSE via Vascular steering group	Covid 4th wave - theatre staff issue	Emergency cases being completed in hybrid theatre and CEPOD list as available	Vascular emergency cases can be lengthy and it is not ideal for them to make use of the general CEPOD list for this reason. Additional capacity required for emergency sessions. 17 January update- Liaise with DGM for theatre to iterate clinical urgency for fistula patients for which the alternate week Monday list is utilised to free up space within the hybrid theatre for waiting list and emergencies. 11 February update - an all day theatre list for vascular emergencies has been factored in to the vascular improvement resource requirements although staff not available to support this currently.
Theatres	4.1.3		Commence lists on time using 'golden patient model'.	Theatre Manager supported by Critical Care Lead YGC and operational lead manager	Vascular Clinical Lead supported by YGC Surgical DGM	01/04/2021	28/05/2021	01/12/2021	31/05/2022		In Progress	QSE via Vascular steering group	VSG Review please	Current fistula cases added wherever possible (surgical skill dependent) before ITU cases to improve start times and utilisation	17 January update - consider VSG to review this as deemed not a viable proposal given the case mix of patients assuming that all day Monday fistula list returned. Discussed using the fistulas with Vascular anaesthetist as golden patients who felt this was unrealistic and that a proportion of these cases are not straight forward.
Vascular presence	4.1.4	Vascular presence at Spoke Sites	Audit via Datix the failure to review patients within 24-48 hours	Vascular Clinical Lead supported by Patient Safety Lead	Medical Directors			30/12/2021	30/04/2022		In progress	QSE via Vascular steering group			11 February update - no incidents raised to date from September. 31 March - none raised - requested governance team to complete a datix review
Vascular presence	8		Full capacity and demand exercise requires completion across all sites.	DGMs Surgery all sites supported by Vascular Network manager and Vascular Clinical Lead	Acute Site Director (Hub)	01/04/2021	30/06/2021		31/05/2022		In progress		Pending BCUHB Demand data and 1st draft capacity by due date	Demand work is currently ongoing from informatics to support this review	All sites are covered with locum backfill for shortfalls in the short term. 24/10/21 Recruitment of additional consultant to cover spoke site will alter the current working pattern for surgeons based at the spoke site. 16 November update - requested demand data from informatics - work will shortly commence to review the current capacity and the potential capacity with recruitment and MG cover. 25 November update - Capacity work has commenced. 17 January update - This action will be delayed due to capacity issues along with leave. 5 April - requested for vascular to be priorities for BCU demand review

Category	Ref	Title	Description	Lead	Responsible	Start	End	Date	Due Date	Status	Governance	Col	Mitigation	Update / Notes
Spoke V	4.2.17		Gap analysis of Junior / middle grade and Consultant vascular staff to be included in BCU pan business case. Additional Deanery and non-training grade vascular surgeons required to allow for learning opportunities at spoke sites and to reduce reliance on general surgery trainees	Vascular Clinical Lead supported by Vascular network manager	Medical Directors	01/04/2021	30/06/2021		30/04/2022	In progress		1st draft capacity by due date. Modelling work complete	Use of Locum middle grades to support aspects of the vascular service	16 November update - Middle grade rotation inclusive of long day on call, weekend on call and spoke site rotation is underway. Supported by Medical workforce, a rolling job plan has been created to identify the number of MGs, the PA allocation and therefore the salary can be reviewed on this basis. Funding approval will be required and lead time for recruitment and start dates. 1 PA has been factored into the establishment requirements for ward and junior Dr support. 17 January update - further work has been requested from workforce to model a 24/7 on call for vascular model **5 April** - Requested workforce to update the model for 24/7 cover - meeting 22 April to review further
Audit	4.2.14	6 Audits identified by vascular T&F group to be undertaken using national vascular registry (NVR) data should be progressed as part of assessment, evaluation and shared learning	Audits on the following for completion: * Same Day discharge following endovascular intervention (FS) Complete * Timeframes for lower limb bypass or endovascular revascularisation procedure for patients admitted with CLI as emergency (AR) * Below, through and above knee amputations since centralisaiton (AR) Completed * Carotid endarterectomy - time from symptoms to referral, referral to surgery and outcomes (RF) Completed * AAA timelines for referral to surgery open & EVAR and outcomes (LP) * Complex aneurysm repairs EVAR / Open and outcomes (SS) Awaiting * Conversion of below knee amputation to through and above knee (AR) Completed	Vascular Clinical Lead	Executive Medical Director	01/04/2021	30/06/2021		26/04/2022	In progress	Vascular CG	Annual Leave prevented presentation of all outstanding audits at December meeting	There is audit progress overall that are presented at the clinical governance meetings however the tow identified remain outstanding	Awaiting details on the outstanding audit subjects. New Audit lead appointed given Mr Taha's leave. Faisal Shaikh now leading. 15/10/21 Same Day Discharge following endovascular intervention - complete / presented 24/10/21 - Update from Soroush 4/7 completed and potential further 2 awaiting presentation, awaiting confirmation from audit leads 10 November update - 3 audits outstanding completion / presentation - aim to be presented 10/12/21 13 December update - 4 audits to be presented at January 18th 2022. Need to extend meeting from half to full day to accommodate. 17 January update - 1 audit presented from the list, 2 more remaining to be presented. 9 march - Insufficient time to present AAA timelines due to agenda items on meeting and 2 other audits. 5 April - emailed consultants to prepare audits for 29th April CG meeting - awaiting response
Additional Reco	4.3.20	Additional Recommendations	Develop a plan to maintain stability and attract further clinicians - consider joint appointments opportunity with LUHFT	Deputy Director operational Workforce	Medical Director	01/04/2021	30/06/2021	20/01/2022	31/05/2022	In progress			Locum use in place to cover existing shortfalls	Advert to be placed for Vascular Surgeons by Medical Director as a rolling 6 monthly action 5 April - Advert has closed and has one applicant for consultant post
Communication	9	Completion of Comms section on intranet	The dedicated (outward facing) vascular services page on our website is under development to include a patient stories section, a 'meet the team' component and pictures and video content to demonstrate the high quality facilities and equipment available	Communication Lead	Acute Site Director YGC	01/04/2021	30/06/2021		31/05/2022	In progress	QSE via Vascular steering group	Risk to delivery by due date On hold pending report from notes review		Work is currently being undertaken to migrate the current intranet platform to a new one - no additions will be made until this work is completed with a potential start date for early next year. 17 January update - work is currently on hold pending secondee RCS report. 5 April - Comms updates have retained a responsive focus for the RCS 2nd stage review and actins taken to support the service. This action is on hold currently
Communication	9	Development of Communications plan	To support the North Wales vascular service and highlight the progress being made, a communications plan is under development and will be reviewed by the Vascular Steering Group.	Communication Lead	Acute Site Director YGC	01/04/2021	30/06/2021		31/05/2022	In progress	QSE via Vascular steering group	Risk to delivery by due date On hold pending report from notes review		Further information required from the clinicians to complete the works for comms to share. Progress to date has been filming in the hybrid theatre an supply of 2 of the clinicians bios and photographs. 17 January update - work is currently on hold pending second RCS report.
Action Plan	10	Review of all risks to ensure captured in the risk log	Risk from all of the above actions are to be logged in the risk log and scored accordingly as to impact with current mitigations detail	Vascular Network Manager supported by Project support	Acute Site Director YGC	01/04/2021			ongoing	In progress	QSE via Vascular steering group		ongoing action	24/10/21 Revised action plan in 1st draft for review at the vascular steering group 25th October 2021 30 December - updated action plan reviewed at VSG 16 December 5 April - all risk register items are contained within the risk log tab below and will kept updated
Action Plan	11	Review of all issues to be added to the issue log	Issues from all of the above actions are to be logged in the issue log and scored accordingly as to impact with current mitigations detail	Vascular Network Manager supported by Project support	Acute Site Director YGC	01/04/2021			ongoing	In progress	QSE via Vascular steering group		ongoing action	Risks and Issues to be fixed agenda item on the CG meeting.
NVR Actions	13	Incomplete data entry for NVR submissions	Improve data entry for IR cases across BCU	BCU Radiology Lead	Executive Medical Director			01/12/2021	31/05/2022	In progress		Requires resource from vascular improvement scheme	BCU radiology lead exploring options to improve	IR consultants required to add NVR data / funding approval and recruitment required to support the B2 data entry person for vascular entry. 30 December - emailed Helen Hughes to escalate the issue. **21 January update** - meeting held with Helen Hughes - she will speak to clinicians re data entry for vascular patients. NVR data entry person would need to support - see below point in line with funding requirement for Band 2 data entry clerk Pending funding approval from HB
NVR Actions	13		Require NVR data entry person	Vascular Network Manager	Acute Site Director YGC			01/12/2021	31/05/2022	In progress		Requires resource from vascular improvement scheme	None until resource available	Funding approval and recruitment required, submitted as part of vascular improvement for IMTP **17 January 2022** - SBAR to be submitted to acute site director for funding to expedite Pending funding approval from HB
NVR Actions	14	Cross ref to action point 6	Improve access to emergency theatres for Lower limb revascularisation / carotid endartectomy / carotid patients / major amputation	YGS Surgical DGM	Acute Site Director YGC			01/12/2021	TBC	Not yet commenced	QSE via Vascular steering group	On hold for covid	The use of CEPOD lists in addition to theatre L for emergencies is in place	Discussed with Acute Site Director (Hub) - need to review the possibility for additional emergency theatres. Additional CEPOD list in place Fridays although not specific to vascular but increased access. Escalated at oversight meeting 21/1/22 the need for the alternate Monday all day DC list to be returned to free up a little capacity from renal access patients Meeting held with Hub DGM Surgery 10 February and assured that all efforts to be made to return the pre-covid alternate Monday list. Require resource approval for vascular improvement scheme and recruitment to allow for additional all day emergency list
NVR Actions	3	Cross ref from above for theatres	Review theatre capacity and ensure all pre-covid lists are returned	YGC Surgical DGM supported by Theatre Manager	Acute Site Director YGC			01/11/2021	31/05/2022	In progress	QSE via Vascular steering group	Covid 4th wave - issues with staffing	Cases previously completed on day case list now being added to hybrid theatres	Alternate Monday all day case list removed during covid 25th November update - issues with theatre staffing prioritising lists in place due to staffing. **11 February update** - meeting with Theatre manager and DGM Surgery YGC - to aim to have the all day alternate week Monday list back with additional staffing.
NVR Actions	16	Prophylactic Antibiotics	Review the use of prophylactic antibiotics for amputees	Vascular Clinical Lead supported by microbiology lead	Medical Director				31/05/2022	In progress	Vascular CG		Previous audit shows good performance. Possibly relates to NVR data entry	Refer to major amputation audit 18 January 2021 - 100% patient had prophylactic antibiotics. Performance through to be linked to data entry. Will re-audit later this year to confirm.
NVR Actions	17	MDT Review	All emergency patients to be discussed with intensivist, anaesthetics and relevant acute medical specialty prior to surgery taking place if unable to discuss at MDT meetings. Out of hours to use on call.	Vascular Clinical Lead supported by specialty leads	Medical Director				30/04/2022	In progress	Vascular CG		Audit to be completed on cases since 10/12/21 when team informed at CG meeting	11 Feb 22 update - Patient details and MDT outcomes received - need table top exercise to review the notes for confirmation.
NVR Actions	17		All amputation decisions taken outside of the NW MDT forum are to be documented	Vascular Clinical Lead supported by specialty leads	Medical Director				30/04/2022	In progress	Vascular CG		Audit to be completed on cases since 10/12/21 when team informed at CG meeting	
NVR Actions			Consider patients with significant co-morbidities carefully by the full MDT / mini MDT for either conservative treatment of above knee amputation to reduce the risk for further interventions ,	Vascular Clinical Lead	Medical Director			10/12/2021	30/04/2022	In progress	Vascular CG		Audit to be completed on cases since 10/12/21 when team informed at CG meeting	
NVR Actions	18	Reporting	Ensure action plans monitored through vascular steering group and clinical effectiveness groups	Vascular Clinical Lead supported by Sally Morris	Acute Site Director YGC				TBC	In progress / ongoing			Monitored at VSG monthly	

Ref	Recommendation	Action	Lead	Responsible	Start	End	Revised	Status	Governance	Assurance	External validation	Comments
20 Internal	Further review of cases informed by (1) and (2) for identified pathways or team including an assessment of whether the cases reviewed were representative	TBC by initial review	Safety and Quality Lead	Hub Medical Director	TBC	TBC		Not yet commenced	QSE via Vascular Steering Group	Plan is progressing	1.Consider external validation of summary from Vascular Society or Liverpool 2. Methodology for review process to be approved at QSE	ToR and scope to be confirmed by initial review - ToR and reporting structure confirmed as of 10/3/22
4.1.1	Ensure patients receive communication in line with regulatory responsibilities	Patients and/or families within (1), (2) and (3) receive updates and clear communication on any need for further treatment and duty candour fulfilled where care has fallen below expectations	Safety and Quality Lead	Hub Medical Director	04/02/2022	TBC		In progress	QSE via Vascular Steering Group	Plan is progressing		
4.1.2	The outcome for patients in all 47 cases (and in addition where needed in patients in (2) and (3)) identified and duty of candour fulfilled	Summary of outcomes to be reported and any impact on current audit outcome reporting considered	Vascular Clinical Lead	Hub Medical Director	TBC	TBC		Not yet commenced	QSE via Vascular Steering Group	Plan is progressing		External validation from NVR or CHKS to be considered
4.2.7 Internal	The Health Board should ensure that current practice in patient record keeping meets national standards as set out by RCS, GMC , NMC and HCPC across BCUHB	Detailed audit leading to clear improvement plans for notes and documentation including MDT discussions and consent and the development of internally owned professional standards as a part of clinical audit plan 22/23	HMT and Clinical Effectiveness Lead	MD / DoN / DoTh	01/04/2022	31/03/2023		In progress	QSE through annual clinical audit programme	Weekly notes audits completed on each site - feedback to teams		
21 Internal	Review of current Clinical Lead Vascular Service Role	Review to ensure capacity and expertise available to lead change in the service	Hub Medical Director	Exec Medical Director	26/01/2022	30/04/2022	08/04/2022	In progress	QSE via Vascular Steering Group	Interim additional leadership capacity appointed pending formal appointment and external validation/support		Pending agreement for a vascular surgeon to provide interim support - interviews planned for 8 April
4.1.4, 4.2.9	Review of MDT arrangements for vascular	Quality assurance of MDT process. To be supported by Liverpool vascular team for formal structure and challenge into clinical decision making	Hub HMT	EDICS	28/02/2022	30/04/2022		In progress	QSE via Vascular Steering Group	Liverpool involved in shorter term before formal QA commissioned		Agreement in principle agreed with Liverpool. 7/3/22 MoU now formalised and forwarded to Liverpool MD Plan to adapt Liverpool methodology for structure and function of MDT MoU signed by Liverpool - costing now needs to be agreed **5 April** - arrival of professional governance lead who has been in attendance of an supporting the MDT
4.1.4	Review of MDT arrangements across BCUHB	Audit programme 22/23 to review standards of MDT across BCUHB	Health economies	EDICS	01/04/2022	31/03/2023		Not yet commenced	QSE through annual clinical audit programme	Interim CD and MD attending and supporting MDT		Use of MDFiT or similar validated tool
22 Internal	Review consent taking practices across BCUHB	Audit programme 22/23 to review standards of MDT across BCUHB	Ethical Lead	Hub Medical Director	01/04/2022	31/03/2023		Not yet commenced	QSE through annual clinical audit programme	Weekly notes audits completed on each site - feedback to teams		
24 Internal	Improvement methodology to be consistent with the approach adopted across the wider Health Board	Transformation team to be involved in development and oversight of the Vascular Improvement Plan	Director of Transformation	Director of Transformation	01/03/2022	31/05/2022		In progress				Initial meeting held 8/3/22 17 March - transformational plan in progress
25 Internal	Improvement of clinical record keeping	Prioritise vascular services for piloting of Digital Health Record (DHR)	Clinical Lead Vascular Service	All Med Directors/ Director of Digital	14/02/2022	Ongoing		In progress	PPPH	Weekly notes audits completed on each site - feedback to teams		DHR project trialling MDT proforma use at NW MDT meetings 5 April - modifications to the system are being made alongside the implementation of the electronic MDT proforma
26 Internal	Review the case sampling to ensure that the notes reviewed provide a representative sample of the service before and after centralisation	Investigate the sampling and sign off of the notes to understand the practice followed	TBC	TBC	TBC	TBC		Not yet commenced				
27 Internal	Develop clinical workforce	Review of current establishment and roles	Vascular Clinical Lead	Hub MD / DWOD / DoN / DoTh	01/03/2022	30/04/2022		Not yet commenced				Need for workforce review in RCS report 1 17 March 22 - Advert placed for Consultant and Specialty Doctor 11 March 22 5 April - potential CD being interviewed on 8 April
28 Internal	Support for vascular service in understanding Good Medical Practice and professional standards	Workshop with GMC planned on Good Medical Practice; Consent and record keeping with support from NMC / HCPC	Hub Medical Director	Exec Medical Director	25/02/2022	05/05/2022		In progress		Meeting planned with GMC/ HIW for sessions delivery to vascular team		Under discussion with GMC and need to ensure regulatory role of GMC does not conflict with formative workshops Workshops planned 29/3/22 for consent and record keeping
29 Internal	Review of regulatory implications from review	Ensure follow best practice and work with PPAS and GMC	Hub Deputy Medical Director	Hub Medical Director	TBC	TBC		Not yet commenced		Planned meeting with all senior clinicians to discuss expectations		Initial discussion with GMC on 27.2.22
30 Internal	Review of escalation processes	Ensure best practice for escalation and early intervention	All Medical director and All Nurse Director	DoN	TBC	TBC		Not yet commenced				
31 Internal	Develop clear levels of assurance for committee structure	Ensure proper scrutiny in place	Director of Governance	EDICS	TBC	TBC		Not yet commenced				
33 Internal	Understand any learning for the Board regarding visibility of, and escalation of, issues within a service under close scrutiny	Detail TBC	Hub Director of Nursing / Hub Medical Director	Board TBC	TBC	TBC		Not yet commenced				Dates suggested for next steps = awaiting update
35 internal	Development of Vascular SOP	Completion of a document that defines what vascular are and do also containing all pathways for reference	Hub Medical Director	Exec Medical Director	22/02/2022	30/04/2022		In progress				
36 internal	Review of Vascular POAC arrangements	Review the process and criteria for vascular patients and CPET review prior to surgery	Anaesthetic leads	All Medical Directors	09/03/2022	30/04/2022	24/03/2022	In progress				Meeting planned for 16 march 2022 - CPET equipment and additional sessions included in the vascular improvement funding scheme. 24 march update - agreement from Bangor to support all site CPET scanning for AAA patients and cross charge to vascular ahead of the funding approval Further review needed in order to ensure that all patients have a clearly identified procedure for anaesthetists to assess the patient for - discussion with team needed.
38 internal	Working with the senior leadership team to support their professional roles as leaders	GMC contribution to leadership team x 1 half day: senior leadership expectations and responsibilities, raising and acting on concerns FtP process and thresholds	GMC link	Exec Medical Director	08/03/2022	24/05/2022		In progress			Executive MD to liaise over dates	Initial meeting 7/3/22 Provisionally 24 May for senior leaders to receive a full workshop
		Interactive professionalism workshops with doctors and doctors in training, to support them in delivering safe care	GMC link	Exec Medical Director	08/03/2022	05/05/2022		In progress			Executive MD to liaise over dates	Workshops planned 29/3/22 and April 2022 and further session 5 May with GMC/HIW
		Maintain dialogue with HIW and secure commitment to joint delivery in key areas in particular record keeping and leadership	I Jones	Exec Medical Director	25/0/2/22	05/05/2022		In progress				Provisionally 5 May session jointly delivered GMC link
39 internal	Provision of professional support for clinicians	Engage HEIW with QAMI to ensure training concerns are being considered	S Mosley	Exec Medical Director	25/02/2022	20/04/2022		In progress				

Category	ID	Issue/Risk	Action	Responsible	Lead	Start date	End date	Revised date	Status	Governance	Extra	Funding	Comments
			Sessions with leadership and case management teams regarding GMC concerns management processes and thresholds	GMC link	Exec Medical Director	TBC	TBC		Not yet commenced				Phase 2
			Secure NMC and HCPC commitment to ongoing joint work where appropriate regarding professional behaviours and consent	GMC link	Exec Medical Director	25/02/2022	20/04/2022		In Progress				Relevant parties have made contact with HCPC and meeting for 15/3 confirmed. Awaiting a response from the NMC
	41 internal	Review of air flow in hybrid theatres	Independent review from NWSSP special estates service	Assoc Director of Planning	Exec Medical Director	09/03/2022	30/04/2022		In progress	QSE via vascular steering group			
	42 internal	Improved documentation	Snap shot audit to be repeated of 20 sets of notes	Safety and Quality Lead	Exec Medical Director	31/03/2022	31/05/2022	01/04/2022	in progress				Initial snap shot completed 1/4/22. Further 20 snap shot completed 8/4/22 by professional governance lead and acting network manager.
	44 internal	Working with the Board to support their role as professional leaders	Preliminary session to be followed by GMC roles and expectations, standards and processes	GMC Link	Exec Medical Director	TBC	TBC		Not yet commenced				
AAA Pathways	45 internal	AAA surveillance management - 2 routes of entry for AAA patient with differing management across BCU and lack of central records	Upload of Betsi wide SharePoint to collate all WAASP referrals from each site to allow for robust check and challenge with operational and clinical teams	Informatics Lead - Hub	Acute Site Director - Hub	11/03/2022	20/04/2022		In progress	Vascular CG			Initial meeting with Ann Pierce - business mandate completed for AAA processes. Awaiting update form informatics
			Review of distribution mailing list and delivery point for the WAASP referrals	Operational Managers Each Site	Acute Site Director - Hub	11/03/2022	30/04/2022		In progress	Vascular CG			Sue Jackson from Public Health keen to keep the distribution list small. Need to review deputies for each allocated person
			All WAASP referrals to be added to the MDT list for awareness prior to POAC etc. and for further clinical management decisions following this	MDT Co-ordinator / equivalent	Operational Managers Each Site	11/03/2022	TBC		Not yet commenced	Vascular CG			
			All WAASP referrals to be discussed at weekly AAA meetings (site attendance compulsory - local Directorate management oversight)	ANPs all sites	Operational Managers Each Site	11/03/2022	30/04/2022	12/04/2022	In progress	Vascular CG			Managed by ANPs across BCU - needs to have Ops oversight - emailed 6 April for inclusion of ops leads or deputies.
			BI and radiology to review and update of methodology for collation of surveillance patients to ensure that they are scanned and managed in line with guidance	Radiology Lead / Informatics lead Hub	Radiology Lead BCU	11/03/2022	TBC		Not yet commenced				
			ANP on each site to be accountable for all AAA surveillance lists - Requires funding	HoN All sites	Acute Site Director - Hub	11/03/2022	TBC		Not yet commenced	Vascular CG		Some funding approved	1 ANP for YGC currently covering both YGC and YG has now resigned. Need to recruit at pace to cover the pending gap
			PABC Managers to identify vascular capacity shortfalls to the weekly OPD planning meetings	Operational Managers Each Site	Acute Site Directors	11/03/2022	30/04/2022		In progress	Vascular CG			
			Any urgent appointments to be escalated to the WL management meetings for capacity concerns	Operational Managers Each Site	Acute Site Directors	11/03/2022	16/04/2022		In progress	Vascular CG			High risk slots made available at YG for such patients - need confirmation of the same from WMH and YGC. 6 April new triage form developed at WMH for PABC to escalate if cant meet timeframe requirements
Workforce	46 internal	Insufficient administrative teams to support the service across BCU - impacting upon typing backlogs, tracking AAA patients, theatre booking	Review of and completion of any backlog in letter typing	Operational Managers Each Site	Acute Site Directors	01/02/2022	20/04/2022		In progress		YGC worst position - agency typist supporting		4 April YGC now at 91 letters (from 120), 102 for YG (10 days time lag), Awaiting WMH Additional temporary resource in place to clear and updated each week at operational meetings
			Recruit admin teams the required level. Included in VIP funding request	Operational Managers Each Site	Acute Site Directors	01/02/2022	31/05/2022		In progress			Some funding approved	ECRs approve for some admin at 3 sites which will improve the ability to monitor this group of patients in the short term 5 April - approval gained for all of YG requirement, part of central and part of East requirements.
	47 internal	Inadequate nursing and therapy workforce with pending maternity leave compounding the issues - Unable to sustain a high level of care for inpatients	12 months strategy to consider the use of more premium rate agency to support the current gap and enable 23 beds to be safely staffed (also enabling the ring fencing of vascular beds) for both nursing AND therapy services to ensure minimum 5 day input	HoN and DoTh all sites	Acute Site Director - Hub	01/02/2022	31/05/2022		In progress	QSE via the vascular steering group			
		Lack of consistent ANP provision across BCU	Recruit ANP to Bangor and YGC to form a robust AAA nurse led pathway	HoN each site	Acute Site Director - Hub	28/02/2022	30/06/2022		In progress	QSE via the vascular steering group		Some funding approved for Bangor only	ANP at Centre has resigned who is currently covering Bangor AAA patients. Urgent requirement to recruit 5 April - Funding approved to advertise the ANP post at Bangor, ECR been completed to progress with Centre.
	48 internal	Medical Workforce	Approval and recruitment of MGs in line with the vascular improvement funding scheme allowing for 24/7 on call for vascular cover and also backfill for consultants annual leave	Vascular Clinical Lead	Medical Director Hub	01/02/2022	TBC		In progress	QSE via the vascular steering group		Some funding approved	31 March - Pending arrival of new recruits, there may be ability to implement steps towards a 24/7 model Pending funding approval from HB and WG
			Review of the consultant of the week / day model	Vascular Network Manager supported by professional governance lead	Vascular Clinical Director	TBC	31/05/2022		Not yet commenced				
			Vascular SOP to include processes for management, induction and support of new medical workforce.	Operational team Hub	Hub Medical Director	TBC	31/05/2022		Not yet commenced	QSE via the vascular steering group			
Transfers	49 internal	Review of the patient flow aspects to the emergency pathway to optimise safe and efficient transfer for all vascular emergency patients	Ring-fencing of vascular beds to enable the emergency pathway to be implemented and optimised	Heads of site	Acute Site Directors	10/03/2022	30/04/2022		In progress	QSE via the vascular steering group	When beds are not available pts are transferred out to make a vascular space		
	50 internal	Emergency transfers from spoke to hub	Ensure 'mini MDT' occurs with intensivist, anaesthetist, vascular surgeon prior to agreement to transfer to the hub for intervention	Vascular Clinical Lead	Medical Directors	30/03/2022	30/04/2022		In progress				
	51 internal	Potential for patients to have their treatment plans delayed that could lead to deterioration in condition	Review of the patient flow aspects to the emergency pathway to optimise safe and efficient transfer for all vascular emergency patients	Heads of site	Acute Site Directors	17/03/2022	30/04/2022		In progress				
Engagement	52 internal	Delay in the referral / triage / prioritisation process leading to potential delays in patient management. Potential delay in follow up appointments and further interventions	Validate the X-reports	DGMs all sites	Acute Site Directors	17/03/2022	31/05/2022		In progress				31 March - YGC currently in worst position. Initial meeting with Medical Physics to review options to clear ABPI backlog and support reduction of the x-report. Validation in progress
			Calculate patient numbers and waiting times for ABPIs / diagnostics	Informatics Lead	DGMs all sites	17/03/2022	20/04/2022		In progress				4 April it is thought that the bulk of patients awaiting ABPI currently are those identified on the X-report. It is noted however that through clinical validation of the FUWL backlog, there may be further ABPI requests
			Review the potential for GPs to have access for direct access for vascular referrals	Informatics Lead	Acute Site Directors	TBC	TBC		Not yet commenced				
			Consider pooling resources across BCU for diagnostics to reduce the waiting time	Site Medical Directors	Executive Medical Director	17/03/2022	TBC		Not yet commenced				
			Carry out Value Stream Mapping of process from point of referral to discharge on all three sites, undertake a gap analysis from current service state to ideal service state, prioritise actions; quick wins, high impact, recognise significant cost maybe associated with changes	Vascular Network Director	Acute Site Director Hub	17/03/2022	31/05/2022		In progress		Rescheduled due to pivotal stakeholders having Covid		Initial meeting YG planned 22/3/22. rescheduled for 11/4/22

											Status					
Referral management		interventions	Directorate teams to evidence weekly management of demand	Operational teams all sites	DGMs all sites			17/03/2022	TBC		Not yet commenced	Operational network meetings				
			Validation of and clinical review of the 750 patients (YGC) follow up waiting list is required - funding required	Operational teams all sites	DGMs all sites			17/03/2022	01/05/2022		In progress					5 April 100% FUWL at YGC now 416, awaiting updates from Spokes.
	4.1	Requirement for agreed and clear pathways to ensure timely and effective treatment at Hub and Spoke sites	Diagnostic and assessment services should be available in a timely manner. CT / MRI / Sonography etc.	BCU Radiology Lead	Executive Medical Director	01/04/2021	31/05/2021		31/08/2022		In Progress		Regular review of Diagnostics waits. CT / MR compliant but sonography requires investment and recruitment lead time	Facilities available at WMH and YGC		25th November update - met with Helen Hughes, report being prepared for 26th to update the board on the progress in recovery relating to diagnostic waits. They are now meeting the Welsh Health Board guidance for 2wk wait for Urgent and 8 Wk. for routine for both CT and MR. Sonography is not yet meeting the targets and is not possible until the resource requirements are addressed to provide the staff to scan. Date has been realistically amended from 1 December to 31 March to allow time for both business case approval and recruitment of staff to achieve the desired timescales for sonography waits. All other locum routes etc. have been exhausted. Regular meetings planned to discuss progress to date and radiography are including this on their action plan. **19 January update** - Despite advertising for sonography post for Bangor - unsuccessful as yet. Plan instead to train our own sonographer and requires a 2 year plan for training completion.
28 Day Plan	53 internal	Recent SIs have lead to additional Make Safes being required for the service	Develop a robust system for image sharing with LUHFT to aid discussion of complex cases	IT lead supported by radiology lead	Acute Site Director Hub			31/03/2022	20/04/2022		In progress					
			Develop a 2nd on call tier for the extended 28 day plan	Operational team YGC	Acute Site Director Hub			01/04/2022	16/04/2022		In progress					
			Weekly monitoring and feedback to Exec team	Vascular Clinical Director	Acute Site Director			30/03/2022	23/05/2022		In progress					
INC 283017	54 internal	Ensure safe and timely transfers between hospitals	Review the actions behind the emergency pathway from WAST and patient flow perspective	Vascular Network Director	Acute Site Director			21/03/2022	30/04/2022		In progress					
		Interprofessional Standards reiteration	Reiterate professional standards in relation to management of referrals	Medical Director Hub	Executive Medical Director			21/03/2022	30/04/2022		In progress					

Action Number	Work stream	Action Description	Action Owner	Action Date	Action Deadline Line	Revised Action Deadline	Issues affecting delivery	Remedial Action - In Place or Planned	Action Complete Date	Action status	Comments	Assurance (how do we know the action has been delivered and
	Spoke site engagement	Joint job planning - consider team job planning with spoke sites to cover all required activity	Sally Morris / Cheryl Goodall / Alison Davies	03/11/2021	28/02/2022	31/05/2022				Not yet due OR In Progress	Completed for WMH Hassan Jararah. Draft completed for Bangor Ruwan Fonsekah	
	Capacity and demand	Capacity and demand for WMH required	Alison Davies	06/11/2021	20/11/2021	31/05/2022		SM commenced capacity - on hold as currently no capacity		Not yet due OR In Progress	Email sent with request 6/11/21 cc'd in Karen Carter to see if informatics can support a timely review across 3 sites	
	Capacity and demand	Capacity and demand for YG required	Cheryl Goodall	06/11/2021	20/11/2021	31/05/2022		SM commenced capacity - on hold as currently no capacity		Not yet due OR In Progress	Email sent with request 6/11/21 cc'd in Karen Carter to see if informatics can support a timely review across 3 sites	
	Capacity and demand	Capacity and demand required for YGC	Sally Morris	06/11/2021	20/11/2021	31/05/2022		SM commenced capacity - on hold as currently no capacity		Not yet due OR In Progress	Email sent with request 6/11/21 cc'd in Karen Carter to see if informatics can support a timely review across 3 sites	
	Pathways	Create and agree a transfer into ward 3 pathway	Linzi Shone / Karen Scrimshaw	04/10/2021	21/12/2021	30/04/2022		Emailed 2/12/21		Not yet due OR In Progress	Discussed with HoNs at all sites. East and West no concerns raised. Require SOP and	
	DFP West	Plan to be made for MDT Clinics and ward round for March with new diabetology Consultant arrival	Bethan Davies-Williams, Rhian Hulse and Sally Morris	14/12/2021	26/01/2022	30/04/2022		Emailed BDW 29/3 update		Not yet due OR In Progress	plan in place for vascular and orthopaedic joint clinics / MDT but no arrangements as yet for Diabetology - pending recruitment	
	DFP BCU	We require an SOP to support the how the pathway will be delivered. Meeting to be convened to link primary care, podiatry together to formulate	Balasundaram Ramesh	04/01/2022	01/02/2022	30/04/2022				Not yet due OR In Progress		
	Vascular Services Nursing	SOP requires completion for transfer pathway into ward 3	Sian Jackson / Vicky Stafford	06/01/2022	27/01/2022	30/04/2022				Not yet due OR In Progress		
	Vascular Services Nursing	Chase up vascular scientist room	Linzi Shone	06/01/2022	27/01/2022	30/04/2022				Not yet due OR In Progress		
	Vascular Services Nursing	Review use of Ward 3 Bathroom	Linzi Shone	06/01/2022	27/01/2022	30/04/2022				Not yet due OR In Progress		
	DFP West	Need to understand when and how many clinics are intended and where to be held	Faisal Shaikh / Haroon Mumtaz	11/01/2022	25/01/2022	31/05/2022	lack of physical space at YG			Not yet due OR In Progress	Jenny Farley linking in with Barry Williams	
160222-01	DFP East	**Objective A** Establish a clinical lead for MDFS to be point of contact and the lead clinician on development of the service. Their involvement in subsequent actions below will be key.	NJ / AD / HJ / PL	17/11/2021	16/03/2022	13/04/2022	Patrick / Hassan and Anthony to discuss			Overdue OR In Progress	2016 guidance suggests this should be Diabetologist but open competition from all key stakeholders could be considered. Consider whether to make a formal CSL role	
010222-02	DFP BCU	Information to be sent to Karen Carter to review the impact of joint clinics at Wrexham on reduction of emergency admission.	Nicola Joyce / GLH	01/02/2022	01/03/2022	06/04/2022		NJ sending 29/3		Overdue OR In Progress		
160222-03	DFP East	**Objective B - Establish OPD Service** B1. Establish essential and close back-up personnel for this service	NJ / AD / HJ / PL supported by relevant managers	16/02/2022	13/04/2022		All planned, timeline required for diabetology			Overdue OR In Progress	2016 guidance suggests this should be Diabetologist, DSN, Podiatrist and orthotist closely supported by other key specialties incl.	
	DFP East	B2. Establish the best time and location for the clinic to operate and adjust job plan of key personnel to suit	CP / SM / / GLH	16/02/2022	13/04/2022		Looking for Thursday - exisiting # Clinic			Overdue OR In Progress	Main options are between dept. 20 and fracture clinic and review of likely use of plaster room will need considering (see action	
	DFP East	B4. Ensure suitable note keeping system involving both therapy manager and standard clinic notes	GLH / CP / SMa	16/02/2022	13/04/2022					Overdue OR In Progress	GLH to gain access for teams across BCU to access Therapy Manager	
	DFP East	**Objective C -Establish in patient service** C1. Establish essential and main back-up personnel for this service	AD / NJ / HJ / PL supported by relevant managers	16/02/2022	13/04/2022					Overdue OR In Progress		
160222-04	DFP East	C2. Establish referral system for other colleagues to efficiently bring patients to the attention of the team possibly including central monitored email inbox	Clinical team / CP / SM / SMa working with IT	16/02/2022	13/04/2022		AD suggesting email referral to diabetology - for forwarding to appropriate specialties. Alternatively bleep AD.			Overdue OR In Progress	It is envisaged that some work will be urgent new referrals requiring a Fist response from MDFS and other work will be more planned 'follow up' work requiring ward rounds form the team. It is envisaged that diabetic foot	
	DFP East	C3. Establish a timetable when key team members will be available to attend ward referrals. May need to be allocated time each day	Clinical team / CP / SM / SMa	16/02/2022	13/04/2022					Overdue OR In Progress		
	DFP East	C4. Establish manner in which fast radiological investigations and surgical opinions can be obtained.	Clinical team supported by relevant managers and working with radiology dept.	16/02/2022	13/04/2022					Overdue OR In Progress		
	DFP East	C5. Establish which ward these patients will be admitted to when necessary assuming the majority will be medical ... likely diabetes ward.	Clinical team supported by relevant managers and working with site team.	16/02/2022	13/04/2022					Overdue OR In Progress		
1	DFP Centre	**Objective A** Establish a clinical lead for MDFS to be point of contact and the lead clinician on development of the service. Their involvement in subsequent actions below will be key	JR / GS / SZ / FA	29/03/2022	13/04/2022					Not yet due OR In Progress	2016 guidance suggests this should be Diabetologist but open competition from all key stakeholders could be considered.	
2	DFP Centre	**Objective B - Establish OPD Service** B1. Establish essential and close back-up personnel for this service	JR / GS / SZ /FA supported by relevant managers	29/03/2022	13/04/2022					Not yet due OR In Progress	2016 guidance suggests this should be Diabetologist, DSN, Podiatrist and orthotist closely supported by other key specialties incl.	
3	DFP Centre	B2. Establish the best time and location for the clinic to operate and adjust job plan of key personnel to suit	Ca H / JR / GLH	29/03/2022	13/04/2022					Not yet due OR In Progress		
4	DFP Centre	B4. Ensure suitable note keeping system involving both therapy manager and standard clinic notes	GLH / CH / KH	29/03/2022	13/04/2022					Not yet due OR In Progress	Require access for teams across BCU to access Therapy Manager	
5	DFP Centre	B5. Establish key radiological support for scan reporting and discussion	CH / KH in liaison with radiology managers	29/03/2022	13/04/2022					Not yet due OR In Progress		
6	DFP Centre	B6. Review the average number of those diabetic foot patients who require the use of the plaster room versus those that are managed by the podiatry team / orthotics etc.	JR	29/03/2022	13/04/2022					Not yet due OR In Progress		
7	DFP Centre	**Objective C -Establish in patient service** C1. Establish essential and main back-up personnel for this service	GS / JR / SZ / FA supported by relevant managers	29/03/2022	13/04/2022					Not yet due OR In Progress		
8	DFP Centre	C2. Establish referral system for other colleagues to efficiently bring patients to the attention of the team including central monitored email inbox	Clinical team / CH / SM / KH working with IT	29/03/2022	13/04/2022					Not yet due OR In Progress	It is envisaged that some work will be urgent new referrals requiring a First response from MDFS and other work will be more planned 'follow up' work requiring ward rounds form the team. It is envisaged that diabetic foot	
9	DFP Centre	C3. Establish a timetable when key team members will be available to attend ward referrals. May need to be allocated time each day	Clinical team / CH / SM / KH	29/03/2022	13/04/2022					Not yet due OR In Progress		
10	DFP Centre	C4. Establish manner in which fast radiological investigations and surgical opinions can be obtained.	Clinical team supported by relevant managers and working with radiology dept.	29/03/2022	13/04/2022					Not yet due OR In Progress		
11	DFP Centre	C5. Establish which ward these patients will be admitted to when necessary assuming the majority will be medical ... likely diabetes ward.	Clinical team supported by relevant managers and working with site team	29/03/2022	13/04/2022					Not yet due OR In Progress		

ISSUE LOG

The purpose of this document is to record all Programme-related issues and their mitigation

Definition of issue: A relevant event that has happened, was not planned, and requires management action. It can be any concern, query, request for change, suggestion or off-specification raised during a Programme. Programme issues can be about anything to do with the project.

Issue ref	Work stream	Date issue raised	Description of the issue	Description of the cause and impact	Severity - Catastrophic/ Major/Moderate/Minor/ Negligible *please use dropdown*	Issue response action
1	DFP	01/12/2021	Failure to be able to fully implement the diabetic foot pathway in advance of funding approval.	Prevention of implementation of NICE guidance for managing patients with the diabetic foot. Pathway in principle signed off on paper but issue remains as to agreement to implement the pathway ahead of the full resource required to deliver the service	Major	All have signed off on paper - now remains the issue of implementation
2	Pathways	01/12/2021	Repatriation Pathway requires an SOP and wider comms to ensure buy in from all sites	Patients remain longer than clinically necessary on ward 3 impacting upon cancellations on the day due to lack of bed availability and vascular patients being managed in non-vascular beds.	Major	Agreement on the repatriation pathway gained. Now need a rehab pathway to compliment this for patients not requiring further in hospital specialty treatment. Approved at CD/AMD meeting 21/3/22
3	Pathways	30/12/2021	Failure to agree consensus on managing day case vascular patients requiring an overnight stay following general anaesthesia at East	Potentially meaning that patients would need to be transferred to YGC for the overnight stay prior to discharge.	Minor	Agreement now gained from spoke sites - awaiting presentation and approval at CEG April 22
4	Pathways	09/01/2022	Failure to determine a single pathway for management of patients presenting with groin swelling in ED with a history of IVDU	Potentially meaning that patients will not be in receipt of standardise care across 3 sites. Likelihood of all patients being transferred to YGC putting pressure on beds.	Minor	Passed through CAG in December as no concerns raised. GS team at West then voiced concerns. Agreement under steer of West Medical Director to follow the pathway and review at 3 monthly intervals for any incidents relating to adaptation of the pathway.
5	Pathways	01/09/2021	Cultural and political issues currently posing a risk to delivery of the hub and spoke model of care	There is still a lot of frustration across the spoke sites that followed centralisation for vascular services and a feeling of being 'done to'. This is leading to some negative behaviour which is hindering development of robust processes between specialties across BCU. Some of this extends to teams refusing to sign up to pathways to improve patient experience / quality / reputation.	Minor	A Vascular Oversight group has been established led by the SRO with Medical and directors and the vascular Lead to expedite delivery of the action plan and manage obstacles. Meetings are currently in place between hub and spoke sites to attempt to alleviate issues. New Ops meetings with secretarial / specialist nurses / renal nurses have been implemented as of 7/10/21 in an effort to pull together to alleviate some bottlenecks in the service and work collaboratively.
6	Governance	01/12/2021	Lack of robust capture and sharing of learning outcomes from vascular governance / practice	Lengthy meetings and discussions but not captured succinctly and shared which could prevent learning from incidents	Moderate	Governance support requested form the vascular improvement funding scheme as insufficient resource at Centre. Acting VNM and Assoc vascular manager to support in the interim the recording of live learning outcome and action logs
7	Governance	09/01/2022	Lack of resource to allow for accurate and timely data entry onto the national vascular registry	Risk of inaccurate data being reported annually reflective of BCUHB performance benchmarked against other organisations	Major	Data entry clerk resource added to the vascular improvement funding scheme
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RISK LOG - The Risk Register provides a record of identified risks relating to the Programme, including its status and history. It is used to capture and maintain information on all of the identified threats and opportunities relating to the Programme. Please link into the milestones listed for this Programme and ensure that any risks which could impact on the delivery of the milestones is included in the risk register, and mitigation considered and recorded.

Risk No	Risk Description	Impact Description	Risk Category	Inherent risk (score before)			Date risk raised	Action Owner	Actionee	Mitigation in place or required description	Residual risk (target score)			Further Action Planned. (Who, What, Why and When anything more will be done to deduce the Residual risk)	Risk Open or Closed	Date Risk Closed DD/MM/YYYY	Risk uploaded /updated on Datix	What is a risk?
				Probability Score 1-5	Impact Score 1-5	Overall Score					Probability Score 1-5	Impact Score 1-5	Overall Score					
1	Lack of resource within the vascular team across all grades	Currently unable to deliver required activity across all 3 sites as providing cover for VCOW and OC commitments in the first instance. Lack of Junior support for the ward, lack of MGs to provide sufficient support and backfill for all activity. ANP currently being absorbed into ward 3 to support due to junior staffing. Interim and permanent solution to admin support for the above will also be required to achieve timely outcomes	Quality/Safety	4	2	8	01/09/2021	Vascular CD / Vascular Network Manager	Sally Morris	Consultant Locum sourced to provide backfill cover. YGC / YG (1/11/21) to ensure robust cover for spoke site as only 2 substantive consultants. Searching for locum Juniors / MGs to bolster YGC support. 2 Locums in place with further to arrive. 1 F1 locum also used to buffer SHO vacancies for ward support Actions underway to determine activity for ANP to support OPD WL and patient management. New starting Consultant 24/1/22 who will support following induction at YGC / WMH	2	2	4	Capacity and demand review along with review of job plans for all clinicians within vascular is required to build into the business case to manage the hub and spoke model robustly	Open		Risk 2793 / 2791 / 4026 updated 6/3/22	• A risk is an event, or a set of related events
2	Lack of resource of all supporting disciplines to support implementation of the DFP	All sites have so far been requested to provide estimates of what they think is required to implement the DFP as without this we are not meeting NICE guidance for managing the patient with a diabetic foot and creates delays for the patient journey	Quality/Safety	4	3	12	01/04/2020	Leads / DGMS all areas across BCU	DGMs BCU Sally Morris to pull together	Current mitigation of non-adherence to a single pathway is that patients are managed through YGC if not at spoke sites although not managed by standardised protocols	3	3	9	Business case approval and recruitment will be required across all disciplines BCU wide to achieve the DFP implementation	Open		Cross ref Risk 3457, 2788, 2794 6/3/22	• It must be possible, but not necessary, for the event(s) to occur
4	Delays in timely diagnostics and assessments i.e. CT/MRI/Sonography	At the time of the RCS report there were reported delays in accessing diagnostics. Information has been requested from informatics to understand what the current position of this is although an SBAR written by BCU radiology lead describes human resource being an issue to deliver optimally which could delay urgent procedures or increase complications	Quality/Safety	4	3	12	01/04/2021	Executive Medical Director	Kakali Mitra	CT / MRI waiting times are compliant with the HBs guidance of 2 wks. urgent and 8 wks. routine. Sonography cannot become compliant until resource has been sourced	2	2	4	Business case approval required and then lead time for recruitment	Open		Risk 2985 06/03/22	
6	Vascular bed resource and management	Ward 3 commonly has a high number of outliers (averages of 2.5 per day since April 2021) with regular high numbers of vascular outliers amongst other wards (average 5 per day since April 21) indicating the requirement of an increased bed base	Quality/Safety	5	2	10	01/04/2021	Acute Site Director	DGM supported by vascular network manager and HoN	Daily board rounds and escalation look to realign the beds but it doesn't make for an optimal patient journey. Ward 3 wish to ring-fence their beds for vascular patients in keeping with the emergency transfer pathways and to ensure the right patient in the right bed. Current figures indicate the requirement for an average of 23 beds per day for vascular patients and workforce would need to reflect this. Agreement in principle to ring-fence 1 male and 1 female bed and to expand the bed base to 23	3	2	6	Ward 3 and HoN are keen to develop a high observation bay to 1) make the recruitment option more attractive ") give a wider ability to grow our own senior staff 3) allow earlier step down from HDU areas to free beds for theatre patients reducing delays and cancellations	Open		Risk 3457 6/3/22	
7	Lack of access to emergency theatres	Lack of emergency theatre leads to delays in treatment and can negatively impact on outcomes and mean failure to achieve national targets. It also leads to cancellations of more planned procedures which can also negatively impact outcomes and failure to achieve targets Delays in decisions for ITU bed availability often cause 2-3 hours delays in start times affecting utilisation	Quality/Safety	3	3	9	01/04/2021	Medical Director (Hub)	Theatres DDGM supported by vascular network manager and Soroush Sorabi	1 additional CEPOD list has been provided Fridays at YGC although not for vascular sole use. Issues lie with physical space and staffing. Need to review with theatre DGM to source other opportunity	2	2	4	Review of whole theatre schedule to see if there is scope to increase access to emergency theatres	Open		Risk 2788 6/3/22	
8	Data accuracy for NVR submission	There is a risk that both the data submitted to NVR has not been fully accurate historically. This can lead to performance data being published which identifies the organisation as an outlier	Reputational	3	3	9	10/12/2021	Medical Director (Hub)	Vascular CD	Consultants are requested to ensure that data is validated by NVR prior to benchmarking. NVR performance an data entry is a standard agenda item for clinical governance	1	3	3	NVR Data entry clerk has been factored into the resource requirements for Vascular improvement programme	Open			
9	Lack of Interventional Radiological (IR) Support for theatres	there is a risk that out of hours and 2.5 days per week do not have IR consultants attached to them to enable less invasive vascular surgery. Furthermore, an IR consultant has left the service meaning less than 2.5 days per week routinely covered.	Quality/Safety	4	3	12	10/12/2021	BCU radiology	Vascular CD	Ad hoc sessions being completed by other team embers but no mitigation for increasing the workforce for this niche group for the next 1-3 years	3	3	9	Following successful recruitment 24/7 cover will be available for YGC and hopefully the 2.5 days of cover can be increased for theatre L	Open		Risk 4250 6/3/22	
10	Lack of OPD capacity	A lack of physical space and a lack of backfill for consultants sessions due to MG availability is creating long FUWL and long new patient backlogs.	Quality/Safety	4	3	12	01/03/2021	Elaine Hodgson	Caroline Hogbin	MG modelling, once funding approval for VIP funding scheme and successful recruitment, will allow for backfill of consultant clinics whilst VCOW or on leave.	3	2	6	Additional physical space needs sourcing for F2F vascular appointments which could allow additional clinics from MG and ANP etc.	Open		Risk 2789 / 6/3/22	
11	Pre-assessment resource for vascular patients	There is a lack of anaesthetic sessions dn CPET availability for vascular patients creating delays in theatre and potentially affecting clinical decision making in MDT	Quality/Safety	4	3	12	10/12/2021	Andy Foulkes	Vascular CD / VNM	CPET has been factored into the VIP funding scheme to allow for sessions at YG and YGC for vascular patients to reduce the delays and optimise pre-op diagnostics	3	3	9	Need to take a more planned approach to managing planning for the waiting list. Awaiting more admin support from VIP funding scheme to achieve this	Open		Risk 3066, 3954 6/3/22	
12	Delayed hospital transfers	Potentially making vascular beds unavailable for routine and emergency transfers and planned theatre cases	Quality/Safety	4	3	12	01/09/2021	Medical Director (Hub)	Vascular CD / VNM	the repatriation pathway and pending rehab pathways are pivotal to this risk. Pending CEG for final approval and then wider distribution and sharing openly on the Trust intranet	3	3	9	Buy in from patient flow teams at 3 sites to push / pull patients and improve ability to flow	Open		Risk 2787, 2794 6/3/22	
13	Cancellation of theatre due to lack of ITU / HDU beds	High risk of delayed procedures both planned and emergent due to the lack of ITU capacity or process by which it is managed	Quality/Safety	4	3	12	01/09/2021	Andy Foulkes	Vascular CD / VNM	Standby patients allocated to lists containing ITU patient	3	3	9	Review of process for decision making for bed availability to achieve earlier start time and improved planning	Open		Risk 2783 6/3/22	
14	Lack of physical space to deliver RFA for Vv treatment	Growing backlog of some routine and some urgent and highly symptomatic varicose vein patients. Some waiting as long as 5 years	Quality/Safety	4	3	12	01/09/2021	DGMs Surgery BCU	DDGMs Surgery BCU	Need to review methods of managing the WL and look to outsource and also start scheduling some symptomatic patients as golden patients ahead of space being available again	3	3	9	Need RFA room and staff reinstated to maintain run rate (across all 3 sites)	Open		Risk 2986 6/3/22	
15																		

RISK REGISTER SCORING AND RATING

LIKELIHOOD SCORING					
LIKELIHOOD SCORE	**1**	**2**	**3**	**4**	**5**
Frequency/How likely is it to happen?	This will probably never happen/recur	Do not expect it to happen/recur, but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur, but is not a persisting issue or circumstance	Will undoubtedly happen/recur, possibly frequently

Category	Consequence (Impact) Scoring				
Consequence Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Negligible (Very Low)**	**Minor (Low)**	**Moderate**	**Major (High)**	**Catastrophic (Very High)**
Quality/Safety	Minor reduction in quality in treatment or service	Single failure to meet national standards of quality or treatment or service	Repeated failure to meet national standards of quality of treatment or service	Ongoing non-compliance with national standards of quality of treatment or service	Gross failure to meet national standards with totally unacceptable levels of quality of treatment or service
	No or minimal effect on patients/staff/ others	Low effect for a small number of patients/staff/ others if unresolved	Moderate effect for a small number of patients/staff/ others if unresolved	Significant effect for numerous patients/staff/ others if unresolved	Very significant effect for large numbers of patients/staff/ others if unresolved
Reputational	Not relevant to organisational goals	Minor impact on achieving organisational goals	Moderate impact on achieving organisational goals	High impact on achieving organisational goals	Organisational goals will not be achieved
	No adverse media coverage	Low level of adverse media coverage	Moderate amount of adverse media coverage	High level of adverse media coverage	National adverse media coverage
	No negative recognition from the public	Small amount of negative public interest	Moderate amount of negative public interest	Negative impact on public confidence	Total loss of public confidence
Finance	Small loss	Deficit of £100,000 or less	Deficit of £100,000 to £500,000	Deficit of £500,000 to £1m	Non-delivery of strategic goal
	Risk of claim remote				Deficit greater than £1m
					Failure to meet specification
					Claims in excess of £1 million
Regulation	No or minimal impact or breach of guidance/statutory duty	Breach of statutory legislation	Single breach of statutory duty	Enforcement action	Continued breaches in statutory duty
			Challenging external recommendations	Improvement notice	Prosecution
				Multiple breaches in statutory duty	Severely critical report
				Critical report	Complete system change required

	CONSEQUENCE				
LIKELIHOOD	**Negligible (Very Low)**	**Minor (Low)**	**Moderate**	**Major (High)**	**Catastrophic (Very High)**
Will undoubtedly happen/recur, possibly frequently	5	10	15	20	25
Will probably happen/recur, but it is not a persisting issue	4	8	12	16	20
Might happen or recur occasionally	3	6	9	12	15
Do not expect it to happen/recur but it is possible it may do so	2	4	6	8	10
This will probably never happen/recur	1	2	3	4	5

ISSUE CONSEQUENCE SCORING

	Consequence (impact) Scoring				
CONSEQUENCE SCORE	**1**	**2**	**3**	**4**	**5**
Descriptor	**Negligible (Very low)**	**Minor (Low)**	**Moderate**	**Major (High)**	**Catastrophic (Very High)**
Quality/Safety	Minor reduction in quality in treatement or service No or minimal effect on patients/staff/others	Single failure to meet national standards of quality or treatment or service Low effect for a small number of patients / staff / others if unresolved	Repeated failure to meet national standards of quality of treatment or service Moderate effect for a small number of patients / staff / others if unresolved	Ongoing non-compliance with national standards of quality of treatment or service Significant effect for numerous patients/ staff/ others if unresolved	Gross failure to meet national standards with totally unacceptable levels of quality of treatment or service Very significant effect for large numbers of patients/ staff/ others in unresolved
Reputational	Not relevant to organisational goals No adverse media coverage No negative recognition from the public	Minor impact on achieving organisational goals Low level of adversse media coverage Small amount of negative public interest	Moderate impact on achieving organisational goals Moderate amount of adverse media coverage moderate amount of negative public interest	High impact on achieving organisational goals High leve of adverse media coverage Negative impact on public confidence	Organisational goals will not be achieved National adverse media coverage Total loss of public confidence
Finance	Small loss Risk of claim remote	Deficit of £100,000 or less	Deficit of £100,000 to £500,000	Deficit of £500,000 to £1m	Non delivery of strategic goal Deficit greater than £1m Failure to meet specification Claims in excess of £1m
Regulation	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation	Single breach of statutory duty Challenging external recommendations	Enforcement action Improvement notice Multiple breaches in statutory duty Critical report	Continued breaches in statutory duty Prosecution Severely critical report Complete system change required

ISSUE SCORING MATRIX

Consequence scoring

5	Catastrophic
4	Major
3	Moderate
2	Minor
1	Negligible

Vascular Improvement Plan (Revised October 2021)

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

Contents

Action Plan	Founded upon RCS review part 1 & 2, NVR performance report and internally guided improvement actions
Action Log	Driven by work stream meetings and internal actions
Issue Log	Driven by work stream meetings and internal actions
Risk Log	Relating to risks held on the risk register and their impact

Current Performance for Actions		
Complete	61	39%
In progress	67	43%
Not yet commenced	27	17%

Total	155

Category	Ref	Requirement	Action	Lead	Executive Lead	Start	End		Revised	Revised	Status	Steering	Issue	Mitigation		Update / Comments
Pathways	4.1	Requirement for agreed and clear pathways to ensure timely and effective treatment at Hub and Spoke sites	Repatriation and rehab pathway to be completed, signed off and utilised for admission to spoke sites from the hub	Medical Directors	Executive Medical Director	01/04/2021	31/05/2021		20/04/2022	21/03/2022	In Progress	QSE via Vascular steering group	Further work required	Patients being co-ordinated between bed management teams on an individual basis currently		4 March - Awaiting information for how to proceed to CEG as CAG has been stood down. Pathways can then receive overall sign off and wider dissemination and placing on the intranet. 21 March - Signed off at extraordinary meeting with YCG CDs and Dep MD as CAG has been stood down - awaiting Exec endorsement. Currently being made uniform with all other pathways for addition to the intranet. 4 April Requires SOP from patient flow to support delivery.
	2 Internal		Create and disseminate Primary Care Pathways / guidance in relation to vascular conditions	Vascular Clinical Lead supported by GP Lead and Clinical Pathway Lead	YGC Medical Director				31/05/2022		in progress	BCU Diabetic foot group	Delay in commencing due to available capacity	Continued contact with GP lead via BCU diabetic foot meetings re vascular development		Clinical Director and or designated Vascular surgeon to work with Bethan to write guidance for primary care starting 2022. 4 March - meeting held with primary care and existing draft pathways shared for their view. Further meeting to be held to determine how their referral pathways feed into secondary care. 5 April - Primary care lead produced a draft pathway and currently in discussion with the newly appointed professional governance lead for development.
	4.1.5	Management of patients post major arterial vascular surgery (Repatriation) Pathway requires final sign off ensuring communication between hub and spoke regarding discharge and follow up is improved	All relevant clinical services at hub and spoke sites are aware of the pathway and have robust mechanisms in place to ensure discharge plans are communicated to relevant teams	Specialty Leads supported by , Vascular Network and DGMs all sites	Acute Site Directors supported by Medical / Nursing Directors	22/05/2020	27/01/2021		20/04/2022		In progress	QSE via Vascular steering group	Awaiting wider comms and SOP	As above - patients transfer where capacity allows back to spoke sites		Communication of the repatriation pathway once signed off. 5 April - All pathways added to BCU wide-pathways library to be linked to the vascular page (now created) so easily accessible. News story to be created in the vascular news feed for raising of awareness
	4.1.8	Pathways are required to enable non-complex / low risk peripheral vascular interventions to be undertaken (in line with VSGBI guidelines) mainly as day cases at spoke sites	Details for inpatient responsibility for patients requiring admission following general anaesthesia	Spoke site Medical Directors	Executive Medical Director	01/04/2021	30/06/2021		19/04/2022		In progress	QSE via Vascular steering group	Pending pathway proposal and meeting with Andy Baker and Keeley Twigg	Agreement for the pathway from East and West - simply needs disseminating and CAG approval		30 December 2021 = West have signed off, General Surgery at East in discussion with MD. 13 December - meeting planned for early February with CL for Gen Surg and Operational lead to discuss. 11 February update - as above, the Medical Directors are reviewing the pathways involving vascular input with their respective teams for sign off. Discussion are ongoing. 20 February - wider dissemination has been completed with a 1 week window for all to raise concerns over previously signed off pathways and will then proceed to CAG, 24 march 2022 - pending CEG in April for formal sign off and addition to intranet
Diabetic and Vascular patient management	4.2.15	Develop Non-arterial Diabetic Foot Pathway should be finalised urgently with involvement of all relevant teams	The diabetic foot pathway will be reserved as a live working document with reviews at 3 monthly (or earlier as indicated) reviews for any non-adherence or incidents stemming from pathway implementation. Full implementation can only occur once funding approved and recruitment complete	Medical Directors supported by and Specialty Leads / DGMs	Executive Medical Director			20/02/2022	31/05/2022		In progress			Soft launch of some of the immediate OPD management and primary consultants to manage care appropriately agreed. Need recruitment before full implementation		4 March - Pathways agreed in principle. Methodology of how we can begin implementation ahead of the resource being made available is under discussion with clinicians, DGMs and medical Directors. 21 March - signed off at YGC CD and AMD meeting ahead of CEG. CAG has been stood down. 5 April - added to BCU pathway library with a plan to add to the vascular news story and page for raising awareness
			Consideration of appointment for a network wide orthopaedic surgeon with special interest in vascular to support the foot salvage service across all sites	Medical Director (Hub)	Executive Medical Director	01/04/2021	30/06/2021	31/03/2022	TBC		In progress		Escalated to Medical Directors	Currently being covered by existing orthopaedic clinicians		Discussed with Gareth Evans 8/10/21 No current progress on this consideration to date. May depend on the outcomes of Orthopaedic surgeon discussions in the first instance at this stage. 25 November update – Unsure that this requirement is necessary - to discuss at Vascular oversight group 10/12/21 30 30 December - communicated to Medical Directors for review as not yet progressed with no sign of requirement for the post unless allocating to existing staff member 5 April - Discussions are taking place in relation to appointment of an orthopaedic surgeon to cover West and Centre and provide cross cover as needed.
Governance	4.1.9	Improvements are required in line with improving the effectiveness of clinical governance	Audit of processes to ensure that agreed changes to clinical practice arising from shared learning are effected	Vascular Clinical Governance Lead	Vascular Clinical Lead supported by Interim Deputy Exec Medical Director		30/12/2021		31/05/2022		In Progress		Awaiting audit outcomes			11 Feb update - Collation of learning to be completed and made reference to for governance meetings and datix events in light of similar incidents. Requires resource for governance to ensure robust included in the vascular improvement funding scheme
			Clarify the requirements for the process of root cause analysis for relevant criteria of major amputations	Vascular Clinical Governance Lead	Vascular Clinical Lead	01/04/2021	31/05/2021	31/10/2021	30/04/2022		In progress		Not presented as planned, deferred to March 22 meeting	Recent review of all major amputation mortality by MDT as per NVR section below		10 November update - discussed at the clinical governance meeting on 9 November - Aw SS response 25th November update: RCA proforma to be presented at the next governance meeting 10/12/21 13 December update - not completed as yet - deferred to January 18th CG meeting. Requested that the proforma be shared prior to presentation for review 17 January update - not yet complete - draft version sent to CD for review and input.
	4.2.13	Improve effectiveness of M &M meetings enabling comprehensive MDT discussion and shared learning	Audit to ensure that there is a robust process to discussion of all mortality and morbidity and carry forward of discussion to nest meeting as needed	Vascular Clinical Lead	Medical Director		30/12/2021		30/04/2022		In progress			Mortality tool updated for the vascular dashboard to make easy reference to mortality patients		Review of cases discussed and cases pending discussion prior to and following each CG meeting
Theatres	3	More effective use of the Hybrid Theatre	Review theatre capacity and ensure all pre-covid lists are returned	YGC Surgical DGM	YGC Acute Site Director			01/11/2021	31/05/2022		In progress	QSE via Vascular steering group	Covid 4th wave - currently on hold	DGM to look at reinstating with additional staffing		Alternate Monday all day case list removed during covid 25th November update - issues with theatre staffing prioritising lists in place due to staffing. 11 February update - meeting with Theatre manager and DGM YGC - to aim to have the all day alternate week Monday list back with additional staffing.
	5		Increase access to Interventional Radiology sessions - Lack of interventional radiography (IR) sessions making theatre allocation more difficult into appropriate session.	BCU Radiology Lead	Executive Medical Director			10/12/2021	31/08/2022		In progress		Lack of available IR consultants to recruit	BCU Radiology Lead picking up vascular sessions		3 year plan for radiology to support recruitment to this specialist discipline. IR radiographer leaving January 22 seeing depleted IR sessions available.
	6		Require increased access to emergency theatres to prevent cancellations of elective cases	YGC Surgical DGM	YGC Acute Site Director			10/12/2021	TBC		Not yet commenced	QSE via Vascular steering group	Covid 4th wave - theatre staff issue	Emergency cases being completed in hybrid theatre and CEPOD list as available		Vascular emergency cases can be lengthy and it is not ideal for them to make use of the general CEPOD list for this reason. Additional capacity required for emergency sessions 17 January update- Liaise with DGM for theatre to iterate clinical urgency for fistula patients for which the alternate week Monday list is utilised to free up space within the hybrid theatre for waiting list and emergencies. 11 February update - an all day theatre list for vascular emergencies has been factored in to the vascular improvement resource requirements although staff not available to support this currently.
	4.1.3		Commence lists on time using 'golden patient model'.	Theatre Manager supported by Critical Care Lead YGC and operational lead manager	Vascular Clinical Lead supported by YGC Surgical DGM	01/04/2021	28/05/2021	01/12/2021	31/05/2022		In Progress	QSE via Vascular steering group	VSG Review please	Current fistula cases added wherever possible (surgical skill dependent) before ITU cases to improve start times and utilisation		17 January update - consider VSG to review this as deemed not a viable proposal given the case mix of patients assuming that all day Monday fistula list returned. Discussed using the fistulas with Vascular anaesthetist as golden patients who felt this was unrealistic and that a proportion of these cases are not straight forward.
Vascular presence	4.1.4	Vascular presence at Spoke Sites	Audit via Datix the failure to review patients within 24-48 hours	Vascular Clinical Lead supported by Patient Safety Lead	Medical Directors			30/12/2021	30/04/2022		In progress	QSE via Vascular steering group				11 February update - no incidents raised to date from September 31 March - none raised - requested governance team to complete a datix review
	8		Full capacity and demand exercise requires completion across all sites.	DGMs Surgery all sites supported by Vascular Network manager and Vascular Clinical Lead	Acute Site Director (Hub)	01/04/2021	30/06/2021		31/05/2022		In progress		Pending BCUHB Demand data and 1st draft capacity by due date	Demand work is currently ongoing from informatics to support this review		All sites are covered with locum backfill for shortfalls in the short term. 24/10/21 Recruitment of additional consultant to cover spoke site will alter the current working pattern for surgeons based at the spoke site 16 November update - requested demand data from informatics - work will shortly commence to review the current capacity and the potential capacity with recruitment and MG cover 25 November update - Capacity work has commenced 17 January update - This action will be delayed due to capacity issues along with leave 5 April - requested for vascular to be priorities for BCU demand review

Section	Ref	Title	Action	Lead	Responsible	Start	Target	Date	Due	Status	Governance	Comment	Mitigation		Update
Spoke V	4.2.17		Gap analysis of Junior / middle grade and Consultant vascular staff to be included in BCU pan business case. Additional Deanery and non-training grade vascular surgeons required to allow for learning opportunities at spoke sites and to reduce reliance on general surgery trainees	Vascular Clinical Lead supported by Vascular network manager	Medical Directors	01/04/2021	30/06/2021		30/04/2022	In progress		1st draft capacity by due date. Modelling work complete	Use of Locum middle grades to support aspects of the vascular service		16 November update - Middle grade rotation inclusive of long day on call, weekend on call and spoke site rotation is underway. Supported by Medical workforce, a rolling job plan has been created to identify the number of MGs, the PA allocation and therefore the salary can be reviewed on this basis. Funding approval will be required and lead time for recruitment and start dates. 1 PA has been factored into the establishment requirements for ward and junior Dr support. 17 January update - further work has been requested from workforce to model a 24/7 on call for vascular model **5 April** - Requested workforce to update the model for 24/7 cover - meeting 22 April to review further
Audit	4.2.14	6 Audits identified by vascular T&F group to be undertaken using national vascular registry (NVR) data should be progressed as part of assessment, evaluation and shared learning	Audits on the following for completion: * Same Day discharge following endovascular intervention (FS) Complete * Timeframes for lower limb bypass or endovascular revascularisation procedure for patients admitted with CLI as emergency (AR) * Below, through and above knee amputations since centralisaiton (AR) Completed * Carotid endarterectomy - time from symptoms to referral, referral to surgery and outcomes (RF) Completed * AAA timelines for referral to surgery open & EVAR and outcomes (LP) * Complex aneursym repairs EVAR / Open and outcomes (SS) Awaiting * Conversion of below knee amputation to through and above knee (AR) Completed	Vascular Clinical Lead	Executive Medical Director	01/04/2021	30/06/2021		26/04/2022	In progress	Vascular CG	Annual Leave prevented presentation of all outstanding audits at December meeting	There is audit progress overall that are presented at the clinical governance meetings however the tow identified remain outstanding		Awaiting details on the outstanding audit subjects. New Audit lead appointed given Mr Taha's leave. Faisal Shaikh now leading. 15/10/21 Same Day Discharge following endovascular intervention - complete / presented 24/10/21 - Update from Soroush 4/7 completed and potential further 2 awaiting presentation, awaiting confirmation from audit leads 10 November update - 3 audits outstanding completion / presentation - aim to be presented 10/12/21 13 December update - 4 audits to be presented at January 18th 2022. Need to extend meeting from half to full day to accommodate. 17 January update - 1 audit presented from the list, 2 more remaining to be presented. 9 march - Insufficient time to present AAA timelines due to agenda items on meeting and 2 other audits. 5 April - emailed consultants to prepare audits for 29th April CG meeting - awaiting response
Additional Reco	4.3.20	Additional Recommendations	Develop a plan to maintain stability and attract further clinicians - consider joint appointments opportunity with LUHFT	Deputy Director operational Workforce	Medical Director	01/04/2021	30/06/2021	20/01/2022	31/05/2022	In progress			Locum use in place to cover existing shortfalls		Advert to be placed for Vascular Surgeons by Medical Director as a rolling 6 monthly action 5 April - Advert has closed and has one applicant for consultant post
Communication	9	Completion of Comms section on intranet	The dedicated (outward facing) vascular services page on our website is under development to include a patient stories section, a 'meet the team' component and pictures and video content to demonstrate the high quality facilities and equipment available	Communication Lead	Acute Site Director YGC	01/04/2021	30/06/2021		31/05/2022	In progress	QSE via Vascular steering group	Risk to delivery by due date On hold pending report from notes review			Work is currently being undertaken to migrate the current intranet platform to a new one - no additions will be made until this work is completed with a potential start date for early next year. 17 January update - work is currently on hold pending secondee RCS report. 5 April - Comms updates have retained a responsive focus for the RCS 2nd stage review and actins taken to support the service. This action is on hold currently
Communication		Development of Communications plan	To support the North Wales vascular service and highlight the progress being made, a communications plan is under development and will be reviewed by the Vascular Steering Group.	Communication Lead	Acute Site Director YGC	01/04/2021	30/06/2021		31/05/2022	In progress	QSE via Vascular steering group	Risk to delivery by due date On hold pending report from notes review			Further information required from the clinicians to complete the works for comms to share. Progress to date has been filming in the hybrid theatre an supply of 2 of the clinicians bios and photographs. 17 January update - work is currently on hold pending second RCS report.
Action Plan	10	Review of all risks to ensure captured in the risk log	Risk from all of the above actions are to be logged in the risk log and scored accordingly as to impact with current mitigations detail	Vascular Network Manager supported by Project support	Acute Site Director YGC	01/04/2021			ongoing	In progress	QSE via Vascular steering group		ongoing action		24/10/21 Revised action plan in 1st draft for review at the vascular steering group 25th October 2021 30 December - updated action plan reviewed at VSG 16 December 5 April - all risk register items are contained within the risk log tab below and will kept updated
Action Plan	11	Review of all issues to be added to the issue log	Issues from all of the above actions are to be logged in the issue log and scored accordingly as to impact with current mitigations detail	Vascular Network Manager supported by Project support	Acute Site Director YGC	01/04/2021			ongoing	In progress	QSE via Vascular steering group		ongoing action		Risks and Issues to be fixed agenda item on the CG meeting.
NVR Actions	13	Incomplete data entry for NVR submissions	Improve data entry for IR cases across BCU	BCU Radiology Lead	Executive Medical Director			01/12/2021	31/05/2022	In progress		Requires resource from vascular improvement scheme	BCU radiology lead exploring options to improve		IR consultants required to add NVR data / funding approval and recruitment required to support the B2 data entry person for vascular entry. 30 December - emailed Helen Hughes to escalate the issue. **21 January update** - meeting held with Helen Hughes - she will speak to clinicians re data entry for vascular patients. NVR data entry person would need to support - see below point in line with funding requirement for Band 2 data entry clerk Pending funding approval from HB
NVR Actions			Require NVR data entry person	Vascular Network Manager	Acute Site Director YGC			01/12/2021	31/05/2022	In progress		Requires resource from vascular improvement scheme	None until resource available		Funding approval and recruitment required, submitted as part of vascular improvement for IMTP **17 January 2022** - SBAR to be submitted to acute site director for funding to expedite Pending funding approval from HB
NVR Actions	14	Cross ref to action point 6	Improve access to emergency theatres for Lower limb revascularisation / carotid endartectomy / carotid patients / major amputation	YGS Surgical DGM	Acute Site Director YGC			01/12/2021	TBC	Not yet commenced	QSE via Vascular steering group	On hold for covid	The use of CEPOD lists in addition to theatre L for emergencies is in place		Discussed with Acute Site Director (Hub) - need to review the possibility for additional emergency theatres. Additional CEPOD list in place Fridays although not specific to vascular but increased access. Escalated at oversight meeting 21/1/22 the need for the alternate Monday all day DC list to be returned to free up a little capacity from renal access patients Meeting held with Hub DGM Surgery 10 February and assured that all efforts to be made to return the pre-covid alternate Monday list. Require resource approval for vascular improvement scheme and recruitment to allow for additional all day emergency list
NVR Actions	3	Cross ref from above for theatres	Review theatre capacity and ensure all pre-covid lists are returned	YGC Surgical DGM supported by Theatre Manager	Acute Site Director YGC			01/11/2021	31/05/2022	In progress	QSE via Vascular steering group	Covid 4th wave - issues with staffing	Cases previously completed on day case list now being added to hybrid theatres		Alternate Monday all day case list removed during covid 25th November update - issues with theatre staffing prioritising lists in place due to staffing. **11 February update** - meeting with Theatre manager and DGM Surgery YGC - to aim to have the all day alternate week Monday list back with additional staffing.
NVR Actions	16	Prophylactic Antibiotics	Review the use of prophylactic antibiotics for amputees	Vascular Clinical Lead supported by microbiology lead	Medical Director				31/05/2022	In progress	Vascular CG		Previous audit shows good performance. Possibly relates to NVR data entry		Refer to major amputation audit 18 January 2021 - 100% patient had prophylactic antibiotics. Performance through to be linked to data entry. Will re-audit later this year to confirm.
NVR Actions	17	MDT Review	All emergency patients to be discussed with intensivist, anaesthetics and relevant acute medical specialty prior to surgery taking place if unable to discuss at MDT meetings. Out of hours to use on call.	Vascular Clinical Lead supported by specialty leads	Medical Director				30/04/2022	In progress	Vascular CG		Audit to be completed on cases since 10/12/21 when team informed at CG meeting		11 Feb 22 update - Patient details and MDT outcomes received - need table top exercise to review the notes for confirmation.
NVR Actions			All amputation decisions taken outside of the NW MDT forum are to be documented	Vascular Clinical Lead supported by specialty leads	Medical Director				30/04/2022	In progress	Vascular CG		Audit to be completed on cases since 10/12/21 when team informed at CG meeting		
NVR Actions			Consider patients with significant co-morbidities carefully by the full MDT / mini MDT for either conservative treatment of above knee amputation to reduce the risk for further interventions ,	Vascular Clinical Lead	Medical Director			10/12/2021	30/04/2022	In progress	Vascular CG		Audit to be completed on cases since 10/12/21 when team informed at CG meeting		
NVR Actions	18	Reporting	Ensure action plans monitored through vascular steering group and clinical effectiveness groups	Vascular Clinical Lead supported by Sally Morris	Acute Site Director YGC				TBC	In progress / ongoing			Monitored at VSG monthly		

2nd Stage RCS notes review

Ref	Recommendation	Action	Lead	Responsible			Start	End	Complete	Status	Oversight		Assurance	Notes	Comments
20 Internal	Further review of cases informed by (1) and (2) for identified pathways or team including an assessment of whether the cases reviewed were representative	TBC by initial review	Safety and Quality Lead	Hub Medical Director			TBC	TBC		Not yet commenced	QSE via Vascular Steering Group		Plan is progressing	1.Consider external validation of summary from Vascular Society or Liverpool 2. Methodology for review process to be approved at QSE	ToR and scope to be confirmed by initial review - ToR and reporting structure confirmed as of 10/3/22
4.1.1	Ensure patients receive communication in line with regulatory responsibilities	Patients and/or families within (1), (2) and (3) receive updates and clear communication on any need for further treatment and duty candour fulfilled where care has fallen below expectations	Safety and Quality Lead	Hub Medical Director			04/02/2022	TBC		In progress	QSE via Vascular Steering Group		Plan is progressing		
4.1.2	The outcome for patients in all 47 cases (and in addition where needed in patients in (2) and (3)) identified and duty of candour fulfilled	Summary of outcomes to be reported and any impact on current audit outcome reporting considered	Vascular Clinical Lead	Hub Medical Director			TBC	TBC		Not yet commenced	QSE via Vascular Steering Group		Plan is progressing		External validation from NVR or CHKS to be considered
4.2.7 Internal	The Health Board should ensure that current practice in patient record keeping meets national standards as set out by RCS, GMC , NMC and HCPC across BCUHB	Detailed audit leading to clear improvement plans for notes and documentation including MDT discussions and consent and the development of internally owned professional standards as a part of clinical audit plan 22/23	HMT and Clinical Effectiveness Lead	MD / DoN / DoTh			01/04/2022	31/03/2023		In progress	QSE through annual clinical audit programme		Weekly notes audits completed on each site - feedback to teams		
21 Internal	Review of current Clinical Lead Vascular Service Role	Review to ensure capacity and expertise available to lead change in the service	Hub Medical Director	Exec Medical Director			26/01/2022	30/04/2022	08/04/2022	In progress	QSE via Vascular Steering Group		Interim additional leadership capacity appointed pending formal appointment and external validation/support		Pending agreement for a vascular surgeon to provide interim support - interviews planned for 8 April
4.1.4, 4.2.9	Review of MDT arrangements for vascular	Quality assurance of MDT process. To be supported by Liverpool vascular team for formal structure and challenge into clinical decision making	Hub HMT	EDICS			28/02/2022	30/04/2022		In progress	QSE via Vascular Steering Group		Liverpool involved in shorter term before formal QA commissioned		Agreement in principle agreed with Liverpool. 7/3/22 MoU now formalised and forwarded to Liverpool MD Plan to adapt Liverpool methodology for structure and function of MDT MoU signed by Liverpool - costing now needs to be agreed 5 April - arrival of professional governance lead who has been in attendance of an supporting the MDT
4.1.4	Review of MDT arrangements across BCUHB	Audit programme 22/23 to review standards of MDT across BCUHB	Health economies	EDICS			01/04/2022	31/03/2023		Not yet commenced	QSE through annual clinical audit programme		Interim CD and MD attending and supporting MDT		Use of MDFiT or similar validated tool
22 Internal	Review consent taking practices across BCUHB	Audit programme 22/23 to review standards of MDT across BCUHB	Ethical Lead	Hub Medical Director			01/04/2022	31/03/2023		Not yet commenced	QSE through annual clinical audit programme		Weekly notes audits completed on each site - feedback to teams		
24 Internal	Improvement methodology to be consistent with the approach adopted across the wider Health Board	Transformation team to be involved in development and oversight of the Vascular Improvement Plan	Director of Transformation	Director of Transformation			01/03/2022	31/05/2022		In progress					Initial meeting held 8/3/22 17 March - transformational plan in progress
25 Internal	Improvement of clinical record keeping	Prioritise vascular services for piloting of Digital Health Record (DHR)	Clinical Lead Vascular Service	All Med Directors/ Director of Digital			14/02/2022	Ongoing		In progress	PPPH		Weekly notes audits completed on each site - feedback to teams		DHR project trialling MDT proforma use at NW MDT meetings 5 April - modifications to the system are being made alongside the implementation of the electronic MDT proforma
26 Internal	Review the case sampling to ensure that the notes reviewed provide a representative sample of the service before and after centralisation	Investigate the sampling and sign off of the notes to understand the practice followed	TBC	TBC			TBC	TBC		Not yet commenced					
27 Internal	Develop clinical workforce	Review of current establishment and roles	Vascular Clinical Lead	Hub MD / DWOD / DoN / DoTh			01/03/2022	30/04/2022		Not yet commenced					Need for workforce review in RCS report 1 17 March 22 - Advert placed for Consultant and Specialty Doctor 11` March 22 5 April - potential CD being interviewed on 8 April
28 Internal	Support for vascular service in understanding Good Medical Practice and professional standards	Workshop with GMC planned on Good Medical Practice; Consent and record keeping with support from NMC / HCPC	Hub Medical Director	Exec Medical Director			25/02/2022	05/05/2022		In progress			Meeting planned with GMC/ HIW for sessions delivery to vascular team		Under discussion with GMC and need to ensure regulatory role of GMC does not conflict with formative workshops Workshops planned 29/3/22 for consent and record keeping
29 Internal	Review of regulatory implications from review	Ensure follow best practice and work with PPAS and GMC	Hub Deputy Medical Director	Hub Medical Director			TBC	TBC		Not yet commenced			Planned meeting with all senior clinicians to discuss expectations		Initial discussion with GMC on 27.2.22
30 Internal	Review of escalation processes	Ensure best practice for escalation and early intervention	All Medical director and All Nurse Director	DoN			TBC	TBC		Not yet commenced					
31 Internal	Develop clear levels of assurance for committee structure	Ensure proper scrutiny in place	Director of Governance	EDICS			TBC	TBC		Not yet commenced					
33 Internal	Understand any learning for the Board regarding visibility of, and escalation of, issues within a service under close scrutiny	Detail TBC	Hub Director of Nursing / Hub Medical Director	Board TBC			TBC	TBC		Not yet commenced					Dates suggested for next steps = awaiting update
35 internal	Development of Vascular SOP	Completion of a document that defines what vascular are and do also containing all pathways for reference	Hub Medical Director	Exec Medical Director			22/02/2022	30/04/2022		In progress					
36 internal	Review of Vascular POAC arrangements	Review the process and criteria for vascular patients and CPET review prior to surgery	Anaesthetic leads	All Medical Directors			09/03/2022	30/04/2022	24/03/2022	In progress					Meeting planned for 16 march 2022 - CPET equipment and additional sessions included in the vascular improvement funding scheme. 24 march update - agreement from Bangor to support all site CPET scanning for AAA patients and cross charge to vascular ahead of the funding approval Further review needed in order to ensure that all patients have a clearly identified procedure for anaesthetists to assess the patient for - discussion with team needed.
38 internal	Working with the senior leadership team to support their professional roles as leaders	GMC contribution to leadership team x 1 half day: senior leadership expectations and responsibilities, raising and acting on concerns FtP process and thresholds	GMC link	Exec Medical Director			08/03/2022	24/05/2022		In progress			Executive MD to liaise over dates		Initial meeting 7/3/22 Provisionally 24 May for senior leaders to receive a full workshop
		Interactive professionalism workshops with doctors and doctors in training, to support them in delivering safe care	GMC link	Exec Medical Director			08/03/2022	05/05/2022		In progress			Executive MD to liaise over dates		Workshops planned 29/3/22 and April 2022 and further session 5 May with GMC/HIW
		Maintain dialogue with HIW and secure commitment to joint delivery in key areas in particular record keeping and leadership	I Jones	Exec Medical Director			25/0/2/22	05/05/2022		In progress					Provisionally 5 May session jointly delivered GMC link
39 internal	Provision of professional support for clinicians	Engage HEIW with QAMI to ensure training concerns are being considered	S Mosley	Exec Medical Director			25/02/2022	20/04/2022		In progress					

Category	Ref	Risk	Action	Lead	Exec Lead	Start date	End date	Revised date	Status	Governance	Resources / Funding	Comments
			Sessions with leadership and case management teams regarding GMC concerns management processes and thresholds	GMC link	Exec Medical Director	TBC	TBC		Not yet commenced			Phase 2
			Secure NMC and HCPC commitment to ongoing joint work where appropriate regarding professional behaviours and consent	GMC link	Exec Medical Director	25/02/2022	20/04/2022		In Progress			Relevant parties have made contact with HCPC and meeting for 15/3 confirmed. Awaiting a response from the NMC
	41 internal	Review of air flow in hybrid theatres	Independent review from NWSSP special estates service	Assoc Director of Planning	Exec Medical Director	09/03/2022	30/04/2022		In progress	QSE via vascular steering group		
	42 internal	Improved documentation	Snap shot audit to be repeated of 20 sets of notes	Safety and Quality Lead	Exec Medical Director	31/03/2022	31/05/2022	01/04/2022	in progress			Initial snap shot completed 1/4/22. Further 20 snap shot completed 8/4/22 by professional governance lead and acting network manager.
	44 internal	Working with the Board to support their role as professional leaders	Preliminary session to be followed by GMC roles and expectations, standards and processes	GMC Link	Exec Medical Director	TBC	TBC		Not yet commenced			
AAA Pathways	45 internal	AAA surveillance management - 2 routes of entry for AAA patient with differing management across BCU and lack of central records	Upload of Betsi wide SharePoint to collate all WAASP referrals from each site to allow for robust check and challenge with operational and clinical teams	Informatics Lead - Hub	Acute Site Director - Hub	11/03/2022	20/04/2022		In progress	Vascular CG		Initial meeting with Ann Pierce - business mandate completed for AAA processes. Awaiting update form informatics
			Review of distribution mailing list and delivery point for the WAASP referrals	Operational Managers Each Site	Acute Site Director - Hub	11/03/2022	30/04/2022		In progress	Vascular CG		Sue Jackson from Public Health keen to keep the distribution list small. Need to review deputies for each allocated person
			All WAASP referrals to be added to the MDT list for awareness prior to POAC etc. and for further clinical management decisions following this	MDT Co-ordinator / equivalent	Operational Managers Each Site	11/03/2022	TBC		Not yet commenced	Vascular CG		
			All WAASP referrals to be discussed at weekly AAA meetings (site attendance compulsory - local Directorate management oversight)	ANPs all sites	Operational Managers Each Site	11/03/2022	30/04/2022	12/04/2022	In progress	Vascular CG		Managed by ANPs across BCU - needs to have Ops oversight - emailed 6 April for inclusion of ops leads or deputies.
			BI and radiology to review and update of methodology for collation of surveillance patients to ensure that they are scanned and managed in line with guidance	Radiology Lead / Informatics lead Hub	Radiology Lead BCU	11/03/2022	TBC		Not yet commenced			
			ANP on each site to be accountable for all AAA surveillance lists - Requires funding	HoN All sites	Acute Site Director - Hub	11/03/2022	TBC		Not yet commenced	Vascular CG	Some funding approved	1 ANP for YGC currently covering both YGC and YG has now resigned. Need to recruit at pace to cover the pending gap
			PABC Managers to identify vascular capacity shortfalls to the weekly OPD planning meetings	Operational Managers Each Site	Acute Site Directors	11/03/2022	30/04/2022		In progress	Vascular CG		
			Any urgent appointments to be escalated to the WL management meetings for capacity concerns	Operational Managers Each Site	Acute Site Directors	11/03/2022	16/04/2022		In progress	Vascular CG		High risk slots made available at YG for such patients - need confirmation of the same from WMH and YGC 6 April new triage form developed at WMH for PABC to escalate if cant meet timeframe requirements
Workforce	46 internal	Insufficient administrative teams to support the service across BCU - impacting upon typing backlogs, tracking AAA patients, theatre booking	Review of and completion of any backlog in letter typing	Operational Managers Each Site	Acute Site Directors	01/02/2022	20/04/2022		In progress		YGC worst position - agency typist supporting	4 April YGC now at 91 letters (from 120), 102 for YG (10 days time lag), Awaiting WMH Additional temporary resource in place to clear and updated each week at operational meetings
			Recruit admin teams the required level. Included in VIP funding request	Operational Managers Each Site	Acute Site Directors	01/02/2022	31/05/2022		In progress		Some funding approved	ECRs approve for some admin at 3 sites which will improve the ability to monitor this group of patients in the short term 5 April - approval gained for all of YG requirement, part of central and part of East requirements.
	47 internal	Inadequate nursing and therapy workforce with pending maternity leave compounding the issues - Unable to sustain a high level of care for inpatients	12 months strategy to consider the use of more premium rate agency to support the current gap and enable 23 beds to be safely staffed (also enabling the ring fencing of vascular beds) for both nursing AND therapy services to ensure minimum 5 day input	HoN and DoTH all sites	Acute Site Director - Hub	01/02/2022	31/05/2022		In progress	QSE via the vascular steering group		
		Lack of consistent ANP provision across BCU	Recruit ANP to Bangor and YGC to form a robust AAA nurse led pathway	HoN each site	Acute Site Director - Hub	28/02/2022	30/06/2022		In progress	QSE via the vascular steering group	Some funding approved for Bangor only	ANP at Centre has resigned who is currently covering Bangor AAA patients. Urgent requirement to recruit 5 April - Funding approved to advertise the ANP post at Bangor, ECR been completed to progress with Centre.
	48 internal	Medical Workforce	Approval and recruitment of MGs in line with the vascular improvement funding scheme allowing for 24/7 on call for vascular cover and also backfill for consultants annual leave	Vascular Clinical Lead	Medical Director Hub	01/02/2022	TBC		In progress	QSE via the vascular steering group	Some funding approved	31 March - Pending arrival of new recruits, there may be ability to implement steps towards a 24/7 model Pending funding approval from HB and WG
			Review of the consultant of the week / day model	Vascular Network Manager supported by professional governance lead	Vascular Clinical Director	TBC	31/05/2022		Not yet commenced			
			Vascular SOP to include processes for management, induction and support of new medical workforce.	Operational team Hub	Hub Medical Director	TBC	31/05/2022		Not yet commenced	QSE via the vascular steering group		
Transfers	49 internal	Review of the patient flow aspects to the emergency pathway to optimise safe and efficient transfer for all vascular emergency patients	Ring-fencing of vascular beds to enable the emergency pathway to be implemented and optimised	Heads of site	Acute Site Directors	10/03/2022	30/04/2022		In progress	QSE via the vascular steering group	When beds are not available pts are transferred out to make a vascular space	
	50 internal	Emergency transfers from spoke to hub	Ensure 'mini MDT' occurs with intensivist, anaesthetist, vascular surgeon prior to agreement to transfer to the hub for intervention	Vascular Clinical Lead	Medical Directors	30/03/2022	30/04/2022		In progress			
	51 internal	Potential for patients to have their treatment plans delayed that could lead to deterioration in condition	Review of the patient flow aspects to the emergency pathway to optimise safe and efficient transfer for all vascular emergency patients	Heads of site	Acute Site Directors	17/03/2022	30/04/2022		In progress			
gement	52 internal	Delay in the referral / triage / prioritisation process leading to potential delays in patient management Potential delay in follow up appointments and further interventions	Validate the X-reports	DGMs all sites	Acute Site Directors	17/03/2022	31/05/2022		In progress			31 March - YGC currently in worst position. Initial meeting with Medical Physics to review options to clear ABPI backlog and support reduction of the x-report. Validation in progress
			Calculate patient numbers and waiting times for ABPIs / diagnostics	Informatics Lead	DGMs all sites	17/03/2022	20/04/2022		In progress			4 April it is thought that the bulk of patients awaiting ABPI currently are those identified on the X-report. It is noted however that through clinical validation of the FUWL backlog, there may be further ABPI requests
			Review the potential for GPs to have access for direct access for vascular referrals	Informatics Lead	Acute Site Directors	TBC	TBC		Not yet commenced			
			Consider pooling resources across BCU for diagnostics to reduce the waiting time	Site Medical Directors	Executive Medical Director	17/03/2022	TBC		Not yet commenced			
			Carry out Value Stream Mapping of process from point of referral to discharge on all three sites, undertake a gap analysis from current service state to ideal service state, prioritise actions; quick wins, high impact, recognise significant cost maybe associated with changes	Vascular Network Director	Acute Site Director Hub	17/03/2022	31/05/2022		In progress		Rescheduled due to pivotal stakeholders having Covid	Initial meeting YG planned 22/3/22. rescheduled for 11/4/22

		intervention	Action	Owner	Responsible	Start	Orig		Revised		Status					Update
Referral manag			Directorate teams to evidence weekly management of demand	Operational teams all sites	DGMs all sites			17/03/2022	TBC		Not yet commenced	Operational network meetings				
			Validation of and clinical review of the 750 patients (YGC) follow up waiting list is required - funding required	Operational teams all sites	DGMs all sites			17/03/2022	01/05/2022		In progress					5 April 100% FUWL at YGC now 416, awaiting updates from Spokes.
	4.1	Requirement for agreed and clear pathways to ensure timely and effective treatment at Hub and Spoke sites	Diagnostic and assessment services should be available in a timely manner. CT / MRI / Sonography etc.	BCU Radiology Lead	Executive Medical Director	01/04/2021	31/05/2021		31/08/2022		In Progress		Regular review of Diagnostics waits. CT / MR compliant but sonography requires investment and recruitment lead time	Facilities available at WMH and YGC		25th November update - met with Helen Hughes, report being prepared for 26th to update the board on the progress in recovery relating to diagnostic waits. They are now meeting the Welsh Health Board guidance for 2wk wait for Urgent and 8 Wk. for routine for both CT and MR. Sonography is not yet meeting the targets and is not possible until the resource requirements are addressed to provide the staff to scan. Date has been realistically amended from 1 December to 31 March to allow time for both business case approval and recruitment of staff to achieve the desired timescales for sonography waits. All other locum routes etc. have been exhausted. Regular meetings planned to discuss progress to date and radiography are including this on their action plan. **19 January update -** Despite advertising for sonography post for Bangor - unsuccessful as yet. Plan instead to train our own sonographer and requires a 2 year plan for training completion.
28 Day Plan	53 internal	Recent SIs have lead to additional Make Safes being required for the service	Develop a robust system for image sharing with LUHFT to aid discussion of complex cases	IT lead supported by radiology lead	Acute Site Director Hub			31/03/2022	20/04/2022		In progress					
			Develop a 2nd on call tier for the extended 28 day plan	Operational team YGC	Acute Site Director Hub			01/04/2022	16/04/2022		In progress					
			Weekly monitoring and feedback to Exec team	Vascular Clinical Director	Acute Site Director			30/03/2022	23/05/2022		In progress					
INC 283017	54 internal	Ensure safe and timely transfers between hospitals	Review the actions behind the emergency pathway from WAST and patient flow perspective	Vascular Network Director	Acute Site Director			21/03/2022	30/04/2022		In progress					
		Interprofessional Standards reiteration	Reiterate professional standards in relation to management of referrals	Medical Director Hub	Executive Medical Director			21/03/2022	30/04/2022		In progress					

ACTION LOG

The purpose of this template is to record all actions from Programme-related meetings, and to record the action's owner, status and any further notes.

Action Number	Work stream	Action Description	Action Owner	Action Date	Action Deadline Line	Revised Action Deadline	Issues affecting delivery	Remedial Action - In Place or Planned	Action Complete Date	Action status	Comments	Assurance (how do we know the action has been delivered and
	Spoke site engagement	Joint job planning - consider team job planning with spoke sites to cover all required activity	Sally Morris / Cheryl Goodall / Alison Davies	03/11/2021	28/02/2022	31/05/2022				Not yet due OR In Progress	Completed for WMH Hassan Jararah. Draft completed for Bangor Ruwan Fonsekah	
	Capacity and demand	Capacity and demand for WMH required	Alison Davies	06/11/2021	20/11/2021	31/05/2022		SM commenced capacity - on hold as currently no capacity		Not yet due OR In Progress	Email sent with request 6/11/21 cc'd in Karen Carter to see if informatics can support a timely review across 3 sites	
	Capacity and demand	Capacity and demand for YG required	Cheryl Goodall	06/11/2021	20/11/2021	31/05/2022		SM commenced capacity - on hold as currently no capacity		Not yet due OR In Progress	Email sent with request 6/11/21 cc'd in Karen Carter to see if informatics can support a timely review across 3 sites	
	Capacity and demand	Capacity and demand required for YGC	Sally Morris	06/11/2021	20/11/2021	31/05/2022		SM commenced capacity - on hold as currently no capacity		Not yet due OR In Progress	Email sent with request 6/11/21 cc'd in Karen Carter to see if informatics can support a timely review across 3 sites	
	Pathways	Create and agree a transfer into ward 3 pathway	Linzi Shone / Karen Scrimshaw	04/10/2021	21/12/2021	30/04/2022		Emailed 2/12/21		Not yet due OR In Progress	Discussed with HoNs at all sites. East and West no concerns raised. Require SOP and	
	DFP West	Plan to be made for MDT Clinics and ward round for March with new diabetology Consultant arrival	Bethan Davies-Williams, Rhian Hulse and Sally Morris	14/12/2021	26/01/2022	30/04/2022		Emailed BDW 29/3 update		Not yet due OR In Progress	plan in place for vascular and orthopaedic joint clinics / MDT but no arrangements as yet for Diabetology - pending recruitment	
	DFP BCU	We require an SOP to support the how the pathway will be delivered. Meeting to be convened to link primary care, podiatry together to formulate	Balasundaram Ramesh	04/01/2022	01/02/2022	30/04/2022				Not yet due OR In Progress		
	Vascular Services Nursing	SOP requires completion for transfer pathway into ward 3	Sian Jackson / Vicky Stafford	06/01/2022	27/01/2022	30/04/2022				Not yet due OR In Progress		
	Vascular Services Nursing	Chase up vascular scientist room	Linzi Shone	06/01/2022	27/01/2022	30/04/2022				Not yet due OR In Progress		
	Vascular Services Nursing	Review use of Ward 3 Bathroom	Linzi Shone	06/01/2022	27/01/2022	30/04/2022				Not yet due OR In Progress		
	DFP West	Need to understand when and how many clinics are intended and where to be held	Faisal Shaikh / Haroon Mumtaz	11/01/2022	25/01/2022	31/05/2022	lack of physical space at YG			Not yet due OR In Progress	Jenny Farley linking in with Barry Williams	
160222-01	DFP East	**Objective A** Establish a clinical lead for MDFS to be point of contact and the lead clinician on development of the service. Their involvement in subsequent actions below will be key.	NJ / AD / HJ / PL	17/11/2021	16/03/2022	13/04/2022	Patrick / Hassan and Anthony to discuss			Overdue OR In Progress	2016 guidance suggests this should be Diabetologist but open competition from all key stakeholders could be considered. Consider whether to make a formal CSL role	
010222-02	DFP BCU	Information to be sent to Karen Carter to review the impact of joint clinics at Wrexham on reduction of emergency admission.	Nicola Joyce / GLH	01/02/2022	01/03/2022	06/04/2022		NJ sending 29/3		Overdue OR In Progress		
160222-03	DFP East	**Objective B - Establish OPD Service** B1. Establish essential and close back-up personnel for this service	NJ / AD / HJ / PL supported by relevant managers	16/02/2022	13/04/2022			All planned, timeline required for diabetology		Overdue OR In Progress	2016 guidance suggests this should be Diabetologist, DSN, Podiatrist and orthotist closely supported by other key specialties incl.	
	DFP East	B2. Establish the best time and location for the clinic to operate and adjust job plan of key personnel to suit	CP / SM / / GLH	16/02/2022	13/04/2022			Looking for Thursday - exisiting # Clinic		Overdue OR In Progress	Main options are between dept. 20 and fracture clinic and review of likely use of plaster room will need considering (see action	
	DFP East	B4. Ensure suitable note keeping system involving both therapy manager and standard clinic notes	GLH / CP / SMa	16/02/2022	13/04/2022					Overdue OR In Progress	GLH to gain access for teams across BCU to access Therapy Manager	
160222-04	DFP East	**Objective C -Establish in patient service** C1. Establish essential and main back-up personnel for this service	AD / NJ / HJ / PL supported by relevant managers	16/02/2022	13/04/2022					Overdue OR In Progress		
	DFP East	C2. Establish referral system for other colleagues to efficiently bring patients to the attention of the team possibly including central monitored email inbox	Clinical team / CP / SM / SMa working with IT	16/02/2022	13/04/2022		AD suggesting email referral to diabetology - for forwarding to appropriate specialties. Alternatively bleep AD.			Overdue OR In Progress	It is envisaged that some work will be urgent new referrals requiring a Fist response from MDFS and other work will be more planned 'follow up' work requiring ward rounds form the team. It is envisaged that diabetic foot	
	DFP East	C3. Establish a timetable when key team members will be available to attend ward referrals. May need to be allocated time each day	Clinical team / CP / SM / SMa	16/02/2022	13/04/2022					Overdue OR In Progress		
	DFP East	C4. Establish manner in which fast radiological investigations and surgical opinions can be obtained.	Clinical team supported by relevant managers and working with radiology dept.	16/02/2022	13/04/2022					Overdue OR In Progress		
	DFP East	C5. Establish which ward these patients will be admitted to when necessary assuming the majority will be medical ... likely diabetes ward.	Clinical team supported by relevant managers and working with site team.	16/02/2022	13/04/2022					Overdue OR In Progress		
1	DFP Centre	**Objective A** Establish a clinical lead for MDFS to be point of contact and the lead clinician on development of the service. Their involvement in subsequent actions below will be key	JR / GS / SZ / FA	29/03/2022	13/04/2022					Not yet due OR In Progress	2016 guidance suggests this should be Diabetologist but open competition from all key stakeholders could be considered.	
2	DFP Centre	**Objective B - Establish OPD Service** B1. Establish essential and close back-up personnel for this service	JR / GS / SZ /FA supported by relevant managers	29/03/2022	13/04/2022					Not yet due OR In Progress	2016 guidance suggests this should be Diabetologist, DSN, Podiatrist and orthotist closely supported by other key specialties incl.	
3	DFP Centre	B2. Establish the best time and location for the clinic to operate and adjust job plan of key personnel to suit	Ca H / JR / GLH	29/03/2022	13/04/2022					Not yet due OR In Progress		
4	DFP Centre	B4. Ensure suitable note keeping system involving both therapy manager and standard clinic notes	GLH / CH / KH	29/03/2022	13/04/2022					Not yet due OR In Progress	Require access for teams across BCU to access Therapy Manager	
5	DFP Centre	B5. Establish key radiological support for scan reporting and discussion	CH / KH in liaison with radiology managers	29/03/2022	13/04/2022					Not yet due OR In Progress		
6	DFP Centre	B6. Review the average number of those diabetic foot patients who require the use of the plaster room versus those that are managed by the podiatry team / orthotics etc.	JR	29/03/2022	13/04/2022					Not yet due OR In Progress		
7	DFP Centre	**Objective C -Establish in patient service** C1. Establish essential and main back-up personnel for this service	GS / JR / SZ / FA supported by relevant managers	29/03/2022	13/04/2022					Not yet due OR In Progress		
8	DFP Centre	C2. Establish referral system for other colleagues to efficiently bring patients to the attention of the team including central monitored email inbox	Clinical team / CH / SM / KH working with IT	29/03/2022	13/04/2022					Not yet due OR In Progress	It is envisaged that some work will be urgent new referrals requiring a First response from MDFS and other work will be more planned 'follow up' work requiring ward rounds form the team. It is envisaged that diabetic foot	
9	DFP Centre	C3. Establish a timetable when key team members will be available to attend ward referrals. May need to be allocated time each day	Clinical team / CH / SM / KH	29/03/2022	13/04/2022					Not yet due OR In Progress		
10	DFP Centre	C4. Establish manner in which fast radiological investigations and surgical opinions can be obtained.	Clinical team supported by relevant managers and working with radiology dept.	29/03/2022	13/04/2022					Not yet due OR In Progress		
11	DFP Centre	C5. Establish which ward these patients will be admitted to when necessary assuming the majority will be medical ... likely diabetes ward.	Clinical team supported by relevant managers and working with site team	29/03/2022	13/04/2022					Not yet due OR In Progress		

ISSUE LOG

The purpose of this document is to record all Programme-related issues and their mitigation

Definition of issue: A relevant event that has happened, was not planned, and requires management action. It can be any concern, query, request for change, suggestion or off-specification raised during a Programme. Programme issues can be about anything to do with the project.

Issue ref	Work stream	Date issue raised	Description of the issue	Description of the cause and impact	Severity - Catastrophic/ Major/Moderate/Minor/ Negligible *please use dropdown*	Issue response action
1	DFP	01/12/2021	Failure to be able to fully implement the diabetic foot pathway in advance of funding approval.	Prevention of implementation of NICE guidance for managing patients with the diabetic foot. Pathway in principle signed off on paper but issue remains as to agreement to implement the pathway ahead of the full resource required to deliver the service	Major	All have signed off on paper - now remains the issue of implementation
2	Pathways	01/12/2021	Repatriation Pathway requires an SOP and wider comms to ensure buy in from all sites	Patients remain longer than clinically necessary on ward 3 impacting upon cancellations on the day due to lack of bed availability and vascular patients being managed in non-vascular beds.	Major	Agreement on the repatriation pathway gained. Now need a rehab pathway to compliment this for patients not requiring further in hospital specialty treatment. Approved at CD/AMD meeting 21/3/22
3	Pathways	30/12/2021	Failure to agree consensus on managing day case vascular patients requiring an overnight stay following general anaesthesia at East	Potentially meaning that patients would need to be transferred to YGC for the overnight stay prior to discharge.	Minor	Agreement now gained from spoke sites - awaiting presentation and approval at CEG April 22
4	Pathways	09/01/2022	Failure to determine a single pathway for management of patients presenting with groin swelling in ED with a history of IVDU	Potentially meaning that patients will not be in receipt of standardise care across 3 sites. Likelihood of all patients being transferred to YGC putting pressure on beds.	Minor	Passed through CAG in December as no concerns raised. GS team at West then voiced concerns. Agreement under steer of West Medical Director to follow the pathway and review at 3 monthly intervals for any incidents relating to adaptation of the pathway.
5	Pathways	01/09/2021	Cultural and political issues currently posing a risk to delivery of the hub and spoke model of care	There is still a lot of frustration across the spoke sites that followed centralisation for vascular services and a feeling of being 'done to'. This is leading to some negative behaviour which is hindering development of robust processes between specialties across BCU. Some of this extends to teams refusing to sign up to pathways to improve patient experience / quality / reputation.	Minor	A Vascular Oversight group has been established led by the SRO with Medical and directors and the vascular Lead to expedite delivery of the action plan and manage obstacles. Meetings are currently in place between hub and spoke sites to attempt to alleviate issues. New Ops meetings with secretarial / specialist nurses / renal nurses have been implemented as of 7/10/21 in an effort to pull together to alleviate some bottlenecks in the service and work collaboratively.
6	Governance	01/12/2021	Lack of robust capture and sharing of learning outcomes from vascular governance / practice	Lengthy meetings and discussions but not captured succinctly and shared which could prevent learning from incidents	Moderate	Governance support requested form the vascular improvement funding scheme as insufficient resource at Centre. Acting VNM and Assoc vascular manager to support in the interim the recording of live learning outcome and action logs
7	Governance	09/01/2022	Lack of resource to allow for accurate and timely data entry onto the national vascular registry	Risk of inaccurate data being reported annually reflective of BCUHB performance benchmarked against other organisations	Major	Data entry clerk resource added to the vascular improvement funding scheme
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RISK LOG - The Risk Register provides a record of identified risks relating to the Programme, including its status and history. It is used to capture and maintain information on all of the identified threats and opportunities relating to the Programme. Please link into the milestones listed for this Programme and ensure that any risks which could impact on the delivery of the milestones is included in the risk register, and mitigation considered and recorded.

Risk No	Risk Description	Impact Description	Risk Category	Inherent risk (score before)			Date risk raised	Action Owner	Actionee	Mitigation in place or required description	Residual risk (target score)			Further Action Planned. (Who, What, Why and When anything more will be done to deduce the Residual risk)	Risk Open or Closed	Date Risk Closed DD/MM/YYYY	Risk uploaded /updated on Datix
				Probability Score 1-5	Impact Score 1-5	Overall Score					Probability Score 1-5	Impact Score 1-5	Overall Score				
1	Lack of resource within the vascular team across all grades	Currently unable to deliver required activity across all 3 sites as providing cover for VCOW and OC commitments in the first instance. Lack of Junior support for the ward, lack of MGs to provide sufficient support and backfill for all activity. ANP currently being absorbed into ward 3 to support due to junior staffing. Interim and permanent solution to admin support for the above will also be required to achieve timely outcomes	Quality/Safety	4	2	8	01/09/2021	Vascular CD / Vascular Network Manager	Sally Morris	Consultant Locum sourced to provide backfill cover. YGC / YG (1/11/21) to ensure robust cover for spoke site as only 2 substantive consultants. Searching for locum Juniors / MGs to bolster YGC support. 2 Locums in place with further to arrive. 1 F1 locum also used to buffer SHO vacancies for ward support Actions underway to determine activity for ANP to support OPD WL and patient management. New starting Consultant 24/1/22 who will support following induction at YGC / WMH	2	2	4	Capacity and demand review along with review of job plans for all clinicians within vascular is required to build into the business case to manage the hub and spoke model robustly	Open		Risk 2793 / 2791 / 4026 updated 6/3/22
2	Lack of resource of all supporting disciplines to support implementation of the DFP	All sites have so far been requested to provide estimates of what they think is required to implement the DFP as without this we are not meeting NICE guidance for managing the patient with a diabetic foot and creates delays for the patient journey	Quality/Safety	4	3	12	01/04/2020	Leads / DGMS all areas across BCU	DGMs BCU Sally Morris to pull together	Current mitigation of non-adherence to a single pathway is that patients are managed through YGC if not at spoke sites although not managed by standardised protocols	3	3	9	Business case approval and recruitment will be required across all disciplines BCU wide to achieve the DFP implementation	Open		Cross ref Risk 3457, 2788, 2794 6/3/22
4	Delays in timely diagnostics and assessments i.e. CT/MRI/Sonography	At the time of the RCS report there were reported delays in accessing diagnostics. Information has been requested from informatics to understand what the current position of this is although an SBAR written by BCU radiology lead describes human resource being an issue to deliver optimally which could delay urgent procedures or increase complications	Quality/Safety	4	3	12	01/04/2021	Executive Medical Director	Kakali Mitra	CT / MRI waiting times are compliant with the HBs guidance of 2 wks. urgent and 8 wks. routine. Sonography cannot become compliant until resource has been sourced	2	2	4	Business case approval required and then lead time for recruitment	Open		Risk 2985 06/03/22
6	Vascular bed resource and management	Ward 3 commonly has a high number of outliers (averages of 2.5 per day since April 2021) with regular high numbers of vascular outliers amongst other wards (average 5 per day since April 21) indicating the requirement of an increased bed base	Quality/Safety	5	2	10	01/04/2021	Acute Site Director	DGM supported by vascular network manager and HoN	Daily board rounds and escalation look to realign the beds but it doesn't make for an optimal patient journey. Ward 3 wish to ring-fence their beds for vascular patients in keeping with the emergency transfer pathways and to ensure the right patient in the right bed. Current figures indicate the requirement for an average of 23 beds per day for vascular patients and workforce would need to reflect this Agreement in principle to ring-fence 1 male and 1 female bed and to expand the bed base to 23	3	2	6	Ward 3 and HoN are keen to develop a high observation bay to 1) make the recruitment option more attractive ") give a wider ability to grow our own senior staff 3) allow earlier step down from HDU areas to free beds for theatre patients reducing delays and cancellations	Open		Risk 3457 6/3/22
7	Lack of access to emergency theatres	Lack of emergency theatre leads to delays in treatment and can negatively impact on outcomes and mean failure to achieve national targets. It also leads to cancellations of more planned procedures which can also negatively impact outcomes and failure to achieve targets Delays in decisions for ITU bed availability often cause 2-3 hours delays in start times affecting utilisation	Quality/Safety	3	3	9	01/04/2021	Medical Director (Hub)	Theatres DDGM supported by vascular network manager and Soroush Sorabi	1 additional CEPOD list has been provided Fridays at YGC although not for vascular sole use. Issues lie with physical space and staffing. Need to review with theatre DGM to source other opportunity	2	2	4	Review of whole theatre schedule to see if there is scope to increase access to emergency theatres	Open		Risk 2788 6/3/22
8	Data accuracy for NVR submission	There is a risk that both the data submitted to NVR has not been fully accurate historically. This can lead to performance data being published which identifies the organisation as an outlier	Reputational	3	3	9	10/12/2021	Medical Director (Hub)	Vascular CD	Consultants are requested to ensure that data is validated by NVR prior to benchmarking. NVR performance an data entry is a standard agenda item for clinical governance	1	3	3	NVR Data entry clerk has been factored into the resource requirements for Vascular improvement programme	Open		
9	Lack of Interventional Radiological (IR) Support for theatres	there is a risk that out of hours and 2.5 days per week do not have IR consultants attached to them to enable less invasive vascular surgery. Furthermore, an IR consultant has left the service meaning less than 2.5 days per week routinely covered.	Quality/Safety	4	3	12	10/12/2021	BCU radiology	Vascular CD	Ad hoc sessions being completed by other team embers but no mitigation for increasing the workforce for this niche group for the next 1-3 years	3	3	9	Following successful recruitment 24/7 cover will be available for YGC and hopefully the 2.5 days of cover can be increased for theatre L	Open		Risk 4250 6/3/22
10	Lack of OPD capacity	A lack of physical space and a lack of backfill for consultants sessions due to MG availability is creating long FUWL and long new patient backlogs.	Quality/Safety	4	3	12	01/03/2021	Elaine Hodgson	Caroline Hogbin	MG modelling, once funding approval for VIP funding scheme and successful recruitment, will allow for backfill of consultant clinics whilst VCOW or on leave.	3	2	6	Additional physical space needs sourcing for F2F vascular appointments which could allow additional clinics from MG and ANP etc.	Open		Risk 2789 / 6/3/22
11	Pre-assessment resource for vascular patients	There is a lack of anaesthetic sessions dn CPET availability for vascular patients creating delays in theatre and potentially affecting clinical decision making in MDT	Quality/Safety	4	3	12	10/12/2021	Andy Foulkes	Vascular CD / VNM	CPET has been factored into the VIP funding scheme to allow for sessions at YG and YGC for vascular patients to reduce the delays and optimise pre-op diagnostics	3	3	9	Need to take a more planned approach to managing planning for the waiting list. Awaiting more admin support from VIP funding scheme to achieve this	Open		Risk 3066, 3954 6/3/22
12	Delayed hospital transfers	Potentially making vascular beds unavailable for routine and emergency transfers and planned theatre cases	Quality/Safety	4	3	12	01/09/2021	Medical Director (Hub)	Vascular CD / VNM	the repatriation pathway and pending rehab pathways are pivotal to this risk. Pending CEG for final approval and then wider distribution and sharing openly on the Trust intranet	3	3	9	Buy in from patient flow teams at 3 sites to push / pull patients and improve ability to flow	Open		Risk 2787, 2794 6/3/22
13	Cancellation of theatre due to lack of ITU / HDU beds	High risk of delayed procedures both planned and emergent due to the lack of ITU capacity or process by which it is managed	Quality/Safety	4	3	12	01/09/2021	Andy Foulkes	Vascular CD / VNM	Standby patients allocated to lists containing ITU patient	3	3	9	Review of process for decision making for bed availability to achieve earlier start time and improved planning	Open		Risk 2783 6/3/22
14	Lack of physical space to deliver RFA for Vv treatment	Growing backlog of some routine and some urgent and highly symptomatic varicose vein patients. Some waiting as long as 5 years	Quality/Safety	4	3	12	01/09/2021	DGMs Surgery BCU	DDGMs Surgery BCU	Need to review methods of managing the WL and look to outsource and also start scheduling some symptomatic patients as golden patients ahead of space being available again	3	3	9	Need RFA room and staff reinstated to maintain run rate (across all 3 sites)	Open		Risk 2986 6/3/22
15																	

What is a risk?

• A risk is an event, or a set of related events

• It must be possible, but not necessary, for the event(s) to occur

RISK REGISTER SCORING AND RATING

LIKELIHOOD SCORING					
LIKELIHOOD SCORE	**1**	**2**	**3**	**4**	**5**
Frequency/How likely is it to happen?	This will probably never happen/recur	Do not expect it to happen/recur, but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur, but is not a persisting issue or circumstance	Will undoubtedly happen/recur, possibly frequently

Category	Consequence (Impact) Scoring				
Consequence Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Negligible (Very Low)**	**Minor (Low)**	**Moderate**	**Major (High)**	**Catastrophic (Very High)**
Quality/Safety	Minor reduction in quality in treatment or service No or minimal effect on patients/staff/ others	Single failure to meet national standards of quality or treatment or service Low effect for a small number of patients/staff/ others if unresolved	Repeated failure to meet national standards of quality of treatment or service Moderate effect for a small number of patients/staff/ others if unresolved	Ongoing non-compliance with national standards of quality of treatment or service Significant effect for numerous patients/staff/ others if unresolved	Gross failure to meet national standards with totally unacceptable levels of quality of treatment or service Very significant effect for large numbers of patients/staff/ others if unresolved
Reputational	Not relevant to organisational goals No adverse media coverage No negative recognition from the public	Minor impact on achieving organisational goals Low level of adverse media coverage Small amount of negative public interest	Moderate impact on achieving organisational goals Moderate amount of adverse media coverage Moderate amount of negative public interest	High impact on achieving organisational goals High level of adverse media coverage Negative impact on public confidence	Organisational goals will not be achieved National adverse media coverage Total loss of public confidence
Finance	Small loss Risk of claim remote	Deficit of £100,000 or less	Deficit of £100,000 to £500,000	Deficit of £500,000 to £1m	Non-delivery of strategic goal Deficit greater than £1m Failure to meet specification Claims in excess of £1 million
Regulation	No or minimal impact or breach of guidance/statutory duty	Breach of statutory legislation	Single breach of statutory duty Challenging external recommendations	Enforcement action Improvement notice Multiple breaches in statutory duty Critical report	Continued breaches in statutory duty Prosecution Severely critical report Complete system change required

	CONSEQUENCE				
LIKELIHOOD	**Negligible (Very Low)**	**Minor (Low)**	**Moderate**	**Major (High)**	**Catastrophic (Very High)**
Will undoubtedly happen/recur, possibly frequently	5	10	15	20	25
Will probably happen/recur, but it is not a persisting issue	4	8	12	16	20
Might happen or recur occasionally	3	6	9	12	15
Do not expect it to happen/recur but it is possible it may do so	2	4	6	8	10
This will probably never happen/recur	1	2	3	4	5

ISSUE CONSEQUENCE SCORING

	Consequence (impact) Scoring				
CONSEQUENCE SCORE	**1**	**2**	**3**	**4**	**5**
Descriptor	**Negligible (Very low)**	**Minor (Low)**	**Moderate**	**Major (High)**	**Catastrophic (Very High)**
Quality/Safety	Minor reduction in quality in treatement or service No or minimal effect on patients/staff/others	Single failure to meet national standards of quality or treatment or service Low effect for a small number of patients / staff / others if unresolved	Repeated failure to meet national standards of quality of treatment or service Moderate effect for a small number of patients / staff / others if unresolved	Ongoing non-compliance with national standards of quality of treatment or service Significant effect for numerous patients/ staff/ others if unresolved	Gross failure to meet national standards with totally unacceptable levels of quality of treatment or service Very significant effect for large numbers of patients/ staff/ others in unresolved
Reputational	Not relevant to organisational goals No adverse media coverage No negative recognition from the public	Minor impact on achieving organisational goals Low level of adversse media coverage Small amount of negative public interest	Moderate impact on achieving organisational goals Moderate amount of adverse media coverage moderate amount of negative public interest	High impact on achieving organisational goals High leve of adverse media coverage Negative impact on public confidence	Organisational goals will not be achieved National adverse media coverage Total loss of public confidence
Finance	Small loss Risk of claim remote	Deficit of £100,000 or less	Deficit of £100,000 to £500,000	Deficit of £500,000 to £1m	Non delivery of strategic goal Deficit greater than £1m Failure to meet specification Claims in excess of £1m
Regulation	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation	Single breach of statutory duty Challenging external recommendations	Enforcement action Improvement notice Multiple breaches in statutory duty Critical report	Continued breaches in statutory duty Prosecution Severely critical report Complete system change required

ISSUE SCORING MATRIX

Consequence scoring

5	Catastrophic
4	Major
3	Moderate
2	Minor
1	Negligible

UROLOGY TRANSFORMATION PROGRAMME

Date:
Presenter:

Primary Drivers	Workstreams/Key Deliverables	Outputs/Measures

Deliver safe, high quality and responsive Urology Services Across Betsi Cadwalader Board

Accessible Services.
The need to provide Safe Well Led Services initially through a Centralised Model then through to the RTS Patients treated in the right place first time
(Accessible Services)

1. Review current service model
2. Design RTCs clinical pathways by 2025
3. Conduct gap analysis between current and future model .
4. Undertake root cause analysis to problem solve
5. Implement changes rapidly

- Clearly defined services on each site
- Patients repatriated immediately back to referral site
- Treatment times in line with national best practice

The need to ensure adequate service provision to meet out patient , in patient and emergency demand
(Capacity and Demand)

1. Undertake capacity and demand review of urology specialties
2. Undertake modelling for wards, day cases and outpatients for centralised serviced and future RTC model
3. Design services to meet demand across the three sites to ensure fit for purpose also for the RTC

- ITU/HDU capacity meets demand
- Ward beds adequate to meet demand on all sites
- Accurate, well managed waiting lists

Effective Clinical and Administrative Pathways to ensure effective treatment
(pathways)

1. Clinicians, WAST other key clinical key stakeholders to design clinical pathways and impact, Ensure robust administrative pathways in place to support delivery of clinical pathways from point of referral to discharge
2. Ensure Transport needs can be met

- Pathways designed to provide effective care from point of referral /arrival to discharge and ongoing non acute care
- Cancer and RTT targets delivered

RTC Designed
(infrastructure)

1. RTC fit for purpose within the agreed timescales
2. Ensure centralised model clinical and standard operating procedures are effective until transfer RTC Model

- Effective and Efficient Centralised Model
- RTC transition effective
- Fully functioning effective RTCs in given timescales

The Need to Ensure Workforce is designed for a sustainable future Urology services
(People, Roles & Responsibilities)

1. Bridge the workforce gaps in all clinical teams including therapies, nursing, junior medicine and consultants
2. Skills analysis to identify future workforce needs.
3. Review the Internal Professional Standards and promote.
4. Review all relevant escalation policies.

- Reduction in the number of vacancies
- Staffing Model adequate to meet service demand
- Reduction in the use of agency staff

Governance Infrastructure

Roles and Responsibilities

Network Director
Will be responsible for:
- Providing oversight on behalf of the board for working with the clinical teams and driving transforming urology services inline with the Board's Strategy
- Driving the redesign or urology services in order to provide consistent model of care which achieve RTT and Cancer Services, targets and reducing variation in service delivery

Senior (?HMT/Execs) Sponsors

Will not undertake any specific actions but will be a

- Point of Escalation for SROs
- Visual leadership and oversight to support all work streams
- Support the SRO in ensuring timescales are delivered

(Exec Sponsors and or Directors from Acute or Secondary Care Providers)

Work Stream Teams (Reporting to the SRO)
- Comprising of clinical and operational leads from each relevant area of BCUHB with responsibility for
- deliver of the work stream project plans
- assessing progress against them
- understanding, and ensuring that risks are assessed appropriately and have effective management plans in place,
- Managing any local barriers that may impact the programme progressing.

Membership may include:
Medicine, Surgery, Cancer Services , Diagnostics , WAST, Community and Primary Care Stakeholders, Patient Representative , Corporate teams including BIU, HR, Finance

SROs
will be responsible for supporting delivery across their work streamsspecifically:
- overseeing and contributing to the development of action plans
- undertaking specific tasks to support the programme members delivery within agreed timescales
- monitoring of agreed action plans to track progress against deliverables and timescales
- supporting workstream SRO's as required to ensure task and finish group delivery and closure
- providing **Programme Highlight Report**s to HMT and BCU Recovery & Transformation Board

- **Define**
  The purpose of the Urology Improvement Programme is to deliver GIRFT standard of Urology Care initiall through a Centralised Model (*Infrastructure*) and then Regional Treatment Centres Model through a work force that is fit for purpose, which meets the needs of the service and has clearly defined roles and responsibilities (*People, Roles, Responsibilities)*

- **Measure**
   Using effective data to understand the base line position of urology service including RTT and cancer standards, mapping out the pathways initially in line with the centralised model and then the Regional Treatment Centres, to design a service that provides high quality patient care & staff experience and to ensure there is the right resources and capacity to manage demand (*Capacity and Demand)*

- **Analyse**
  Using Lean process mapping methodology and approach conduct value stream mapping for all non clinical and clinical patient pathways identify root cause of problems and develop short, medium and long term action plans to provide safe and effective pathways regardless of whether it is an RTC model or a centralised model (*Pathways)*

- **Improve**
  Run PDSA cycles to test the changes to services *(Accessible Services*)

- **Control**
  the rapid improvements completed have made a positive difference- review the data, ensure it is embedded in normal practice and effective processes across the centralise service

Programme Work Streams (Define)

1 — **People** are at the heart of Surgical services, it is imperative to ensure services are well led and people have clear **Roles and Responsibilities,** who use intelligence, data and insights to drive improvement.

2 — **Accessible Services** so that patients move seamlessly through their pathways within the Centralised model, initially then the Regional Treatment Centres regardless of where the patient is on their pathway or the infrastructure in a safe and efficient way

3 — Urology patients will have timely access to treatment as **Capacity** will be designed to ensure it meets the **Demand** to provide and excellent patient experience

4 — **Clinical and Administrative Pathways** will be designed to maximise efficiency and safe patient care from point of referral to discharge

5 — Ensuring the right **Infrastructure** to deliver safe surgical care within an effective Centralised model (transferable to the RTCs) and aligned clinical pathways

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

TRAWSNEWID & GWELLIANT TRANSFORMATION & IMPROVEMENT

People, Roles and Responsibilities

Accessible services

Infrastructure

Safe, high quality and responsive vascular emergency care

Pathways

Capacity & Demand

Time Scales
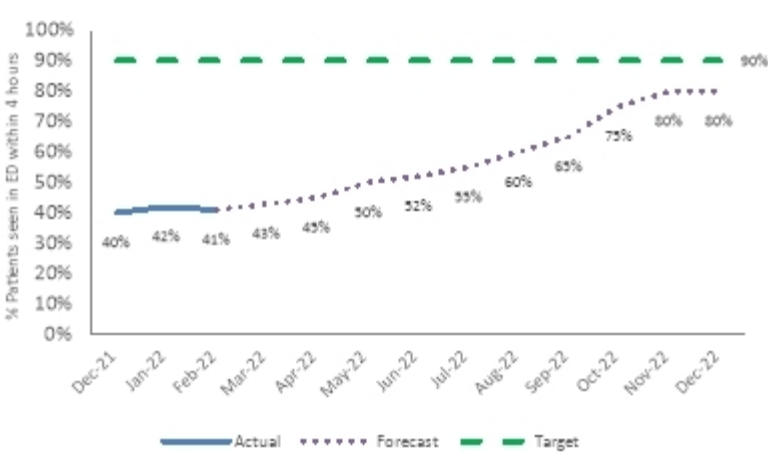
Workstream	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	RAG Narrative	RAG
Peoples Roles and Responsibilities													🔴
Accessible Services													🟢
Capacity and Demand													🟡
Clinical and non Clinical Pathways / Infrastructure (Centralise/RTCs)													🟣

Milestone Key: 🟣 Complete   🔴 Delayed   🟡 On Track with minor issues   🟢 On Track   ⚪ Not Due to Start

QUALITY BENEFITS REALISATION (**M**easure)

Outcome Measures: Cancer targets, Access targets, Diagnostic targets – by specialty and modality within RTC Planned Care specialties

Insert supporting bulleted narrative within this area:

Financial Implications

Insert graph/illustration within this area:

Insert supporting bulleted narrative within this area:

Reduction in SI

Insert graph/illustration within this area:

Insert supporting bulleted narrative within this area:

Ward 3 LoS

Insert graph/illustration within this area:

Insert supporting bulleted narrative within this area:

WORKSTREAM UPDATE

COMPLETE ONE OF THESE FOR EACH AREA OF WORK

SRO	TBC
Exec Sponsor	

Key objectives/deliverables

Outputs and measures of success

Project status (RAG)

Key Actions by who & when

Progress update

Risks & Issues

£

Controlling your Programme:

EMonthly Programme Highlight Report – ##/##/####

Programme detail

Programme Title	Regional Treatment Centre
RAG	
Quantifiable Outcomes	
Strategies	
Cost	
Sponsor		Clinical Lead	
Operational Lead		Programme Lead	

Exec summary

Exec summary headlines – latest status, key achievements, risks/issues since last update

Decisions / Escalations required

Critical milestones

ID	Milestone Description (achieved and upcoming)	Completion Date (PRAGG)	Owner	Update

Templed adroddiadau'r Bwrdd/Pwyllgor
Board/Committee report template

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

Cyfarfod a dyddiad: Meeting and date:	**QSE, 3rd May 2022**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	YGC Action Plan
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Deputy Chief Executive
Awdur yr Adroddiad Report Author:	Neil Rogers, Acute Care Director, YGC.
Craffu blaenorol: Prior Scrutiny:	*YGC Hospital Management Team 29th April 2022*
Atodiadau Appendices:	1. HIW immediate assurance action plan. 2. Restart Programme. 3. Immediate turnaround – 21 day actions. 4. Multi Agency Discharge Events.

Argymhelliad / Recommendation:
The Committee is asked to note the improvement work that is underway at YGC which is designed to improve patient flow through the system and thereby reduce congestion within the Emergency Department and enable improved outcomes and a more patient focussed service to be delivered. Combined with the specific actions outlined in response to the HIW review of the YGC Emergency Department, this should address the concerns identified by HIW as requiring immediate assurance. Additionally there are separate improvements underway with regard to the Vascular Service arising subsequent to the Royal College of Surgeons review and subsequent case note review, and many of these focus on the YGC site as the arterial hub. More recently, issues with regard to surgical services on the site more generally, particularly in relation to Urology, will be the focus of further improvement activity.

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						**No**	

Sefyllfa / Situation:
Emergency pressures at the Ysbyty Glan Clwyd site remain significant, with ED attendances and emergency admissions being above pre-Pandemic levels. The post visible manifestation of this is the delays in ambulance offload, with average turnaround times approaching two hours in March 2022.

Clearly this is needs to be urgently addressed with a more rapid transformational approach to achieve a level of service that we would wish to provide for our patients, and to mitigate against the multiple risks associated with congestion. A number of recent incidents related to care on our emergency pathways both within ED and through to the assessment units and wards, combined to the significant challenges posed by HIW's review of the Emergency Department, has led the YGC Hospital Management Team to redefine the streams of work and areas of focus. Further challenges are evident from the backlog of elective care, the Royal College of Surgeons report on Vascular services, and in Urology. The Health Board has also engaged with Public Health Wales Improvement Cymru, who have undertaken preparatory meetings and a two day site visit during April 2022. Their recommendations, when received, on the areas of work will have most impact, and crucially on the harnessing of clinical engagement and embedding change for long term positive impact, will further inform our approach.

Cefndir / Background:

The HIW inspection identified the following key areas as requiring immediate assurance.

- HIW is not assured that the current arrangements for discharging vulnerable patients from the emergency department are safe and robust, to prevent risk of harm.
- HIW is not assured that the arrangements for monitoring, observing and tracking patients throughout the department are sufficient to protect patients from avoidable harm.
- HIW is not assured that sufficient risk assessment processes are in place to protect patients from avoidable harm.
- HIW is not assured that nursing staff are adequately recording and documenting the care and treatment they provide. This poses a significant risk to patient safety.
- HIW was not assured that there is a supportive culture which promoted accountability and safe patient care. Senior operational and nursing leadership was inconsistent and did not always support the staff within the department to deliver safe and effective care.

Whilst the full report has not yet been published, the Health Board's action plan to address the above points has been accepted by HIW and the delivery of it is being closely monitored. The action plan is at **Appendix 1**. There is significant refocussing on roles and responsibilities, alongside Emergency Department processes and staff training, and particular scrutiny of how the waiting room is safely managed and the arrangements wrapped around vulnerable patients.

Since September 2021, with the support of Executives to deploy additional interim resource, the YGC site has had a "Restart" programme in place. This was set up provide a programme management approach to ensure that systems and processes were reviewed and redesigned with the engagement of clinical teams, to ensure that change was more likely to be successful and embed if there was dedicated project resource. Key achievements through the programme have been the role out of criteria led discharge and board rounds. More recently, work has moved in to elective pathways as we work to get back to (and beyond) pre-Pandemic levels of activity to reduce the unacceptably long waiting lists for consultation and treatment that have developed.

The full list of currently active work as part of Restart is at **Appendix 2**.

A 2 week "Reset Programme" ran across Wales commencing on 1st March 2022, as a result of significant challenges with regard to ambulance offloads and the impending loss of military mutual aid as part of the Pandemic response. At YGC, in view of the significant challenges faced in our emergency pathway, we broadened this approach and at the end of the Reset programme evolved this in to a 21 day Rapid System Improvement Programme. This complimented what was being achieved as part of the Restart, but the priorities were to achieve the rapid turnaround of what

appeared to be a potentially worsening position. Key achievements have been the strengthening of the site's escalation procedures, including the targeted use of boarding against planned ward discharges to spread the risk felt in ED, as well as daily focus on "stranded" (over 7 day length of stay) patients and further measures to support and improve the Same Day Emergency Care (SDEC) model. The full list of workstreams is at **Appendix 3**.

Following its first Multi Agency Discharge Event (MADE) at the beginning of March, the YGC site and wider Central system has embraced the methodology and has run "mini MADE" events focussing on up to six wards for the last four weeks. On 25th & 26th April, there was a two day MADE event spanning the Community Hospitals and YGC. It is planned that these will now be strategically positioned throughout the year at times when flow is likely to be compromised, and that the weekly focus on stranded patients using discharge to recover and assess (D2RA), what matters, Criteria to Reside and "why not home, why not today" principles continues. Further detail on the MADE events is at **Appendix 4.**

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The improvement work at YGC is focussed on providing a highly responsive service for patients presenting in an unscheduled way, and is committed to the development of Same Day Emergency Care (SDEC.) To enable this and to achieve the alignment of demand and capacity, there is a necessary focus on reducing length of stay and and bringing forward the time of day of discharge, and working with system partners to create alternatives to admission, such as current work with WAST in developing a falls team to avoid conveyance to hospital.

It is crucial that this work happens at pace to enable the return of capacity that has been used through the pandemic period to support unscheduled care back to planned care, in order to support the delivery against Ministerial commitments to reducing elective delays. This will also assist in providing the necessary capacity to deliver our challenged surgical specialities in terms of emergency provision and timely access to theatre, including Vascular and Urology.

Opsiynau a ystyriwyd / Options considered

There remains a degree of day to day fire fighting at YGC as a result of current operational pressures, and the Hospital Management Team acknowledges this and also that an over-arching improvement plan is required to provide teams with consistent direction and a vision for a better future. Inparticular, the workload associated with stabilising the vascular service at YGC as the arterial hub, and now focussing in on the provision of Urology care on the site, has been significant. The closer working with Central Area functions as we move in to the new Operating Model provides an excellent opportunity to work differently and more innovatively for the benefit of patients. The improvement approach at YGC thus far has been fluid based immediate operational pressures; however, given the recent engagement of Improvement Cymru who will imminently be providing feedback on what they have observed at YGC, there is an opportunity to bring all of this work together in the coming months in to a single plan which incorporates all elements of the site's activities.

Goblygiadau Ariannol / Financial Implications

Additional funding has been deployed to support the Emergency Department workforce and the Same Day Emergency Care model, and deployment is progressing. There has been very significant funding identified for Vascular services and the diabetic foot pathway. A number of other schemes were put forward as part of the Integrated Medium Term Plan (IMTP.) In terms of resourcing, the most significant issues identified are changed to the medical model (to improve cover to assessment units across the 7 day week), staffing arrangements for the Discharge Lounge and medical cover for Ward 10 (currently closed ward with refurbishment due for completion in early June 2022.)

Balanced against this, there is an opportunity to become less reliant upon escalation staffing for opening areas in an unplanned way to deal with pressures, and hence avoidance of premium agency costs.

Dadansoddiad Risk / Risk Analysis

A number of risks exist in relation to inadequate flow through the hospital, placement of patients in the incorrect area, congestion and ambulance turnaround. It is envisaged that the focus on ED safety described in this paper following the HIW visit, and improvement work aimed at improving flow and reducing congestion, will mitigate against these risks. The ability to protect beds to be available on demand for emergency speciality activity, including cardiac, vascular, stroke, non-invasive ventilation and fractured neck of femur, is crucial to delivering reduced risk. Similarly, the significant risks associated with delayed elective treatment will ease when the better control of the unscheduled care pathway is achieved, enabling capacity for planned care to be protected and efficiency optimised. We acknowledge that staff are working under pressure and that this has an impact on recruitment, retention and absence rates; again it is envisaged that taking a more methodical and consistent approach to improvement will mitigate against these risks.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

It is suggested that the over-arching improvement plan and KPIs, when developed with Improvement Cymru and including a whole YGC approach incorporating Vascular, Urology and other priority areas, comes back to the Committee for further discussion and scrutiny.

Asesiad Effaith / Impact Assessment

Each change as part of the improvement work is subject to QIA / EQIA as appropriate.

APPENDIX 1

Immediate Improvement Plan

Service: **Ysbyty Glan Clwyd**

Area: **Emergency Department**

Date of Inspection: **8th – 10th March 2022**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
HIW requires the health board to have an ED specific discharge process in place and ensure all staff are aware of and trained in this process, to ensure the safe discharge of patients from this department.	**Standard 5.1 Timely Access**	Daily spot checks of the ED Discharge Checklist will be undertaken manually for admitted and non-admitted patients (until the symphony system is embedded, which will enable the automated pull of the information.) The results from this will be extended to include Minor Injuries Units (MIUs) and will be presented to the HMT on a weekly basis to provide oversight of the discharge process.	Head of Nursing and Clinical Director	Immediate and ongoing	🟥	Sali Williams 22711	
		The ED Leadership has requested (through the BCU wide symphony user group) that the Discharge Checklist is made mandatory for all patients.	Directorate Manager ED	30th March 2022	🟧		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
		Currently it is only mandatory for patients where a decision to admit has been made. Symphony goes live at YGC on the 30th March 2022 and we are seeking assurance that this programming change is achievable by this date.					
		It has been agreed by ED leads to include extra fields to the mandatory checklist, including safeguarding prompts, concerns and mental capacity. This will be applied to all admitted and non-admitted patients	ED Leadership team	30th March 2022			
		The BCUHB wide Discharge Policy is being reviewed and will include specific ED discharge elements. The policy will be in place from early May 2022 and a roll out process will be implemented with ED staff.	Deputy Chief Executive and Executive Director of Nursing and Midwifery, and Assistant Director of Central Area	Early May 2022			
		Whilst awaiting the updated Discharge Policy, all EDs have been	Deputy Chief Executive and Executive	Immediate		Sali Williams 22716	

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
		instructed to use the BCU wide discharge checklist, and the applicability of the MIUs is being assessed.	Director of Nursing and Midwifery				
		Professional accountability is being reinforced via the ED leadership, supported by the HMT (who will personally undertake random spot checks) in relation to the responsibility and accountability when discharging patients from ED by strengthening processes, improving oversight and introducing spot checks, further training and reinforcing professional expectations.	Head of Nursing / Clinical Director and HMT	Immediate		Sali Williams 22717	
		Educational sessions regarding professional regulation and record keeping have already commenced for all registered nursing staff. The importance of quality checks will feature within this, including safeguarding, pressure ulcers, falls and	Head of Nursing / AHP Lead / Clinical Director	Commenced 10th March, due for completion by 24th April 2022 in YGC			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
		identification of infection risk and sepsis. This will be extended to all clinical and support staff.					
		Prior to the next version of the rota, we will ensure an experienced Band 6 is available to lead on all shifts 24/7, if there is not a Band 7 not already rostered.	Head of Nursing / Matron	16th March 2022		Sali Williams 22722	
		A band 7 senior leadership meeting has been undertaken (16th March 2022) to feedback the key findings from the HIW report. It has been agreed that there will be a band 7 on duty 24/7 to ensure senior oversight of the department. This will take effect from the next version of the rota, which is from 8th May.	Head of Nursing / Matron	8th May 2022			
		ED Safety Huddles will be undertaken every 2 hours to provide oversight of any patient safety, quality, experience and concerns, and the safety of the department. Key areas will	Head of Nursing / Matron	16th March 2022		Sali Williams 22725	

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
		include managing a deteriorating patient, as well as managing associated risk.					
		A SOP describing this approach (incorporating the roles and responsibilities of the HMT, the senior doctor and nurse on duty at every shift) in order to manage whole site and system risk will be rolled out for implementation by 25th March 2022.	HMT	25th March 2022		22727	
		A series of steps have been agreed around roles and responsibilities that will enhance oversight of patient safety and quality, whilst ensuring that the ED nurse in charge can be entirely focused on patient safety quality and experience. These steps are commencing on the 22nd March and include: i) A further CSM based within the EQ throughout the daytime ii) Move from EQ based huddles to ED safety	Head of Nursing/ Head of Site / Directorate Manager / Matron	22nd March 2022		Geraint Parry 22734	

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
		huddles with a defined SOP on the key areas of focus iii) The flow responsibilities that currently sit within the Nurse in charge role will move to an ED Clinical Flow co-ordinator.					
		Volunteers will be requested to focus on ensuring patients are offered food and drinks and that contact with families/friends and carers can be maintained, escalating as appropriate.	Head of Nursing/ Head of Site / Directorate Manager / Matron	25th March 2022		Geraint Parry 22736	
		Discharge planning will commence from the point of arrival. All patients of any age or with any type of vulnerability to be raised at ED safety huddle prior to discharge, to ensure that relevant risk assessments have been undertaken.	Head of Nursing/ Head of Site / Directorate Manager / Matron	1st April 2022			
HIW requires details of how the health board will ensure that all staff are aware of their duty to maintain	**Standard 3.5 Record Keeping**	Educational sessions regarding professional regulation and record keeping have commenced for registered nurses and support staff, and will be	Head of Nursing / Clinical Director / ED Practice Development Nurse /	Commenced 10th March 2022/ ongoing		Sali Williams 22739	

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
accurate, up-to-date, complete and contemporaneous records at all times.		rolled out to include medical and AHPs. This will be augmented by clinical audit support from corporate teams, which will be part of a broader cycle of audits undertaken. This will also include the implementation of CIWA guidelines.	Corporate Education Team				
		The HIW report has been shared with the senior nursing and medical teams. A daily spot check of record keeping will be undertaken (incorporating input from HMT) and findings reported to the governance meeting	Clinical Director / ED Matron / ED Nurse in Charge	Commenced 16th March 2022/ ongoing		Sali Williams 22740	
		The BCU Clinical Executive Directors have indicated to all clinicians the importance of the professional standards, in relation to maintaining appropriate and comprehensive reports.	Clinical Executive Directors	Commenced 17th March 2022		Tom O'Driscoll 22742	
		Following acceptance of this improvement plan by	HMT	Commenced10th March 2022		22744	

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
		HIW, the report will be shared across the site and the importance of the findings. Once the report has been submitted and approved this will be formally shared through site PSQ, the Clinical Director Forum and other forms. Learning will also be shared across sites through the North Wales Emergency Care Forum.					
		We have commenced NMC record keeping and accountability training sessions specifically for ED staff. This is being led by Associate Director of Professional Regulation and Education.	Associate Director of Professional Regulation and Education	End of April 2022			
		We are undertaking a review of PADR compliance, preceptorship arrangement for new qualified staff and induction programmes for all registered and support staff (medical and nursing). This will inform	Head of Nursing/ Clinical Director	25th March 2022		Sali Williams 22746	

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
		any gaps in knowledge and will include contemporary record keeping standards. General training has already commenced. In order to address any gaps in knowledge around record keeping we will implement a tailored training plan based on individual needs.					
		All registrants will be issued a formal notification with regard to their roles and responsibilities as a registrant. The letter will contain their job description, NMC/GMC code of Professional Conduct and how to mitigate or escalate any actual or potential concerns whilst on shift and beyond. Staff side and HR engagement is already underway with agreement in place.	Clinical Director / Head of Nursing / AHP Lead / Chief Pharmacist	25th March		Sali Williams 22749	
HIW requires details of how the	**Standard 2.1**	In order to enhance the current Manchester triage	ED Nurse in Charge	25th March 2022		Sali Williams 22748	

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
health board will ensure that there are measures in place to ensure patients accommodated in all areas of the department, including the waiting room, are observed and monitored to ensure their safety.	Managing Risk and Promoting Health and Safety	review arrangements, the nurse in charge will ensure that a dynamic risk assessment of the waiting areas, including ambulances will take place every 30 minutes.					
HIW requires details of how the health board will ensure that there are measures in place to ensure risks to patient safety are assessed and mitigated.		The nurse in charge will redeploy additional staff when required to mitigate any risks. An SOP is being developed to outline the roles and responsibilities of the registered nurses and HCAs that are accountable for the waiting areas on a shift by shift basis – and this will be in place by 25th March 2022.	ED Nurse In Charge and Clinical Flow coordinator	25th March 2022		Geraint Parry 22749	
The health board must provide HIW with details of the action to be taken to ensure consistent		Reinforcement of Intentional rounding and clinical observations processes will be reflected in the safety huddles and	ED Nurse In Charge	25th March 2022		Sali Williams 22750	

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
monitoring and recording of visual observations, physiological observations and NEWS scoring for all patients.		escalated to the nurse in charge where indicated.					
		This will be validated on a daily basis and the results reported to HMT on a weekly basis.	Head of Nursing / ED Matron / Matron of the Day	25th March 2022			
		HMT to implement Health Board workforce recommendations, ensuring refresh of plans in line with professional standards, ensuring all gaps are in the process of being recruited to.	HMT	Immediate		Neil Rogers 22751	
		Roster compliance will be strengthened to ensure compliance with KPIs. This will be validated for approval by the HoN and Clinical Lead prior to every roster sign off.	Head of Nursing and ED Matron	23rd March 2022		Sali Williams 22752	

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
		In addition to the above, real-time staffing levels for the ED are monitored via the Safe Care systems twice daily meeting between the matron of the day and the HoN. Any actual or potential issues are mitigated/escalated via staff movement or bank or agency, or escalated to HMT/silver or gold out of hours.	Head of Nursing and ED Matron	23rd March 2022		Sali Williams 22754	
		Nurse in charge and Clinical Flow Coordinator to ensure that all patients in ED are accounted for at all times. A roll call will take place before every 2 hourly safety huddle and any concerns escalated. Spot checks of the safety huddles will take place to ensure compliance with process. If a patient leaves without being seen, there are clear posters in place stating that they must make the receptionist aware. Where this happens, this will be	Head of Nursing / Directorate General Manager	15th April 2022			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
		escalated to the nurse in charge immediately.					
		Safeguarding team are providing training on the process of identifying vulnerable patients/children in ED. This process will also be cross –referenced in the Discharge Policy, which will also include the management of vulnerable patients.	Safeguarding Deputy Chief Executive/ Executive Director of Nursing	Early May 2022			
		All staff have been reminded of their professional responsibilities to escalate concerns. HMT and ED leadership will increase their visibility in clinical areas by undertaking the safety huddles, and undertaking walkabouts, particularly in times of high escalation.	HMT	30th March 2022		Neil Rogers 22759	
		This will be underpinned by an escalation plan to be devised that outlines what key actions need to take	Head of Nursing / ED Matron	30th March 2022			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
		place as the acuity and volume in the department increases.					
		All band 5 and band 6 Registrants will undertake the RCN Emergency Nurse management competencies which include taking observations and how to escalate and manage risks where appropriate.	ED Matron	September 2022			
		A gap analysis will be undertaken with regard to band 6 and 7 clinical and leadership skills that will lead to generic and bespoke training to meet the clinical and leadership requirements of their roles.	Head of Nursing/Clinical Director	End of April 2022			
		KPIs will be set for all roles.	Head of Nursing	End of April 2022			
		A Foundation for Emergency Nursing Course will be implemented on a rolling basis to include all band 5 RN's.	Head of Nursing	End of April 2022			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
		Emergency Department Discharge checklist to be amended so that all patients receive a final set of observations prior to transfer out of the department and discharge. This will be aligned with the BCU discharge policy and compliance spot checked on a daily basis and reported to HMT on a weekly basis.	Head of Nursing / Clinical Director	End of April 2022			
		Clear identification of Nurse in Charge will be in place by the end of April 2022.	Head of Nursing	End of April 2022			
The health board must provide HIW with details of how it will ensure that there are robust and appropriate leadership arrangements in place with robust and effective governance processes and measures.	**Governance and Leadership** **Standard 7.1** Workforce	The Health Board will put in a place a process enabling the HMT, Executive Team, and Independent Board members a regular process of gaining visibility and accessibility across service and clinical areas, which will incorporate walkabouts, safety huddles, *Ask the Panel events*, as well as hosting	HMT Executive Team and Independent Board Members	Commenced for Board visits 30th March 2022 for HMT		Neil Rogers 22764	

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
		monthly listening events for ED staff.					
HIW requires assurance from the health board that our findings are not indicative of a systemic failure to provide safe, effective and dignified care across all services.		HMT will put in place a process of triangulating information from different sources such as: Incidents, complaints, Speak out safely guardians, risks and monitor this as part of a mechanism to assess effectiveness.	HMT	30th April 2022		22765	
The health board must provide HIW with details of the action to be taken to ensure that, at all times, staffing levels are appropriate in order to meet the needs of patients on the ED.		As part of regular performance review meetings, there will be corporate oversight of this action plan. This will incorporate assurance reports through to the Patient Quality and Safety Group.	HMT / Executive Team	30th April 2022		22767	
The health board must provide HIW with details of the action to be taken to provide on-going support to staff and		Interim Head of Nursing in place to ensure cover for long term absence. This role will provide daily Senior visibility and give staff an opportunity to	HMT	Implemented			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
promote and maintain staff well-being.		share information and escalate concerns.					
		Staff wellbeing initiatives are in place and will be promoted, and Speak out Safely Guardians have attended the EQ Governance Meeting on 24th February 2022 and all staff were encouraged to raise issues. Following this we will implement a monthly collaborative forum consisting of HMT, Staff Side and SoS Guardians, where the HMT can be appraised of any emerging issues from the SoS Guardians.	HMT/SOS Guardians	4th April		22769	
		Management of rosters will be strengthened to ensure compliance with KPIs. This will be validated for approval by the HoN and Clinical Lead prior to every roster sign off.	Head of Nursing/ED Matron	7th April 2022			
		In addition to the above real-time staffing levels for the ED footprint are	DoN/HoN	May 2022			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
		monitored via the Safe Care systems twice daily meeting between the matron of the day and the HoN where any actual or potential issues are mitigated via staff movement or bank or agency.					
		Implement a 'QI Thursday' for senior nursing and medical staff to increase visibility, share good practice and undertake assurance visits.	DoN/HoN and Medical Director	May 2022			
		Safety huddle/debrief post shift, which will include review of shift log and documentation. This will link to existing support around TRIM where required.	ED Leadership Team	May 2022			
		We will extend the use of LEAF (Learning, Education, Alerts and Feedback) across all staff groups and ensure learning from incidents and	ED Leadership Team	End of April 2022			

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale	RAG	Named Person/Datix No.	Updates
		concerns is implemented into practice.					
		Build in PADR/appraisal/LEAF process e.g. to include the submission of a piece of reflective practice.	ED Leadership Team	End of April 2022			
		Bespoke training in Risk Management will be implemented in a prioritised manner, starting with those in key leadership positions in the department across medical, nursing and operational staff. This will focus on 3 key areas risk assessment, risk escalation arrangements and documentation of risk assessments, and will specifically address areas such as seizures, pressure areas, sepsis management, mental health assessments and alcohol withdrawal.	ED leadership team / Interim Board Secretary	End of April 2022			

APPENDIX 2

Ref	Live Transformation Projects as at April 2022 – YGC RESTART Programme
DC01	G&A Bed Demand & Capacity Modelling
ER06	Preoperative Assessment (POA) Pathway Redesign
ER06(a)	ePOAC Business Case (Health Board EAST, WEST & CENTRAL)
ER07	DOSA (Surgery) Relocation & Elective Recovery
PF01	Discharge Lounge Pathway Redesign and Business case
PF02	Board Round SOP
PF09	Medical Model - Medicine
PF03	Criteria Led Discharge (CLD)
PF11	Internal Professional Standards (IPS)
PF05	YGC Capacity Management Policy
PF06	Patient Flow Roles and Responsibilities
PF07	Internal Escalation Procedures
PF09	Right Patient, Right Place Dashboard
PF14	Extended Ward Clerk Provision
PF12	MET Calls
PF13	EQ Reconfiguration (Including SDEC)
OP01	Escalation Ward (EW19) SOP

OP02   STREAM User Group

OP03   Repatriation SOP

OP04   COVID-19 Management SOP

OP05   Oxygen Management SOP

OP06   Central System MADE

OP07   21-day System Improvement Plan (10 Priority Measures)

OP08   UEC Model Options (includes SDEC)

OP09   UEC and Patient Flow Improvement Standards

OP10   Boarding SOP (includes Ward Boarding and ED Corridor)

OP11   YGC Mini MADE

OP12   LLOS Process

APPENDIX 3 – Immediate Turnaround 21 Day Actions

Please see attached excel document

APPENDIX 4 – Multi Agency Discharge Events

Please see attached powerpoint presentation

System Improvement Plan - March 2022 (version 4)

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

This plan represents **10 priority measures** that will be taken to eliminate ambulance handover delays experienced on the Glan Clwyd Hospital site. **The plan is effective <u>Monday 21 March 2022</u>**

	Priority Measure	Responsible Lead	Immediate Delivery (next 7 days)	Short Term Delivery (next 14 days)	Medium Term Delivery (next 21 days)
1	**Eliminate ambulance handover delays (zero tolerance)**	Jane Woollard, Director of Nursing, Central	**Site Escalation** - Boarding risk assessments to be undertaken, confirming number, priority tiers and nurse ratios - Chief Nurse approval required prior to implementation and formal communication with ward staff to be enacted		
		Jane Woollard, Director of Nursing, Central	**Site Escalation** - Implement Boarding SOP to provide protocols and plan for patient boarding on wards		
		Jane Woollard, Director of Nursing, Central	**ED Escalation** - complete risk assessment and develop plan (location and staffing) for ED corridor nursing		
		Geraint Parry, Director General Manager, Emergency Quadrant	**ED Escalation** - Implement ED Corridor SOP (? Red Release Policy)		Establish ambulance holding area to support offload for up to 5 patients at any one time
		Paul Andrew, Director of Operations, Central		In collaboration with WAST implement 7-day trial for Fit2Sit within ED , to review impact and determine next steps	
2	**Clinical response to support early senior review and flow**	Mr Balasundaram Ramesh, Medical Director, Central	Clinical justification for additional blood requests for medically optimised patients	Composition of the MET and Crash calls to reduce burden on medical registrar	
		Mr Tushar Ramesh, Deputy Medical Director, Central	Discharge Registrar role to be protected to enable consistent response to MET and Crash calls		
		Mr Balasundaram Ramesh, Medical Director, Central	Escalation process of non-response to request for speciality review (no response within 1 hour of referral) - escalation to include on call consultant, moving to Directorate Clinical Director		
3	**New Discharge Lounge Model**	Rhodri Morgan, Head of Site Management, Central	Financial agreement to proceed at risk - 7 day staffing model (includes nursing and integrated pharmacy hub) operating 7-days a week, 08:00hrs to 20:00hrs	Installation of STREAM board on Ward 6 to support active monitoring and pull of medically optimised patients	
		Rhodri Morgan, Head of Site Management, Central	Implement daily **Discharge Lounge Transfer List** to detail patients scheduled for next day transfer to the discharge lounge, SOP will support escalation of wards that have no transfers listed		
		Paul Andrew, Director of Operations, Central	Provide current Discharge Lounge SOP to Director of Nursing for review	Provide list of functionality update requirements for STREAM to support discharge lounge reporting	
		Rhodri Morgan, Head of Site Management, Central	Extend discharge lounge operational hours to 7-days, 08:00hrs to 21:00hrs, confirming staffing to include B7 Manager and integrated pharmacy team	Implement new Discharge Lounge SOP	
		Neil Rogers, Acute Care Director, Central			Seek agreement for the longer term Discharge Lounge Redesign Business Case, post proof of concept

#	Theme	Lead			
4	**Long Length of Stay (>14 day LOS), Admission Avoidance and Reduction in Readmission**	Mr Balasundaram Ramesh, Medical Director, Central	Confirm named clinical leads to contribute to **daily** LLOS reviews		
		Paul Andrew, Director of Operations, Central	Implement a process for daily LLOS review; review group to include multi professional team (nursing, therapy and clinical)	Confirm arrangements for April 2022 Central System Multi-Agency Discharge Event (MADE) to span two days (day 1 community hospitals to create capacity pipeline, ahead of acute event on day 2)	Increase LLOS review focus to >7 day LOS
		Neil Rogers, Acute Care Director, Central			Confirm arrangements for 22/23 clinical input into high risk patient management to introduce case management approach
5	**Alternatives Pathways to ED**	Paul Andrew, Director of Operations, Central	Financial agreement to proceed at risk - SDEC operating 7-days a week, 08:00hrs to 23:00hrs		
		Geraint Parry, Director General Manager, Emergency Quadrant, Central	SDEC reconfiguration to convert beds to trolleys to support same day emergency assessment principles and capacity to enable direct acceptance of GP referrals (avoiding ED)		
		Geraint Parry, Directorate General Manager, Emergency Quadrant, Central	Review of the assessment footprint (AMU, SAU, EDOU, Frailty) and model, to increase assessment capacity and support a combined emergency assessment and short stay model of care		
		Nikki Ryan, Directorate General Manager, Medicine, Central		**Assess to Admit** - confirm and write up (SOP) process for emergency assessment units and early specialist assessment and decision, to ensure only those patients whom require acute inpatient intervention are admitted	
		Mr Balasundaram Ramesh, Medical Director, Central		**Assess to Admit** - confirm and implement clinical model to support early senior review and decision making within the emergency assessment units	
		Neil Rogers, Acute Care Director, Central	Review Hospital Full Policy to ensure SDEC is a protected area subject to GOLD Command escalation controls - area can **only** be opened up to escalation capacity following GOLD Command authorisation		
6	**Improve ED Safety and Flow across ED**	Sali Williams, Head of Nursing, Emergency Quadrant, Central	Establish 2 hourly safety huddle (HIW) to focus on the safety of the department and patients within ED	Implementation of ED Streaming and Redirecting SOP (including staff training programme and schedule)	
		Rhodri Morgan, Head of Site Management, Central	Re-clarification of roles to provide dedicated CSM within assessment areas linking in with ED		
7	**Discharge to Recover and Assess (D2RA)**	Paul Andrew, Director of Operations, Central	Implement direct transfer process for COTE patients requiring community bed care (wards 1, 2, 7 and 14)		
		Steven Grayston, Assistant Area Director, Therapy Services, Central			Implement community based therapy assessment model to enable functional assessments to be completed in the community setting for medically optimised patients
		Steven Grayston, Assistant Area Director, Therapy Services, Central			Plan for the relocation of Stroke Rehabilitation to be achieved by end of April 2022 (releasing 10 beds to the acute system)
		David Allison, Asst Director, Intermediate Care Services and Specialist Medicine, Central	Set the standards and targets for D2RA transfer s (P2 24hrs, P3 48hrs)	Embed D2RA transfer standards and targets across the system (P2 24hrs, P3 48hrs)	
		Paul Andrew, Director of Operations, Central	Set the standards and targets for same day discharge for all medically optimised patients, no longer requiring acute intervention or community or social care support (P0)	Embed **same day discharge** expectations for all medically optimised patients no longer requiring acute intervention nor community or social care support (P0)	

8	Board Rounds	Jane Woollard, Director of Nursing, Central	Review current board round script to identify any gaps in required discussion points; strengthen the embedding of the use of the board round script	Implement Board Round Audit schedule to include daily (ward level) and quarterly monitoring and reporting	
		Jane Woollard, Director of Nursing, Central	Review nurse and clinical responsibilities in YGC Board Round SOP to identify and address any gaps; strengthen the embedding of role and expectations	Following previous listening and engagements events (Aug, Sept 21), arrange nursing Listening events to capture learning and experience to inform next steps	
		Mr Balasundaram Ramesh, Medical Director, Central	Engage clinicians with Criteria Led Discharge to support embedding and adherence to BCU policy		
		Rhodri Morgan, Head of Site Management, Central	Implement a Matron and senior clinical board round rota, to support attendance at daily board rounds (Monday to Friday)		
9	Patient Flow Management	Rhodri Morgan, Head of Site Management, Central	Review site meeting structure, schedule and attendance to ensure meetings are held with the appropriate attendance at key points throughout the day		
		Rhodri Morgan, Head of Site Management, Central	Develop and implement action cards for Patient Progress Facilitators to support ward staff progress discharge planning		
10	Urgent Care Centre (UCC)	Paul Andrew, Director of Operations, Central		Develop plan for the establishment of a UCC on the YGC site	Relocate GPOOH service to the YGC site
		Paul Andrew, Director of Operations, Central			Explore options to develop the urgent and emergency care pathway based on the emergency village concept

Additional Interventions

Intervention	Description	Expected Delivery	Responsible Owners
Falls Response Team (Central)	Emergency WAST vehicle and team based in the community to respond to 999 calls relating to falls - operating 4 days per week, the team will comprise of nominated paramedics (working towards therapy joining the team); based on previous models expecting <25% conveyance rate This intervention will be implemented ahead of the full BCU business case to implement a FRT across the health board		Paul Andrew, Director of Operations, Central Steve Sheldon, WAST/Steve Williams WAST
WAST contribution to Central System Multi Agency Discharge Event (MADE) 25 - 26 April 2022	WAST senior team leader to join the MADE on 26 April (acute site) to support improved patient flow across the assessment areas, focusing on pathway improvements and admission avoidance	26-Apr-22	Paul Andrew, Director of Operations, Central Steve Sheldon, WAST

Issues

Issue	Response	Expected Delivery	Responsible Owners
Inpatient Phlebotomy Services Inconsistent phlebotomy service to wards, impacting early pathology diagnostics and decision making; level of service to wards compounded by continued service provision to primary care and community, frequently taking priority over acute services	Ward based Patient Progress Facilitators (PPFs) to be trained as competent to undertake cannulation and blood sampling; x3 PPFs already trained (subject to competency sign off), plans to complete next x3 team members		Rhodri Morgan, Head of Site Management, Central
Senior Clinical Escalation (delayed speciality review) SYMPHONY recording of time to referral (time stamp) needs to be consistently recorded by ED staff to ensure accuracy of information and appropriate escalation to the Consultant on Call or Clinical Director, and enable an auditable trail of time stamps	ED 2hr huddles to inlcude review of referral times to ensure data recording and integrity and act as a check point for senior clinical escalation; plans to incorporate ED Referral dealys into the Right Patient, Right Place (RPRP) Dashbaord to enable organisational visibility		Sali William, Head of Nursing, Emergeny (Interim) Paul Andrew, Director of Operations, Central

Central System
Multi Agency Discharge Event (MADE)

MADE Team Guidance Pack

25 - 26 April 2022

Central System MADE

Following the first system event held in March 2022, and using the feedback and learning provided by participants, the next **Central System Multi Agency Discharge Event (MADE)** will run over **two days.**

Day 1: Monday 25 April - Community MADE (Central)
- led by the Area team, in partnership with Denbigh, Flintshire and Conway local authorities

Day 2: Tuesday 26 April - Acute MADE (Glan Clwyd Hospital)
- led by the acute team (clinical, nursing, therapy, operational), in partnership with the community step down matron (with escalation into Denbigh, Flintshire and Conway Local Authorities), Primary Care (GP) and the Welsh Ambulance Service Trust (WAST)

- will comprise of four multi-professional MADE teams and a command hub for escalation and senior intervention or decision making where required. MADE teams will have assigned loggists that will capture and record the actions and next steps required to progress a patients discharge

- will include focused sessions, including board round attendance including critical review of all patients to identify delays and actions to progress discharge, and a targeted team to review the emergency pathway, to identify alternatives to ED, understand the causes for emergency admissions and what could have been avoided

  See Acute MADE Team: Activities and Remit

Acute Pre-Made Interventions

De-escalation of acute patients from Ward 19

- to commence Friday 22 April. The aim is to de-escalate acute patients to enable the ward to act as a step down area for medically optimised (MFD) patients who are expected to discharge within the next 24-48hrs; optimising all discharge opportunities to create step down capacity during and/or post bank holiday period

De-escalation of escalated RED Wards (Ward 4)

- working towards repatriation of Ward 4 as COVID-19 positive numbers decrease; this will commence ahead of the Easter bank holiday, and continue until positive cases reduce to a point they can be accommodated within cubicle capacity

MADE Objectives

The two day event is targeted to deliver collaborative working, momentum and improved performance, to:

- increase the number of simple and supported discharges to provide emergency bed capacity across the system pre and post bank holiday period to increase flow

- maximise bed occupancy in the community, optimising Discharge to Recover and Assess (D2RA) capacity (Pathways 2 and 3) and ensure early and robust discharge plans are in place for patients needing supported discharge

- de-escalate from DOSA (Medicine) **focusing on discharge rather than transfer to another inpatient area**, to reduce medical outliers and enable relocation of DOSA (Surgery) to support central system elective activity to fully resume from May-22

- reduce length of stay across medicine and surgery and increase the number of morning discharges

- identify social admissions (within previous 48hrs) for social care review and plan to support early discharge and prevent readmission

- system awareness of social care provision going into the back holiday period, seeking to optimise any additional discharge opportunities

Acute MADE Objectives

Our collective objective today is to achieve 70 discharges

The Acute MADE will be measured by the following metrics:

- Number of discharges before 10:00hrs
- Number of discharges before 12;00hrs
- Number of discharges before 15:00hrs
- Number of patients transferred to the discharge lounge
- Number of empty beds
- Reduced number of patients with LLOS (>7 days and > 21 days)
- Reduced number medical outliers

YGC Adult Discharge Profiles (emergency discharges, exc W&C and Maternity)
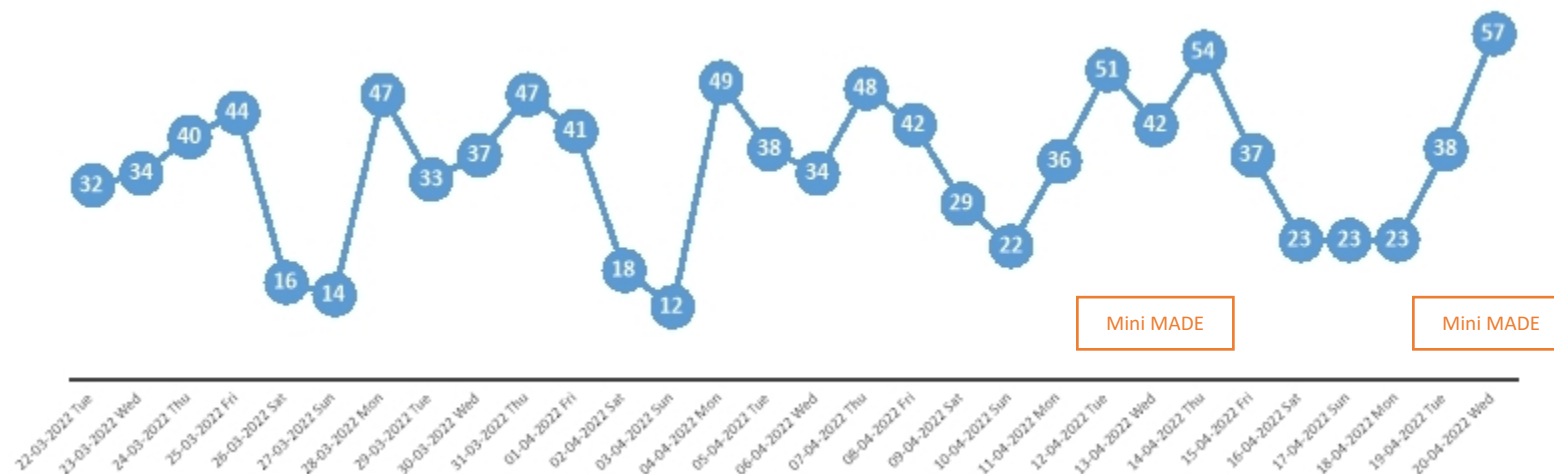
7 day discharge profile

- Increased discharges numbers during April, corresponding with YGC Mini MADE
- Increased weekend discharge numbers over bank holiday weekend compared to previous weeks
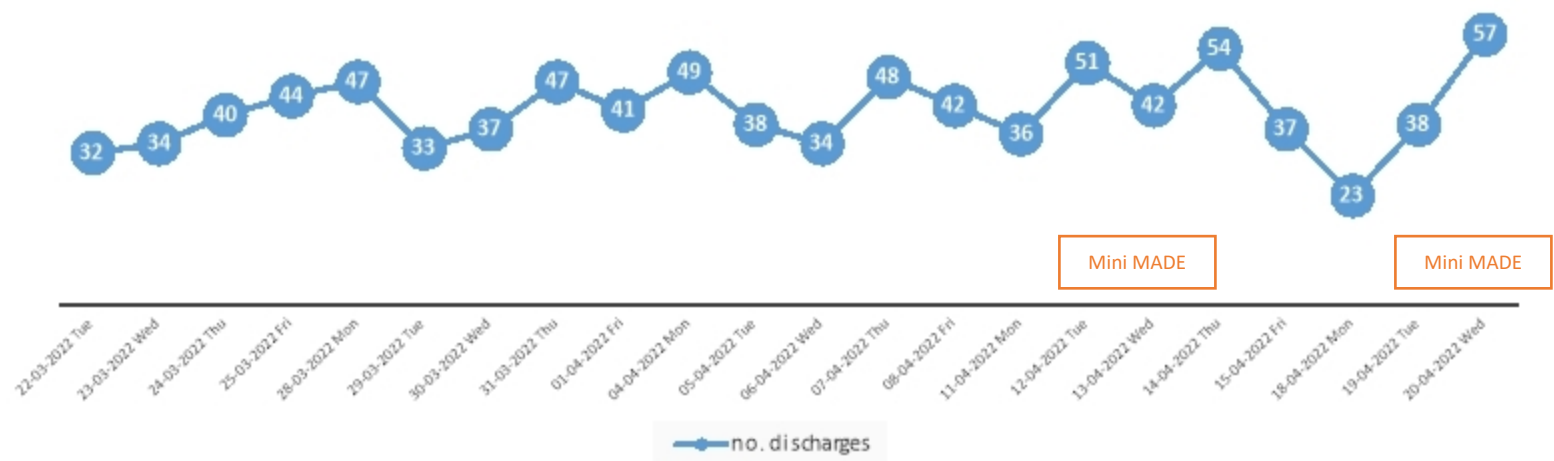
weekday discharge profile

- Median weekday discharge number = 41
- Increased discharges numbers during April, corresponding with YGC Mini MADE

Acute MADE Schedule

All sessions (not requiring ward or ED attendance) will be held in the **Lecture Theatre, Clinical School, YGC,** located on the first floor, above the Education Centre

08:00 - 08:30	**Welcome and aims of the day** - Paul Andrew, Director of Operations (YGC)

MADE Teams 1, 2, and 3	
08:30 - 08:45	Comfort break and meet your team
08:45 - 12:30	Attend allocated ward Board Rounds
12:30 - 13:00	Feedback Session
13:00 - 13:30	Comfort Break
13:30 - 15:30	Professional Group Session

MADE Team 4	
08:30 - 08:45	Comfort break and meet your team
08:45 - 12:30	Attend ED to review alternative pathways
12:30 - 13:00	Feedback Session
13:00 - 13:30	Comfort Break
13:30 - 15:30	Deep Dive Session

15:30 - 16:00	**Reflection Session** - David Allison, Unscheduled Care Programme Director (BCU)

Acute MADE Teams: Activities and Remit

Teams 1, 2, 3	
Morning Session Assigned MADE Team	MADE Teams join allocated ward board rounds for critical review of all patients to: a) confirm patient list and predicted date of discharge (PDD) b) identify any immediate delays to patient journey and discharge c) identify any social admissions (within previous 48hrs) for social care review and plan to support early discharge and prevent readmission d) identify patients indicating supported discharge (D2RA) and plans are in place e) identify alternative solutions (where necessary) for LLOS patients (>21 day) where discharge has failed to progress f) capture thematic issues and barriers that impact patient flow across the system g) report immediate and next step actions (including assigned owner) to the Team Loggist, throughout the morning session, for recording and tracking
Feedback Session	Identify a nominated individual from each of the teams to provide verbal feedback from the morning session, focusing on thematic issues and opportunities for 'what can we change from tomorrow'
Afternoon Session Professional Groups	MADE participants to split into professional groups (clinical, nursing, therapy, operational) to: a) target and manage immediate actions to resolve delays or barriers to discharge b) identify next step actions to be taken forward by ward teams in the next 24hrs
Reflective Session	The final session of the day will provide an overview of the key learning, insights and emergent themes to be reflected in the Unscheduled Care Improvement Programme (all 4 workstreams)

Acute MADE Teams: Activities and Remit

Team 4	
Morning Session	MADE Team attend ED to: a) review alternative pathways to reduce emergency admission b) understand the relationships and communications between the ED, community services, primary care, social care and ambulance services c) capture thematic issues and barriers that impact alternative pathways
Feedback Session	Identify a nominated individual from the team to provide verbal feedback from the morning session, focusing on thematic issues and causes for ED attendance, and opportunities for 'what can we change from tomorrow'
Deep Dive Session	MADE Team to: a) ED case note review (4 - 5 patients currently in ED, ideally patients identified as high risk) to determine what was happening in the community prior to arrival, if attendance could have been avoided, and gaps in community services, that if in place would have avoided ED attendance
Reflective Session	The final session of the day will provide an overview of the key learning, insights and emergent themes to be reflected in the Unscheduled Care Improvement Programme (all 4 workstreams)

Acute MADE Teams: Activities and Remit

Command Hub	
Escalation	a) Act as a point of escalation for delays or barriers to discharge that require senior intervention or decision making
Recording	a) Maintain a MADE log, to record all actions, next steps and feedback reported by the MADE Teams b) Maintain an in day discharge position (using the 08:00hrs position as the baseline) with a updated position reported at the reflective session
Reporting	a) Collate all feedback, and acute discharges numbers and occupied bed days (for periods 24-Apr to 2-May) to be used as part of a **MADE Feedback Report,** to be shared with MADE participants and system partners within 7-days of the event

MADE Information and Reports

MADE Teams 1, 2 and 3 will be provided an information pack at the 08:00hrs welcome session

The pack will include:

- Detailed **patient level lists** (by ward, assessment area) including patients referred to community hospital beds (D2RA Pathway 3), medically optimised (MFD) and patients >21 day LOS
- Action Record Sheets
- Feedback Record Sheets

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Healthcare Inspectorate Wales (HIW) Update
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO
Awdur yr Adroddiad Report Author:	Claire Manuel, Quality Assurance Manager Erika Dennis, Senior Quality Assurance Manager
Craffu blaenorol: Prior Scrutiny:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO Matthew Joyes, Acting Associate Director of Quality
Atodiadau Appendices:	HIW Inspection Reports

Argymhelliad / Recommendation:

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

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

Sefyllfa / Situation:

This paper provides the Committee with an annual look-back report on HIW activity during the preceding year. As part of the Committee's return to normal business following easing of pandemic arrangements, it will now form a regular report going forward.

Cefndir / Background:

Health Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales. HIW reviews and inspects NHS services in Wales, and regulates healthcare providers against a range of standards, policies and regulations to ensure they comply with regulations and meet the healthcare standards, highlighting areas of improvement.

HIW also monitor the use of the Mental Health Act and review the Mental Health service to ensure that vulnerable people receive good quality of care in mental health services.

HIW are also requested by HM Inspectors of Prisons to provide a clinical review of a prisoner's healthcare if they die in custody.

The Health Board manages correspondence and inspections from HIW via an internal standard operating procedure.

All correspondence from HIW is received into the Health Board via the Chief Executive's Office or direct to the Quality Directorate (to a dedicated inbox) depending on the request i.e. inspection, request for information, raising of concerns. All correspondence to HIW follows a review and approval process from the service through to the appropriate director sign off, prior to submission. Monthly engagement meetings are held between the Health Board (the Associate Director of Quality) and an assigned relationship manager/team from HIW.

The Quality Directorate continues to capture and monitor HIW activity via the DatixWeb concerns system, whereby action plans developed in response to HIW inspections and enquiries are inputted and assigned to responsible officers. Actions are followed up to completion, with the support of the Quality Assurance Team, and evidence supporting progress is uploaded. This enables an efficient and auditable process for regulatory activity and Health Board response, as well as an opportunity to provide regular reports.

The cloud based DatixCymru system that has been implemented as of the 1st April 2022 does not support HIW activity capture and management; discussions have been held with the national Once for Wales Management System (OFWCMS) to address this deficit, but will not be realised within this financial year. In the interim, the Quality Assurance Team are looking to develop an internal bespoke system that replicates the functionality to ensure that there are no gaps.

Asesiad / Assessment & Analysis

In the period April 2021 – March 2022 the inspections covered the following areas:

Mental Health & Learning Disabilities National Review of Mental Health Crisis Prevention in the Community Mesen Fach Ward, Bryn y Neuadd Hospital Hergest Unit, Ysbyty Gwynedd Tan Y Coed, Bryn Y Neuadd Foelas Ward, Bryn y Neuadd	5
Acute Hospital National WAST Review National Review of Patient Flow Emergency Department, Ysbyty Gwynedd Emergency Department, Ysbyty Glan Clwyd	4
IRMER Compliance Inspection of the Diagnostic Imaging Department – Wrexham Maelor Hospital	1

Due to the continuing COVID-19 pandemic, HIW have continued to use a three-tiered model of assurance and inspection that reduces the reliance on onsite inspection activity as the primary method of gaining assurance:

- **Tier 1** - activity will be conducted entirely offsite and will be used for a number of purposes but, at this stage, primarily where issues cannot be resolved via their standard concerns process and where the risk of conducting an onsite inspection remains high.
- **Tier 2** will introduce a combination of offsite and limited onsite activity, whilst
- **Tier 3** will represent a more traditional onsite inspection.

As would be expected the majority of inspections in the period April 2021- March 2022 were carried out off-site by a process identified as a 'Tier 1 – Quality Check'. This process included the completion of a self-assessment form and a call (preferably video-call) with the local manager/lead of the area under inspection. The approach seeks assurance around four key areas of service. These are: arrangements for dealing with COVID-19, environment, infection prevention and control (IPC), and governance.

Summary of inspections April 2021 - March 2022

Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover, April 2021 (Appendix A)

As part of their annual programme HIW undertook a remote review of WAST. The focus of the review was to consider the impact of ambulance waits outside Emergency Departments (ED) on patient safety, privacy, dignity and their overall experience. As a result of their findings from this review HIW made a number of recommendations (national) around patient flow through ED, escalation and staff handover and improving patient experience.

National Review of Mental Health Crisis Prevention in the Community, April 2021 (Appendix B)

As part of their National Review, HIW undertook a remote review of Mental Health Crisis Prevention in the Community. The focus of this review was to identify how people at risk, or facing a mental health crisis are supported in the community, and how timely support can be accessed.

As part of this review HIW engaged with professionals in the Mental Health Community Services and Primary Care along with a national public survey to capture the views of people. As a result of their findings, HIW made a number recommendations around accessing services and receiving timely care. Whilst HIW have not requested submission of an Improvement Plan, action plan will be reported to the Patient Safety & Quality Group in May 2022.

Mesen Fach Ward, Bryn y Neuadd Hospital, May 2021 (Appendix C)

HIW undertook a remote quality check of Mesen Fach ward, Bryn y Neuadd Hospital. Mesen Fach provides assessment and treatment, and therapeutic support services for up to nine patients with learning disabilities.

The quality check identified one recommendation for improvement around the discharge planning progress for patients admitted for lengths of stay. Overall HIW found evidence of a dedicated staff team that were committed to providing a high standard of care to patients. There was evidence of strong and supportive leadership and HIW found the service provided safe and effective care.

IR(ME)R Compliance Inspection of the Diagnostic Imaging Department – Wrexham Maelor Hospital, October 2021. (Appendix D)

HIW is responsible for monitoring service compliance with the Ionising Radiation (Medical Exposure) Regulations 2017. HIW completed an announced IR(ME)R inspection of the Diagnostic Imaging Department and identified areas of improvements in governance and leadership, delivering safe and effective care and workforce processes.

Hergest Unit, Ysbyty Gwynedd, September 2021 (Appendix E)

Healthcare Inspectorate Wales (HIW) completed two unannounced mental health inspections of Ysbyty Gwynedd, Hergest Unit within Betsi Cadwaladr University Health Board. The first starting the evening of 6 September 2021, the second starting the evening of 20 September 2021. During the inspection commencing 6 September, HIW identified a number of areas of concern particularly around Infection Prevention and Control, and Governance and Leadership. Due to concerns about patient safety, HIW issued an immediate assurance letter, where they wrote to the service immediately after the inspection with their findings requiring urgent remedial action. They then returned to undertake a further unannounced inspection on 20-22 September to ensure the Hergest Unit was providing safe and effective care. Overall, they found evidence that the Health Board had started to implement systems and processes to address areas identified in the immediate assurance issued. However, further improvements were identified in the inspection on the 20-22 September 2021.

The inspection found a dedicated staff team that were committed to providing a high standard of care to patients and treating patients with dignity and respect. From their findings improvements needed around infection prevention measures, governance and leadership, and patient safety of which an immediate assurance letter was issued. Staffing issues were also escalated during the inspection along with communication and engagement. Improvements were also required in the completion of patient care plans and staff rotas.

The published report has been presented at the Quality and Safety Executive Committee.

Tan Y Coed, Bryn Y Neuadd, 19 October 2021 (Appendix F)

HIW undertook an unannounced inspection of Tan y Coed on 19-20 October 2021. Tan y Coed provides a rehabilitation service for people with learning disabilities. HIW found evidence that overall the service provided a positive patient experience, with a good level of safe and effective care delivered to patients. HIW found evidence of a well-established management team, which was supported by a committed workforce and sound local governance arrangements. The inspection identified a small number of improvements to strengthen the service model and promote a quality patient experience.

National Review of Patient Flow, December 2021

As part of their annual review HIW will undertake a national review of Patient Flow. The focus of the review is to gain a greater understanding of the challenges that healthcare services face in relation to how patients flow through healthcare systems, and to test if arrangements for patient flow are robust. In order to assess the impact of patient flow challenges on quality and safety of care for patients awaiting assessment and treatment, HIW decided to focus our review on patients travelling through the stroke pathway. This will include the point of requesting an ambulance (or someone self-presenting at an Emergency Department), through to their discharge from hospital or transfer of care to other services. Following the submission of a self-assessment and an update on discharge processes (against national recommendations) HIW will undertake onsite visits, which will focus on case studies of people travelling through the stroke pathway. HIW have confirmed they will be visiting YGC on 9 – 11 August 2022.

Terms of Reference for the review is available on the HIW website.

Emergency Department, Ysbyty Gwynedd, February 2022

HIW undertook a two stage remote quality check of the ED department, which focused on infection prevention, environment, governance and staffing. The inspection found immediate assurance improvements were needed around timely access, discharge planning and record keeping and identified improvements needed for patient accessing facilities in the department and staff oversight of the waiting

areas. An Immediate Assurance Improvement Plan was submitted and accepted by HIW; we are currently waiting for the final report to be published.

Publication of the inspection report by HIW is scheduled for 19 April 2022.

Foelas Ward, Bryn y Neuadd, February 2022.

HIW undertook a remote quality check of Foelas Ward, which is an eight bedded learning disability ward. The focus of the quality check was on infection prevention, environment, governance and staffing and the Mental Health Act. The inspection found a dedicated staff team that were committed to providing a high standard of care to patients. There was evidence of strong and supportive leadership and HIW found the service provided safe and effective care. The quality check identified one recommendation for improvement around the risk assessments for mechanical restraint to be included in risk assessments. An Improvement Plan was submitted and accepted by HIW.

Publication of the inspection report by HIW is scheduled for 22 April 2022.

Emergency Department, Ysbyty Glan Clwyd, March 2022

HIW undertook a two stage remote quality check of the ED department, in response to intelligence received from a significant incident reported to Welsh Government, and information provided by the health board. The quality check focused on patients receiving safe and effective care. Following the quality check HIW found immediate assurance improvements were required around timely access, discharge planning, record keeping, managing risk, and governance and leadership. An Immediate Assurance Improvement Plan has been submitted and accepted by HIW.

Publication of the inspection report by HIW is provisionally 18 May 2022.

Concerns, enquiries and requests for information

As well as formal inspections, the Health Board has also received a number of concerns raised by staff and patients/carers to HIW, as well as information requests following the submission of Early Warning Notifications to Welsh Government and deaths in custody health record requests. These include staffing issues, access to services and safeguarding concerns. All concerns/information requests are responded to through the established process.

Actions status

Inspection	Date of inspection	Action Status			Total
		Implemented	**In Progress**	**Overdue**	
WAST Review	September 2021	Awaiting service update			19
Mesen Fach Ward, Bryn y Neuadd Hospital	May 2021	1	0	0	1
IR(ME)R Compliance Inspection of the Diagnostic Imaging Department – Wrexham Maelor Hospital	October 2021	5	13	0	18
Hergest Unit, Ysbyty Gwynedd	September 2021	29	0	3	32
Tan Y Coed, Bryn Y Neuadd	October 2021	12	1	0	13
National Review of Patient Flow	December 2021	2	6	5	13
Emergency Department, Ysbyty Gwynedd	February 2022	17	4	8	29
Foelas Ward, Bryn y Neuadd	February 2022	1	0	0	1
Emergency Department, Ysbyty Glan Clwyd	March 2022	12	21	12	45
Total		**79**	**45**	**28**	**171**

Action plan development is a key skill to ensure that actions are SMART (specific, measurable, achievable, realistic and timely) and the Quality Directorate has included Action Planning within its training portfolio. Whilst monitoring of Action Plans is a role within the Quality Assurance Team, the responsibility sits within each service area to ensure that actions are completed on time and provide evidence of completion and continued oversight to ensure any changes are sustained.

We would like to assure the committee that the Quality Assurance Team are working with key service leads to ensure that updates and evidence for all overdue actions are uploaded to the Datix system for appropriate approval and sign off, as a matter of priority.

In relation to the inspection of **Emergency Department, Ysbyty Gwynedd,** 17 actions have been successfully implemented by the service for which evidence has been received. For the remaining 4 actions in progress and 8 actions overdue, appropriate assurance has been received that these actions are a priority and are being monitored with oversight at the Site Quality and Safety meetings.

Key themes/findings

It is important to note that many of the actions or improvements arising relate to the health board providing safe and effective care and governance. The most common Health and Care Standards themes which relate to the actions noted in the table above are as follows;

- Safe and Clinically Effective Care
  - Infection control
- Timely Access
  - Discharge planning

- Staff and Resources
  - Training
  - Staff wellbeing
- Effective care
  - Record keeping

Conclusion

The HIW inspection process provides the Health Board with significant opportunities for learning, from both the improvement plans and the positive practices and experiences described in the reports. The Quality Assurance Team support key leads from within the services to ensure focus on the required improvements from inspections, helping to create a positive culture of learning and to avoid repeated errors and instances of harm. Furthermore, it ensures that sufficient assurance is provided to the Board.

The Clinical Executive Directors are meeting with the Acting Director for Quality to review all HIW inspections to triangulate with data from other areas e.g. concerns, external reviews including Royal College, to identify services and/or areas requiring improvement. This session is being arranged for early May 2022.

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered - Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – This is contained within the report.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – This is contained within the report.

Asesiad Effaith / Impact Assessment – Impact assessments are not required for this report

Welsh Ambulance Services NHS Trust

Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover

Emergency Department

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare.

Our values

We place patients at the heart of what we do.

We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance:
Provide an independent view on the quality of care.

Promote improvement:
Encourage improvement through reporting and sharing of good practice.

Influence policy and standards:
Use what we find to influence policy, standards and practice.

Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. We are responsible for inspecting, reviewing and investigating NHS services and independent healthcare services throughout Wales against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. In our role, it is important that we maintain an overview of each of the NHS health boards and Trusts in Wales.

The COVID-19 pandemic has introduced unique and unprecedented pressures on the healthcare system, however, it is our continued commitment and goal to check that people in Wales are receiving good quality care, which is provided safely and effectively, in line with recognised standards.

As part of the HIW annual reviews programme for 2020-21, we committed to undertake a local review of the Welsh Ambulance Services NHS Trust (WAST). This was due to concerns identified with long handover delays during a previous WAST local review carried out in 2019-20, where we explored how the risks to patients' health, safety and well-being were being managed, whilst they were waiting for an ambulance to arrive. A copy of this report can be found on our website[1].

This review set out specifically to consider what the impact of ambulance waits outside of Emergency Departments is having on the overall experience of patients, which included their safety, care, privacy and dignity. We considered the period between 1 April 2020 and 31 March 2021.

This report sets out our findings and recommendations for improvement. It is our expectation that our recommendations are considered at a system level and are taken forward in the context of broader improvement work underway to tackle the challenges faced in this area over recent years.

We would like to express our thanks to all of the patients who helped inform our review by completing our survey and sharing their experiences with us. We also convey our gratitude to staff working within WAST and health boards across Wales who participated in this review, which included completing our professional surveys and participating in interviews with the HIW review team.

In addition, we wish to thank the Community Health Councils[2] in Wales, which provided their support in developing our questionnaire and with obtaining patient views.

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1   www.hiw.org.uk/sites/default/files/2021-09/20200923WASTReviewFinalENG.pdf – WAST Review

2   Community Health Councils (CHCs) are independent bodies who listen to what individuals and the community have to say about the health services with regard to quality, quantity, access to and appropriateness of the services provided for them. They then act as the public voice in letting managers of health services know what people want and how things can be improved.

Summary

This report highlights the findings of our review of the experience of patients waiting on board an ambulance outside emergency departments during delayed handovers. The key findings of our review are outlined below.

It is clear from our review that the issue of prolonged handover delays is a regular occurrence outside Emergency Departments (ED) across Wales. Whilst patients were positive about their experience with ambulance crews, it is clear that handover delays are having a detrimental impact upon the ability of the healthcare system to provide responsive, safe, effective and dignified care to patients.

Whilst there are clear expectations and guidance for NHS Wales[3] in relation to hospital handovers, and a clear and apparent will to meet and achieve these, there are substantial challenges inhibiting the ability of the NHS in Wales to do so. The problem of delayed handovers is symptomatic of the wider issue of patient flow throughout the NHS, with consequent increased risks to patients associated with prolonged waits on ambulance vehicles outside EDs, impacting the ability of WAST to coordinate responses for patients waiting in the community for an ambulance.

Our review has noted that whilst work is ongoing to try and tackle this issue, with various approaches and initiatives in progress at a national level, such as the development of a National Quality and Delivery framework for Emergency Departments in Wales[4], which commenced in 2018, it is unclear how effective these activities have been to date. This is not a problem that WAST can resolve by itself, it is a challenge that requires WAST, health boards, and Welsh Government to work together and consider whether a different approach is required to ensure reinvigorated, strengthened and concerted action is taken to make sure that these issues are overcome.

Whilst we found that overall, handover processes at EDs across Wales are broadly similar, some variations exist in processes between individual EDs within health board areas. This was due to a number of local joint Standard Operating Procedures (SOPs) being in place within WAST and EDs, due to geographical layouts of ED environments, staff roles and levels of staffing available. This inconsistency can introduce risk, with our findings indicating that some WAST staff may be unfamiliar with SOPs specific to the ED that they are handing over to.

Further to this, feedback suggests that local handover processes can differ from day to day, depending sometimes on the clinician and or member of ED staff being dealt with. Again, we are concerned that this inconsistency could have a detrimental impact on patient care and safety and requires attention.

It is concerning that our review found that only 41% of WAST staff clearly understood who has responsibility and accountability for the patient at all times. This is despite three quarters of ED staff reporting that they clearly understood who is responsible for the patient. Ensuring absolute clarity over who has responsibility for patient care on board an ambulance following triage, until transferred in to the ED, is an important issue requiring attention to ensure safety of care.

Some health boards have introduced specific roles with the purpose of improving handover processes, such as Ambulance Patient Flow Co-ordinators or Hospital Ambulance Liaison Officers (HALO); these have reportedly had a beneficial impact on handover, and on patient experience by ensuring better coordination of the process. However, these roles are not in place across all EDs, and we believe that all health boards should consider the benefits that these roles may bring.

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3 Wales Hospital Handover Guidance 2016

4 The Emergency Department Quality & Delivery Framework Programme www.nccu.nhs.wales/urgent-and-emergency-care/framework/

Attention is required from WAST and health boards regarding some of the specific operational challenges faced by staff during the handover process. This includes the need to address some of the procedural challenges associated with timeliness of handover process. There is also a need to ensure that procedures to provide timely investigations, such as blood tests and X-rays, for patients on board ambulances awaiting handover are strengthened. This would have the benefit of enabling ambulance crews to be released, to undertake their primary role of providing on scene urgent or emergency care.

We found there are appropriate processes in place to escalate a deterioration in a patient's condition to ED staff. It was disappointing to find however, that only 49% of staff we engaged with felt there was a robust process in place. More work is required from WAST to ensure the escalation process is clearly communicated to and understood by its staff.

WAST also needs to ensure that its workforce is adequately supported, and that staff wellbeing is maintained, when they wait for long periods on board an ambulance due to delayed handovers. Some approaches have improved the situation, for instance the introduction of the Duty Operational Manager which has facilitated crews to take their allocated breaks, and to finish their shift on time wherever possible, by taking over the care of patient. However, work remains on WAST's behalf to ensure that it adopts a consistent approach across Wales to support its workforce.

Improvements are also needed to strengthen collaborative working between WAST and health boards in relation to communication and the management of serious incidents arising from delayed handover. This includes the need to ensure health board representatives attend WAST Serious Clinical Incident Forum (SCIF) meetings, to enable timely management of concerns, development of action plans and ensure learning via feedback throughout the organisations.

Concerns were also highlighted to us around the consistency of feedback from incident reporting within WAST. Our findings highlight the need for WAST to identify more effective processes for sharing feedback and learning from incidents with ambulance crew following incident investigations, to improve quality and safety of patient care. In addition, WAST needs to do more to ensure that its staff feel confident that any concerns they raise would be addressed.

Patients were generally positive about their experiences and provided good feedback about ambulance crews, particularly in relation to their kindness, overall communication and management of distressing situations. Patients reported that they were treated with dignity and respect by ambulance crews, and felt safe and cared for. Patients also indicated that they were satisfied with the care and treatment from ED staff. Overall, our findings indicate that the severe impact of the pandemic did not negatively affect the experience of patients who used emergency ambulances services across Wales, and that on the whole patients were satisfied with the care provided.

Whilst patient feedback has been positive, this should not detract from the issues associated with delayed handover. It is clear that there are genuine frustrations held by WAST and health board staff regarding their inability to effectively carry out their roles as a consequence of this issue. The positive experiences shared by patients should also not detract from areas of concern regarding patient care, including the difficulties in facilitating patients to access a toilet during their wait, the risk to patients of sustaining skin tissue pressure damage, and the problems faced in providing them with food and drink. In addition, a number of staff raised concerns about their ability to appropriately achieve and appropriately maintain high standards of hygiene and infection, prevention and control measures on board the ambulance.

We have found that whilst WAST has developed clear systems, which identify risks, provide mitigation and escalate concerns, it is clear that these systems alone are not enough and more collaborative work between WAST and health boards is required to resolve the issue of prolonged handover delays.

Context

WAST is the primary frontline service delivering ambulance transport in Wales. The Trust was formed in 1998, and serves a population of around 3.2 million people across seven health boards in Wales.

WAST responds to more than 1800 emergency calls a day across the country. It operates 24 hours a day, 365 days a year, and provides emergency medical services, advice and appropriate signposting to other healthcare services. In addition to emergency transport, WAST also provides a Non-Emergency Patient Transport Service (NEPTS)[5], as well as hosting the 111[6] service, which consists of the NHS Direct Wales[7] and clinical triage elements of the GP out-of-hours services[8].

The workforce is made up of over 3,500 staff who contribute to the delivery of patient care across Wales. In addition, it has over 300 vehicles based in 90 ambulance stations across Wales which work collaboratively with the three Emergency Medical Service Clinical Contact Centres (EMSCCCs) in Wales.

WAST ambulance crews are highly skilled professionals who are able to treat and stabilise patients before taking them, if necessary, to the most appropriate hospital. The ambulance vehicles hold a wide range of emergency care equipment including oxygen, a defibrillator, advanced life-saving equipment and emergency drugs including pain relief.

A range of information sources indicate that ambulance waiting times, outside hospital EDs, can be excessive, particularly when the healthcare system is under pressure. These information sources include Welsh Government ambulance monthly performance indicators, Serious Incident notifications to Welsh Government, intelligence held by WAST, media reports, and discussions between HIW and senior staff within both WAST, and health boards. In addition, delays in the handover process with EDs resulting in reduced ambulance availability, were highlighted during HIW's local review of WAST during 2019-20, and within the Amber Review report publised by the Emergency Services Committee in 2018[9].

In response to these issues, our review set out to consider the impact of ambulance waits outside of EDs on patient safety, privacy, dignity and overall experience. The review set out specifically to consider the impact that ambulance waits outside EDs are having on the overall experience of patients, and considered the period between 1 April 2020 and 31 March 2021.

As part of our review, we also engaged with all health boards across Wales providing emergency care. This included Aneurin Bevan, Betsi Cadwaladr, Cardiff and Vale, Cwm Taf Morgannwg, Hywel Dda and Swansea Bay University Health Boards. Each of the health boards have between one and three EDs within their localities, with a total of 12 across Wales.

Powys Teaching Health Board does not provide an emergency care service, although does provide minor injury care within its four Minor Injury Units (MIUs) across its localities.

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5   Non-Emergency Patient Transport Services are provided to get patients, who are unable to transport themselves due to medical reasons, to and from hospital and clinic appointments.

6   The 111 service is an online or free telephone number available 24 hours a day, providing health information, advice and access to urgent out-of-hours primary care.

7   NHS Direct Wales is a health advice and information service available 24 hours a day. It has operated across Wales for many years and forms the backbone of the 111 service which is currently operating in four of the seven health board areas in Wales and will, over time, be replaced by 111 entirely.

8   The GP out of hours service is for people who need urgent medical treatment but cannot wait until their doctor's practice is open.

9   Amber Review Report 2018 www.wales.nhs.uk/sitesplus/documents/1134/NHS-Amber-Report-ENG-LR.PDF

The map below details the location of each ED and MIU across Wales:

WALES
ED HOSPITALS AND MINOR INJURY UNITS

Ysbyty Penrhos Stanley*

Llandudno General*

GLAN CLWYD

Holywell Community*

YSBYTY GWYNEDD

Denbigh Community*

Mold Community*

WREXHAM MAELOR

Ysbyty Alltwen

Bryn Beryl*

Dolgellau & Barmouth District*

Victoria Memorial

Tywyn Memorial*

BRONGLAIS GENERAL

Llandrindod Wells County War Memorial*

Cardigan Integrated Care Centre*

Llandovery*

Brecon War Memorial

WITHYBUSH GENERAL

GLANGWILI GENERAL

PRINCE CHARLES

Nevill Hall

Prince Philip

Ystradgynlais Community*

Ysbyty Aneurin Bevan*

THE GRANGE UNIVERSITY

Ysbyty Cwm Cynon*

Tenby Walk-in Centre*

Ysbyty Cwm Rhondda*

MORRISTON

Neath Port Talbot*

ROYAL GLAMORGAN

Ysbyty Ystrad Fawr

Royal Gwent

UHW

PRINCESS OF WALES

Barry*

Local Health Board Boundary (1st April 2019)

Local Authority Boundary

▲ ED

★ Minor Injuries Unit

not open 24 hours

Source: NHS Wales Directory

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Cartographics • Welsh Government • ML/29/21.22

July 2021

OGL

What we did

Focus of review

We reviewed how patient safety, privacy, dignity and their overall experience was managed by WAST ambulance crews and health board ED staff, whilst they waited on-board ambulances during delayed handover to ED staff. To achieve this, we explored the following five areas:

- **Patient handover** – to consider the procedures in place between the WAST and each acute hospital ED for accepting patients from ambulances into the care of health board staff

- **Patient experience** – to assess the overall experience of patients whilst waiting in an ambulance to include their safety, care and any impact on their wellbeing. We also considered how patient dignity is maintained and needs are met, to include nutritional, hydration and toilet needs

- **Workforce** – to consider the impact of handover delays on ambulance crew to include their welfare and support

- **Escalation processes** – to consider the risk management and escalation arrangements of WAST during periods of high pressure as a result of delayed handovers

- **Governance arrangements** – to consider incident reporting, investigation of incidents of patient harm due to delayed handovers and learning from incidents.

Scope and methodology

The pandemic introduced unique and unprecedented pressures on the healthcare system; in view of this, we considered patient experiences between 1 April 2020 and 31 March 2021 in order to understand what impact the pandemic had on this issue.

To review the areas detailed above, we requested relevant documentation and issued a self-assessment document to WAST and each health board. We also considered local and national performance data and statistics.

We held interviews with a variety of WAST staff, and conducted a survey for both WAST and health board staff.

In addition, we conducted a survey of people who used the emergency ambulance service in the 12 month period highlighted above.
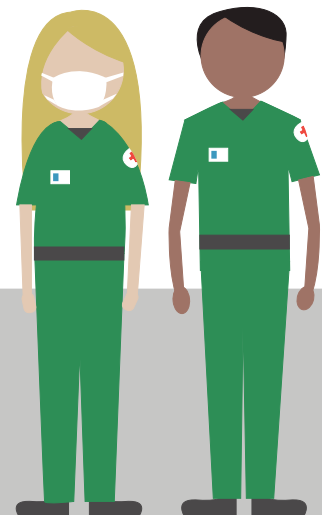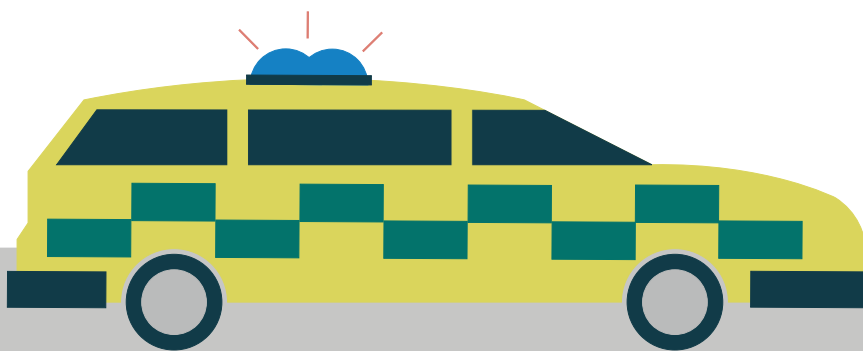
Self-assessment

We asked six of the seven health boards across Wales to complete and return a self-assessment document. This helped us to understand the degree of insight each health board has of its strengths and areas for improvement with the process in place for ambulance patient handover, and the management of patients awaiting handover.

We wanted to understand the views of the public and staff on ambulance handover delays, and developed and launched two national surveys to help capture this information.

Staff survey

We developed and launched a staff survey to obtain the views of WAST and health board staff on the patient handover processes in place between ambulance crew and ED staff. This was to help us understand the impact of delays in the process on staff well-being, and to identify any areas for improvement.

We asked WAST and health boards to distribute our online smart survey details to relevant staff, and we also promoted the survey through our social media channels.

We received a total of 438 responses, which covered a range of staff across Wales, which included:

- 271 WAST Paramedics and Ambulance Technicians
- 64 'other' WAST staff, which included First Responders, Duty Operational Managers and Urgent Care Assistants
- 98 health board ED staff and ED managers
- 5 'other' ED staff which included Patient Flow Managers.

Despite engagement with the six health boards providing emergency services, only staff within four health boards provided a response. We therefore did not receive the opinions from ED staff working within Aneurin Bevan University Health Board and only one response was received from Betsi Cadwaladr University Health Board. These two health boards cover four of the 12 EDs across Wales. Therefore, where reference is made to ED staff survey comments, this may not be reflective of staff within Betsi Cadwaladr or Aneurin Bevan University Health Boards.

Breakdown of staff responses per health board

Which Health Board / Trust are you employed by?

Cardiff and Vale University Health Board, **33.33%**

Others, **1.96%**

Cwm Taf Morgannwg University Health Board, **26.47%**

Hywel Dda University Health Board, **13.73%**

Swansea Bay University Health Board, **24.51%**
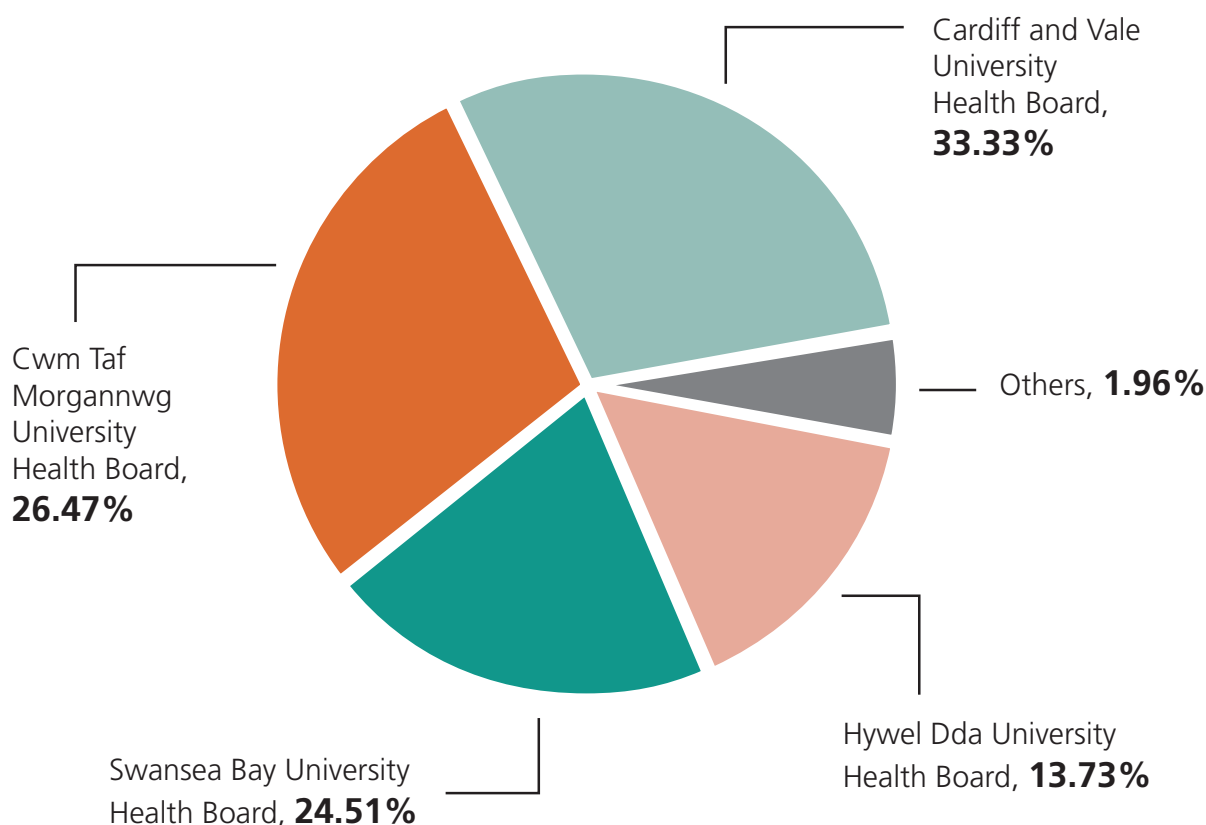
Public survey

In parallel with the staff survey, we also launched a national public survey, to capture the views of patients who had used an emergency ambulance. This was to gain an understanding of their experiences whilst waiting on board an ambulance outside an ED.

The survey was distributed via smart survey and was open to all people in Wales to capture the views of those who used WAST emergency services between March 2020 and April 2021. We engaged with WAST, health boards, and also the Community Health Councils in Wales, who provided their support with obtaining patient views.

We received a total of 137 responses, with 85% having used WAST emergency services within the last 12 months. Representation was from patients who had attended EDs across health boards in Wales.

Public Survey response per hospital

Other
37%

University Hospital of Wales
8%

The Grange University Hospital
13%

Glangwilli
10%

Morriston
20%

Prince Charles Hospital
12%
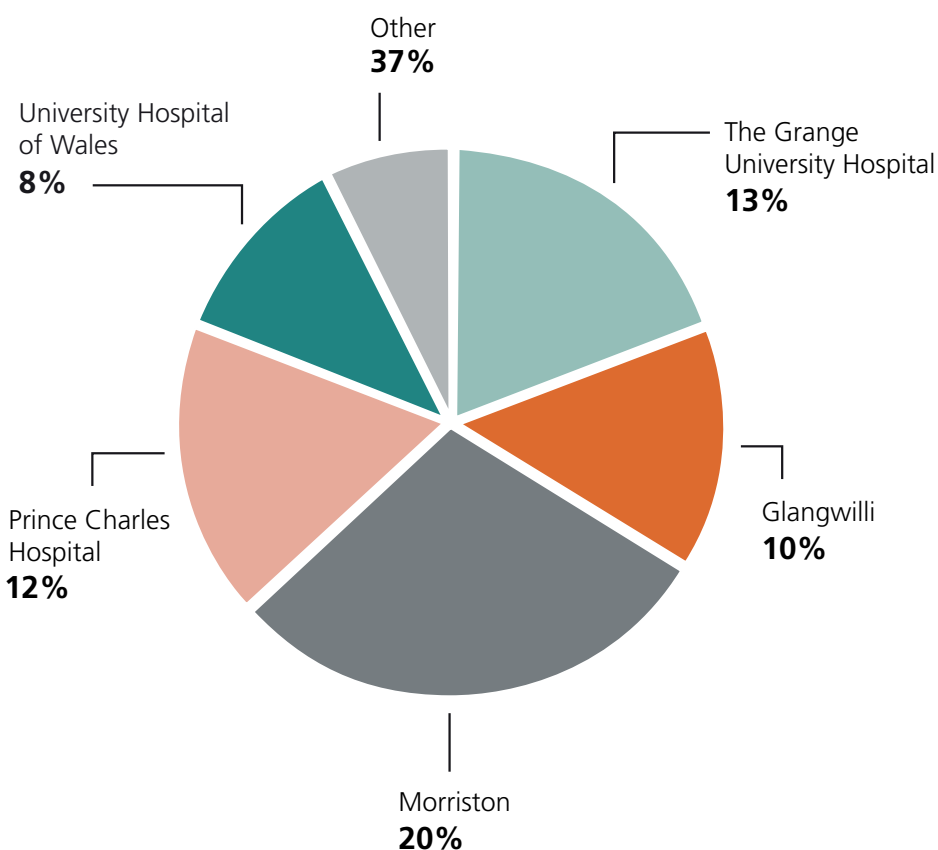
Staff Interviews

Due to restrictions in place relating to the COVID-19 pandemic, the majority of our fieldwork was completed remotely, including most of our staff interviews. Where we completed site visits, each was individually risk assessed to minimise the risks to our staff and healthcare providers.

We held a number of interviews with ambulance crews from across Wales. This included Paramedics, Ambulance Technicians, Duty Operational Managers and Urgent Care Assistants. Staff we interviewed shared their views and experiences of working within the service, which included the main challenges they faced with handover delays.

As part of our fieldwork, we also interviewed senior staff from within the Trust, including members of the Executive Team. We completed a total of 31 interviews and our findings will be highlighted throughout the report.

What we found

It is a regular occurrence across Wales for multiple ambulances to be stationary outside hospitals for prolonged periods, waiting to hand over their patients to the health board.

The handover process

Wales Hospital Handover Guidance 2016[10]

The hospital handover guidance issued by Welsh Government in 2016 stipulates the need for timely handover of patients from ambulance crew to hospital staff, to optimise performance and patient care. The guidance highlights that health boards are responsible for arranging the safe emergency transfer and timely treatment of citizens in their local area.

The statement of intent within the guidance indicates that the safety, effectiveness and patient dignity must be at the forefront of systems of emergency care. In addition, that the best care is provided to patients in the correct care environment. Therefore, when an ambulance crew takes a patient to hospital, it is essential that they are released promptly so they can continue to provide a safe and efficient service to the local community.

According to the above guidance, when a patient is conveyed to a hospital by ambulance, care must be handed over to the hospital team within 15 minutes. Health boards are responsible for ensuring this happens reliably. Hospital clinical staff must ensure that any patient waiting more than 30 minutes has been assessed and moved immediately into hospital if there is a risk to patient safety. Management of delays of over 60 minutes are unacceptable, and Welsh Government states that they should be the exception.

Data published by Welsh Government on the StatsWales[11] website, highlights that between April 2020 and March 2021 there were approximately 185,000 handovers at acute EDs throughout Wales. Of which, just over 79,500 occurred within the target of 15 minutes.

10 Wales Hospital Handover Guidance 2016

11 Ambulance Quality Indicators – Number of notification to handover within 15 minutes of arrival at hospital Tier 1 Major A&E units (AQI20ii)

This is highlighted in the chart below and relates to over 105,000 handovers falling outside of the Welsh Government target.

Tier 1 Major A & E units – total number of handovers (AQ120) (15)

Tier 1 Major A & E units – notification to handover within 15 minutes (15)
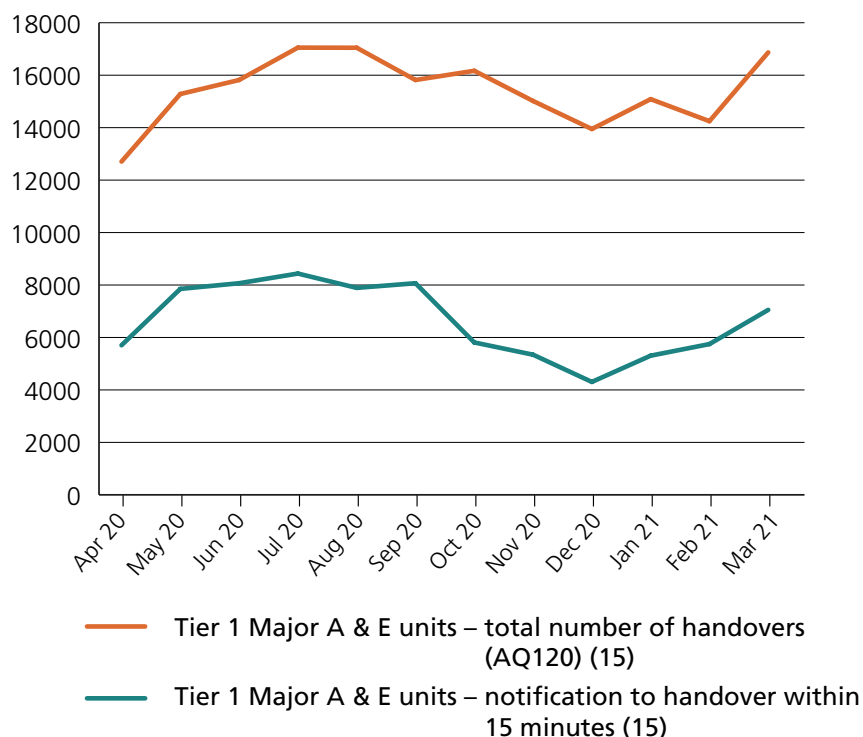
The impact of handover delays is that there are occasions where multiple ambulances are waiting together outside EDs for long periods of time. This can often affect the service to the extent that there are no ambulance resources available to respond to new emergencies within the community, thus increasing the risk to patient safety or life.

WAST data demonstrates that between April 2020 and March 2021, there were 32,699 incidents recorded across Wales, where handover delays were in excess of 60 minutes, of which, 16,405 involved patients over the age of 65. This is a concern since many older adults can be considered more vulnerable and at risk of unnecessary harm due to frailty and pre-existing health conditions which are more common with older age.

Data published by Welsh Government of the recorded number of lost hours as a result of hospital handover delays, highlight that in December 2020, a total of 11,542 hours were lost due to handover delays. This is a further monthly increase in the data published in the 2018 Amber Review Report, as highlighted earlier. These delays have serious implications on the ability of the service to provide timely responses to patients requiring urgent and life threatening care.

Patient flow issues, such as system bottlenecks and discharge problems can negatively impact on the availability of beds within EDs, since the departments cannot transfer patients to wards due to insufficient ward bed availability. These concerns were echoed by numerous WAST and ED staff within our survey. Patient handover delays are not directly a WAST problem, but are a consequence of wider systemic patient flow issues through NHS healthcare systems and social care services. Concerns were also highlighted to us of severe overcrowding within EDs, which leads to the inability to offload patients from ambulances. This is consistent within a number of our findings during previous HIW inspections of EDs across Wales.

We found handover delays impact on the ability of ambulance crew to provide a positive experience for patients. It may also increase the risk to patient safety, through delays in diagnosis and receiving treatment, as well as to the risk to people awaiting an ambulance in the community, with fewer ambulances available to respond to their needs.

During our review of WAST in 2019-20, we made a recommendation to WAST to consider a holistic review with stakeholder engagement, of the handover arrangements in place across Wales, to help address the patient flow issues through NHS healthcare systems.

The Trust has been working on actions to make improvements in this area and with its stakeholders since 2020. However, our review has found ongoing issues in relation to patient flow within each health board across Wales. We have therefore recommended that Welsh Government considers how this broader issue can be tackled, and to coordinate a collaborative approach to ensure consistency across Wales.

Recommendation

Health boards, and Welsh Government should consider what further actions are required to make improvements regarding the patient flow issues impacting on delayed patient handover. This may include consideration of whether a different approach is required by WAST, health boards, and social care services within Wales, to that taken to date in tackling this system-wide problem.

Ambulance arrival at ED

Six health boards were asked to complete a self-assessment regarding ambulance patient arrival and handover procedures within their EDs. The assessment responses helped us to understand the degree of insight each health board has into its own strengths and areas for development with ambulance patient handover.

Overall, we found that handover processes across Wales were broadly similar. There were, however, some variations in processes between each individual EDs within health board areas, and some disparities with the processes in place across health boards in Wales. This was due to local joint SOPs being in place within WAST and EDs, due to geographical layouts of ED environments, staff roles and levels of staffing available. We will elaborate further on these inconsistencies and the risks associated later within the report.

Since the start of the pandemic, we found that handover processes were consistently reviewed to meet the evolving national COVID-19 guidance. This included social distancing guidance and admission routes into EDs to support Red and Green pathways, and processes were changed to align with this to maintain patient and staff safety.

Pre-alert calls

In emergency and life threating situations, there are consistent arrangements in place across Wales for ambulance crew to provide pre-alert calls to a dedicated phone in ED, to notify staff of inbound patients who require immediate attention. For example, with patients experiencing cardiac arrest, difficulty breathing or heavy bleeding.

Pre-alert calls allow time for ED staff to prepare and prioritise for the arrival of the patient. Upon arrival to ED, ambulance crew immediately transfer the patient to an allocated space for assessment and treatment by the ED team. Once the patient transfer from ambulance stretcher to an ED trolley is complete, a formal dual pin handover[12] is completed between ED staff and ambulance crew, and is documented on the Hospital Arrival Screen (HAS).

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12 Dual Pin Handover refers to an element of the handover process where both a paramedic and ED staff nurse communicate the formal handover of care, with each entering their pin number into the hospital arrival screen. Welsh Government statistics relating to handover times are generated as a result of the timings of the dual pin handover process.

We were informed that ED staff regularly monitor the HAS for inbound ambulances. When patients arrive by ambulance (not requiring a pre-alert), an ambulance crew member registers the patient either at the ED reception, or with a dedicated ambulance receptionist, which in some EDs is a dedicated role. Patients are triaged[13] (assessed) either on board the ambulance or within a designated triage area of the ED, dependent upon capacity.

Dual pin handover process

The handover process involves both a paramedic and ED staff nurse communicating the formal handover with each entering their pin number into the hospital arrival screen. Welsh Government statistics relating to handover times are generated as a result of the timings of the dual pin handover process.

We received negative comments from ambulance crew in our survey regarding the timing of the formal handover to ED staff. They stated that at times, ED staff may complete the dual handover process and patients would be classified as handover complete whilst the formal handover was still taking place.

In addition, we received 15 comments from ED staff who provided an insight from their perspective, around the difficulties that hospital staff are facing with the dual pin process. One comment included:

"As ED staff - once the ambulance verbal handover is complete and a patient is in the care of the ED in an appropriate area, I find it very frustrating to have to spend extra time chasing the ambulance crew, often back outside for their PIN number to clear the crew from the HAS handover screen. Ambulance crew are also sometimes reluctant to provide their PIN number to ensure a timely handover. This takes extra time which removes nurses from providing care to patients."

In response to our self-assessment evidence from WAST, we were told that the dual pin handover process has led to improved data quality when examining the lost hours due to hospital handover delays. However, during our fieldwork interviews with ambulance crew, the issue of inaccurate handover recordings was repeatedly highlighted, which supported our findings from the staff survey. Correct application of the dual pin process will ensure that accurate timings of handovers are recorded and reported on by Welsh Government.

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13 Triage is the process of determining the priority of patients' treatments by the severity of their condition or likelihood of recovery with and without treatment.

We also received a number of concerns around the process for dual pin handover from health board self-assessments, where the process is not consistent between hospitals or across health boards. Some said that the processes in place does not always provide an accurate picture of handover timings.

<div style="background-color: #d8543a; color: white; padding: 8px;">
Recommendation
</div>

WAST should engage with health board representatives to ensure there is improvement in practice between ambulance crew and ED staff to ensure the dual pin process is consistently followed, and ensure Welsh Government reporting data is accurate.

Patient triage

We found variation across Wales in the staff roles that undertake triage assessments. This ranged between dedicated ED Triage Nurses, dedicated Ambulance Triage Nurses, the Nurse in Charge, or a Rapid Assessment Team (which may include a registered nurse, ED doctor and Healthcare Support Worker).

Across Wales, it is the aim is to commence triage within 30 minutes of patient arrival at ED, in line with the Welsh Government target. Patients are triaged using the Manchester Triage System[14], which enables the triage clinician to assign a clinical priority, according to the patient's presenting signs and symptoms. Data published on the NHS Wales National Collaborative Commissioning Unit (NCCU) website[15] for its Urgent and Emergency Care Programme highlights that on average, between October 2020 and July 2021, patients are being triaged within 30 minutes.

If, following triage, patients are deemed as 'Fit to Sit', meaning people are well enough to sit within the ED waiting area, they are transferred from the ambulance and escorted to the ED waiting area, and a dual pin handover between ambulance crew and ED staff takes place.

When patients are not considered to be suitable to stay in the waiting room, the patients are usually offloaded from an ambulance and transferred to an appropriate area according to clinical priority. If there is no capacity within the ED to accept patients from the ambulance crew, they will remain on board the ambulance until a space becomes available.

Following triage, we found a commonality across Wales where patient investigations commence, such as blood tests, X-rays or Computerised Tomography (CT) scans. Where appropriate, other time critical procedures and/or treatments are also commenced, such as Sepsis and Stroke pathways. This will commence regardless of ED space, and will include patients located on board ambulances.

Mitigating risks for patients arriving by ambulance

We asked health boards how they identify, manage, and mitigate any risks associated with patients arriving on ambulances. Each response highlighted the aim to achieve a 15 minute handover time for patients arriving at ED. When this is achieved, and an ambulance is released, it is beneficial to the patients' condition, positively impacts on their experience, and further benefits those awaiting an ambulance resource within the wider community. However, our review has found that this target is not often met across Wales.

14 The Manchester triage system is an algorithm based on flowcharts and consists of 52 flowchart diagrams (49 suitable for children), that are specific for the patient's presenting problem. The flowcharts show six key discriminators (life threat, pain, haemorrhage, acuteness of onset, level of consciousness, and temperature), as well as specific discriminators relevant to the presenting problem. Selection of a discriminator indicates one of the five urgency categories, with a maximum waiting time ("immediate" 0 minutes, "very urgent" 10 minutes, "urgent" 60 minutes, "standard" 120 minutes, and "non-urgent" 240 minutes)

15 NCCU – Urgent and Emergency Care Programme https://nccu.nhs.wales/urgent-and-emergency-care/experimental-kpis/

During times of increased pressure and numerous ambulances waiting to hand over the care of their patients to ED staff, a WAST Duty Operational Manager (DOM), may attend the hospital site, to provide welfare support to ambulance crews who are unable to offload and handover their patients. This is a new role that has been introduced by WAST. The DOM will provide cover for ambulance crew to take their breaks, and/or help enable crews to finish their shift on time, by taking over the care of the patient. The DOM will also liaise closely with ED staff and the hospital site managers, to plan what action is required to progress and facilitate the handover of patients to the care of the ED staff.

Health boards also highlighted to us the benefits of the role of Ambulance Patient Flow Co-ordinators or HALO within the EDs. Their role is to assist in achieving a timely handover, and to maintain effective communication between ambulance crew, ED staff and patients. In addition, they aim to reduce delays by helping to mitigate risks to patient safety on board an ambulance, by minimising long waits outside ED, which in turn will benefit those waiting in the community for emergency care. Furthermore, the role also aims to improve the overall experience for patients, by working with ambulance crew in providing care. Our review has found that where these roles have been introduced, they have helped to ease some of problems associated with the handover process and have been beneficial to patient experience as a consequence.

During times of delayed handover, we identified that ambulance crews monitor the patient's condition and escalate any concerns to the ED nurse in charge. In the event of a patient's condition deteriorating further, ambulance crew will enact a formal process for escalating a clinical concern with a deteriorating patient outside the ED. We will elaborate further on the effectiveness of this process later within the report.

We also found consistently across Wales, that during periods of high demands on the service, such as multiple delays with handover, each hospital has an internal escalation plan which is actioned, and plans are implemented with the to aim to reduce ambulance offload delays.

Other consistent measures in place across Wales are regular hospital patient flow meetings and hospital bed management meetings. The meetings allow staff to assess the availability of hospital beds, and to monitor the capacity within ED and the number of ambulances waiting to handover. However, despite these measures, the problem of prolonged handover remains an issue.

Strengths with handover processes

Health boards were asked to tell us about the strengths they have identified as part of their handover processes. Across Wales, there was unanimous agreement that EDs have introduced an effective COVID-19 point of contact testing, where patients are tested for the virus at their point of entry, and are allocated a waiting area based on their expected or predicted status for the virus. Some health boards highlighted an improvement with patient flow, as a result of point of contact testing particularly during the height of the pandemic, which resulted in reduced delays with transferring patients to wards.

During our interviews with ambulance crew, they spoke of the positive impact on handover, as a consequence of the roles of the dedicated Ambulance Triage Nurses or Ambulance First Point of Contact. As mentioned, staff in these roles determine the level of acuity of patients arriving by ambulance, and assist in helping to achieve 15 minute handover targets and to commence triage within 30 minutes of arrival.

Ambulance crew also highlighted that dedicated ambulance receptionists help make the handover process more efficient in enabling them to register patients upon their arrival. The role of the HALO or Ambulance Flow Co-ordinator was also reported to help assist with handover and relieve pressure from the Ambulance Triage Nurse. We found that the introduction of these roles assists in improving the patient experience and welfare by providing positive links for effective communication between ambulance crew and ED staff. However, the presence of these receptionist, liaison, and patient flow roles is not consistent across each ED in Wales.
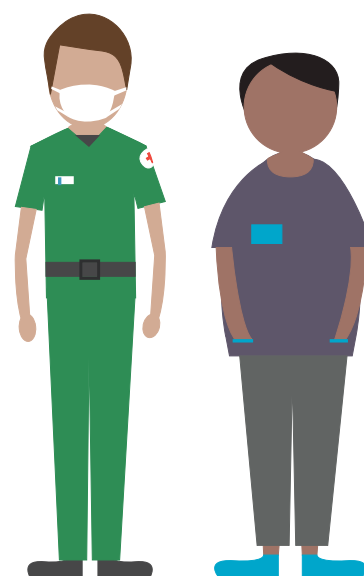
We were told that patients are re-triaged once clinical interventions have been initiated on board ambulances. As a consequence, any improvements in a patient's clinical condition could expedite their admission to the department, for example if they are assessed as 'Fit to Sit' in the ED waiting area. In addition, in some instances, patients may be well enough for discharge, to recover at home.

Areas that require improvement

Health boards highlighted some areas that require strengthening with handover. There was unanimous agreement across Wales that improvement is required with patient flow through hospitals, in order to improve bed availability and trolley space capacity within EDs. This included improvement in the timely discharge of patients from hospitals, to assist with patient flow. This would lead to improved patient handover times from ambulance crew to ED staff, an improvement in the overall patient experience, and benefits to timely care with emergency responses in the community.

We found that improvements need to be made in relation to collaborative working between WAST and health boards, particularly in regards to communication and the management of serious incidents arising from delayed handover. There is a need to ensure health board representatives regularly attend WAST SCIF meetings, to enable timely management of concerns and to develop action plans and feedback throughout the organisations. This is referred to in more detail later within this report. Whilst there appear to be robust processes in place for triage, initiating treatment and handover process, issues remain with delayed handover due to the lack of bed space within ED and the wider hospitals, which significantly affects patient flow.

Recommendation

Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process the handover of patients from ambulances.

Health boards must ensure that appropriate representation is present at WAST Serious Clinical Incident Forum meetings, to aid with the timely management of concerns and service improvement.

Staff perceptions of the handover process

We considered the perspective of ambulance crew and ED staff of the handover process. This was achieved through our staff survey and our interviews with ambulance crew.

Through our staff survey, we found that 90% of ED staff were familiar with the handover policy for their hospital. This was slightly less for ambulance crews, with just over three quarters of them aware, although with a slight increase in number for their most frequented hospital. These numbers give rise to concern, as it is suggestive that some ED staff and ambulance crews are unfamiliar with handover policies.

The majority of ambulance crew respondents also expressed frustrations of their experience of waiting outside hospitals and their dissatisfaction with the handover process in place both at a local level and nationally. We had a strong response on the comment section for this area with almost half of WAST respondents providing additional detail when sharing their experiences.

The comments enabled us to identify some key themes such as, some ambulance crews told us that handover processes frequently change and they are not familiar with current practices. Ambulance crew who regularly attend more than one ED also face the challenge in different local practices. Some said that processes differ day to day, and that each clinician and member of ED staff implements them in different ways therefore, making it difficult for staff to remain up to date with current processes. There are variations in processes due to local SOPs, geographical layout of each environment, job roles and levels of staffing. It was also highlighted to us that the impact of the pandemic on practices has been that it is challenging for staff to stay up to date with current processes.

Recommendation

If and where local standard operating procedures are absolutely necessary, WAST and health boards must work together to ensure that ambulance crew are familiar with the handover policy for that ED.

Ambulance crews also provided their comments in our survey on their view of the effectiveness of the hospital guidance issued by Welsh Government in 2016 process. These included:

> *"The process seems to be centred around ambulance turnover rather than a focus on patient care. This in turn creates more delays for ambulances as the processes put in place differ day by day, nurse by nurse as there is no full understanding of what the procedure should be. My experience has been waiting upwards of 30 mins just to notify the hospital of our patient. That's before they are booked into the department and triaged."*
>
> *"ED staff are excellent and do as much as they can to assist/handover patients however they cannot do this when there are not beds available. It is not appropriate to manage patients on the back of an ambulance for several hours and should be avoided where possible."*
>
> *"There is a reluctance to follow the 'Fit to Sit' agreements that the Welsh ambulance service have in place."*

Our staff survey responses noted ambulance crew sometimes attend EDs within England. Concerns were highlighted that handover delays have become routine in Welsh hospitals, and are less frequent in England. A number of ambulance crew provided their opinions to us during interview, that handover processes within EDs in England are more efficient than the processes in place in Wales, which compound the frustrations with handover delays across Wales. Comments from ambulance crew included:

> *"Patients waiting in the community are coming to a wide range of harm due to no ambulances to send to them due to the ambulances being queued outside hospitals. I've recently transferred to Wales from England and this problem very rarely happens in England but is a daily problem in Wales. Very poor."*
>
> *"When I visit other ED outside of Wales, we take the PT straight in to EDs, even large City EDs. But for some reason Welsh EDs struggle with this."*

Relationship between ambulance crew and ED staff

Throughout our interviews, ambulance crew told us that in general, positive relationships had been formed with ED staff across Wales. We were told that both parties were working towards the same goal of achieving early handovers to release ambulance crews to respond to emergencies. However, this was not consistent with our survey results, with 71% of ambulance crew stating that they did not feel ED staff and the service provided by ambulance crew worked together to provide seamless patient treatment and care. However, 69% of ED staff felt they work together with ambulance crew to provide seamless patient care.
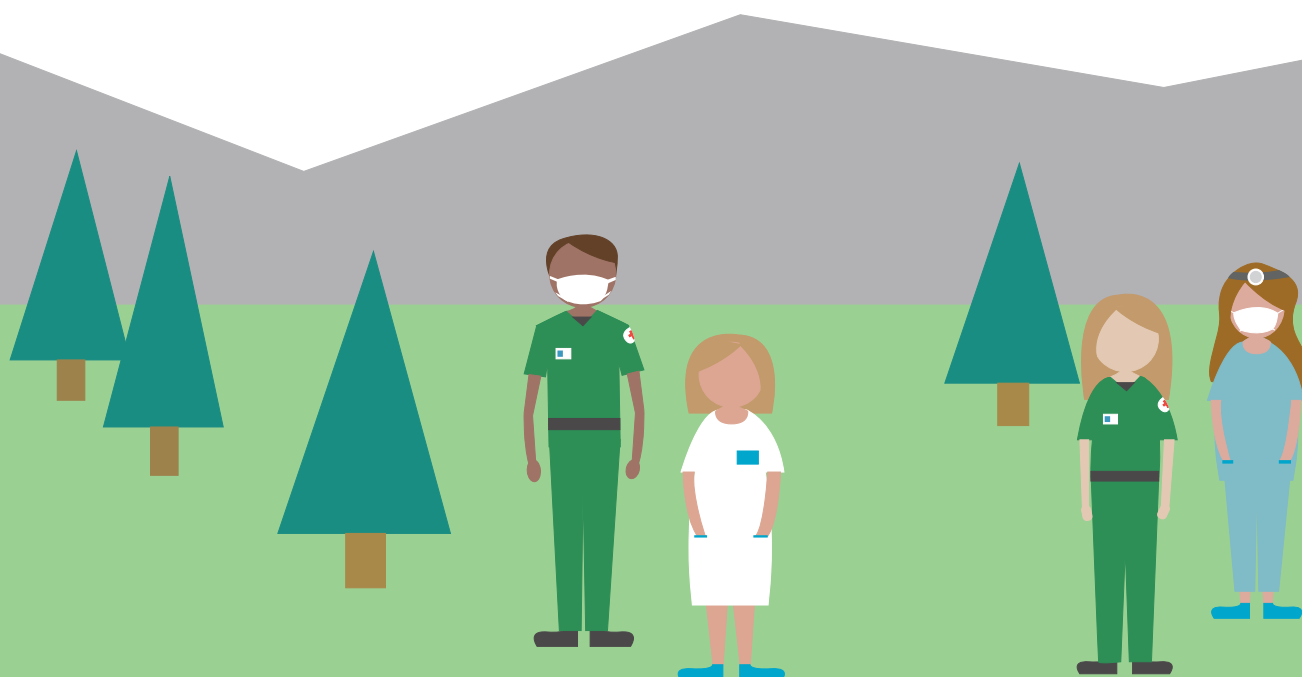
One comment received from a member of ED staff highlighted:

> "There is no single issue which would resolve the problem, neither is it solely a problem of a specific group. Again, I would like to reiterate that ED is locked between a rock and a hard place; trying our best but with many obstacles in our way. We used to have a really positive working relationship with our WAST colleagues which has deteriorated over time."

The findings from our survey and interviews suggests a mixed relationship, and issues can occur on a case by case basis. We recognise the pressure and intensity that handover delays must have on both ambulance crew and ED staff to minimise risks to patients, and that working relationships may be strained as a consequence. However, this can have a negative impact on the overall patient experience.

We also found through our interviews and staff survey that ambulance crew feel their vehicles are used inappropriately, and as an extension of the ED. The term 'warding' was commonly used to refer to this. Ambulance crew told us that ambulances are used as waiting rooms or additional beds, with many staff elaborating that a bed shortage within ED is the reason for this.

We also learned that patients are often taken off an ambulance for scans or other investigations, and returned to the ambulance due to no capacity in the EDs. We were also told about occasions when following investigations and treatment, patients who did not require hospital admission, were transported home by the same ambulance crew who had responded to the initial emergency call. Some ambulance crew also said that hospitals manage their own risks by keeping patients on the ambulance. Comments from ambulance crew included:

> "The feeling that the patient isn't the problem of the hospital until they get in through the front doors is widespread. We are extended waiting rooms for the hospitals and this shouldn't be the situation."

> "The current system is not working, emergency departments are using ambulances to treat patients in and this is not what they are intended to do. While this is happening and we are waiting to handover our patients there is patients within the community not getting the medical help needed for many hours."

> "The problems with handover are not due to WAST. The issue is severe overcrowding of the EDs which then leads to lack of ability to offload. The systems in the hospitals prioritise patients who have been seen and treated (inpatients) over patients who have not been seen or treated by the ED which is wrong and unsafe. As well as this, having ambulances stacked outside causes there to be increased response times by WAST. So in turn, we are prioritising seen and treated patients (inpatients) over those waiting for an ambulance…..The subsequent problems of even more overcrowding that will cause, will lead to innovation within the hospital. Unless we bring the problem into the hospital, the hospital will not solve it."

As highlighted earlier, the role of ambulance crew is to provide an emergency response and transportation for patients to EDs. Welsh Government guidance is clear that patient care should be handed over to hospital staff within 15 minutes of their arrival, but most certainly before 60 minutes.

Ambulances are designed as a pre-hospital environment and are equipped to transport ambulance crew and other first responders to the waiting patient. The vehicles carry equipment for administering emergency care to treat patients at the scene, and transport patients when necessary to EDs for advanced treatment. They are not designed and equipped for patients to be cared for during periods of extensive waits outside EDs. The impact of patients remaining within the back of an ambulance can negatively impact on the patients' experience and their safety.

Patient experience

Impact of the pandemic on patient experience

The NHS Wales activity and performance summary highlights fewer attendances to all NHS Wales EDs during the first wave of the pandemic, with April 2020 seeing the lowest number of attendances at ED since current reporting began in 2012.

Handover delays during the first wave of the pandemic were substantially lower. We were informed that this was the result of a significant decrease in demand, and an initial pandemic response to improve hospital capacity. This is highlighted in the chart below, which reflects the number of patients who experienced handover delays over 60 minutes across all health boards in Wales.

Trend of number of Patiens Waiting >60mins

Arrival at Hospital Month and Year
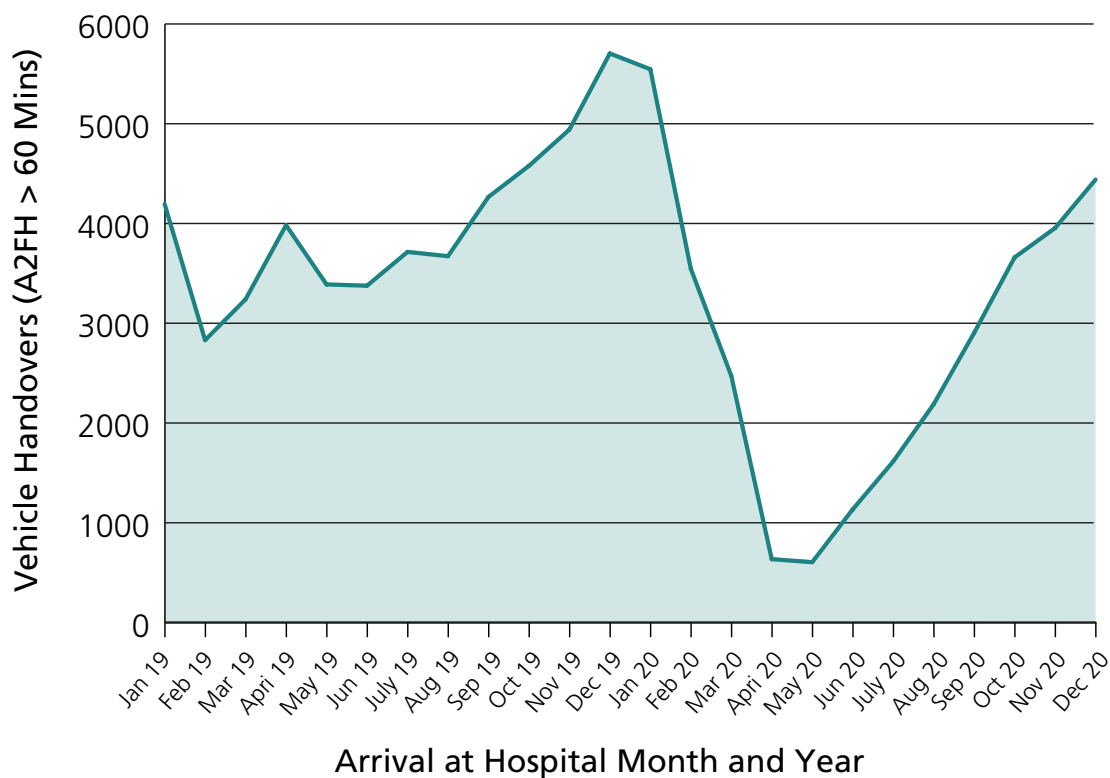
We considered the views of patients on whether the pandemic impacted on their experience of attending the ED. In the public survey responses, the majority said they were not displaying COVID-19 symptoms, and were not attending ED due to suspected COVID-19.

It was positive to learn that the majority of respondents felt that measures to minimise the spread of COVID-19 were being followed by both ambulance crew and ED staff. The majority of respondents said all staff wore PPE on the ambulance and at hospital, their temperatures were taken on arrival at hospital, and they were transferred to a designated green areas away from suspected or positive COVID-19 patients. However, we did find in a small minority, where some concerns were highlighted in the survey, as highlighted below:

> *"Unfortunately dad was infected with COVID in hospital."*
>
> *"We were all asked to wear masks in the house whilst the paramedics were there. However, I noticed that although the crew were wearing masks they weren't wearing any other form of PPE."*

Overall, our findings reflect that despite the severe impact of the pandemic, it did not negatively affect the experience of patients who used emergency ambulances services across Wales, and on the whole patients were satisfied with the care provided. Our COVID-19 themed national review report[16] highlights further our understanding of how healthcare services across Wales met the needs of people and maintained their safety during the pandemic.

Patients awaiting ambulances in the community and their arrival at the ED

Standard 5.1 within the Health and Care Standards 2015[17] states that all aspects of care should be provided in a timely way, ensuring people are treated and cared for in the right way, at the right time, in the right place and with the right staff.

Of the 137 responses to our public survey, approximately half waited under an hour in the community for an ambulance to arrive, with most waiting less than 30 minutes. However, 26% of respondents waited between one and four hours, and 22% waited over four hours. For those who waited over four hours, each commented that they felt their health condition deteriorated over this time. Around a third of these patients were admitted immediately into the hospital on arrival, however, another third had a further wait of over two hours on-board an ambulance following arrival at the hospital.

We received several concerning comments from people about prolonged ambulance waits, despite the possibility of them experiencing a stroke, heart attack or other serious health concerns. Comments included:

> *"I waited over 2 hours for an ambulance after having a stroke. Ambulance never showed. First responder arrived at 2 hours and tried to get an ambulance and was told none available."*
>
> *"Things could have been a lot worse as Dr said by rights my dad should not still be here after having to wait 3hrs whilst having a major heart attack."*

Several people in response to our public survey highlighted long waits of between four and 13 hours for an ambulance after sustaining an injury due to falls at home, particularly in relation to older adults. Long waits in the community were also substantiated by ambulance crew in response to our staff survey and during our fieldwork interviews. Staff highlighted that the risk from handover delays is not only to the patients waiting in ambulances but also to patients in the community, who are waiting for an emergency response.

Comments included:

> *"Patients queuing up in ambulances probably have the same outcomes as patients in the ED, as HB clinicians will always see and treat our patients. It's the patients that are waiting for ambulances that are most at risk."*
>
> *"Handover delays impact me and my patients negatively as I am often on scene with an unwell patient waiting for an ambulance to become available. It is common to have to wait 2-4 hours for 'emergency' backup. This can be very detrimental to patients and is hugely stressful for me. I have been on my own with patients having multiples seizures, heart attacks or severe breathing difficulties for 1-2 hours. As well as patients likely to come to harm, this is very stressful for me and affects my mental health."*

Throughout our fieldwork, the majority of ambulance crew interviewed expressed their frustrations of waiting outside EDs to handover patients, in the knowledge that patients are waiting in the community in need of an emergency response. This is consistent with the findings highlighted in the Amber Review report in 2018. These patients have not been physically assessed by a clinician and therefore, their clinical condition is unknown. This is particularly concerning for conditions such as strokes or heart attacks, where time critical treatment is essential due to specific therapeutic window timescales, and any delays to treatment may negatively impact on their clinical outcome, future rehabilitation or even their life.

People indicated in the survey comments, that due to long ambulance waits they sometimes had to arrange alternative transport, such as driving their loved one to the hospital or arrange a taxi. Comments included:

> *"Ambulance wait time over 2 hours. This was not made clear at 999 call only that an ambulance has been requested. After 2nd call to 999 after half an hour I was told it could be 2 hours. Took him in the car and hospital was excellent. Could and should have gone sooner if wait time had been honest in the first place."*

The risk to patients in the community was a key finding from our previous review of WAST in 2019/2020, and has been repeatedly highlighted by staff throughout this review.

As referred to earlier in this report, a recommendation was made in our previous report that WAST should consider a holistic review with stakeholder engagement, of the current handover arrangements in place, which should include current escalation arrangements during periods of high demand. Whilst we are satisfied that progress has been made, this re-iterates the need for Welsh Government to ensure a prompt collaborative approach between WAST, health boards, and social care services within Wales, to make improvements with the ongoing patient flow issues.

Patient experience with handover and triage

We asked patients in our public survey to tell us about their experience during handover between ambulance crew and ED staff. As highlighted earlier, the Welsh Government target for patient handover to the ED team, is within 15 minutes of arrival at the hospital.

Our public survey identified that only half the respondents said they were admitted to ED within 15 minutes. A further 15% waited between 15 to 30 minutes, and a minority waited between 30 minutes to 2 hours. However, 1 in 5 patients told us they waited over two hours in the ambulance, before being handed over to the care of ED staff.

> *"I had a four and a half hour wait for the ambulance which had been requested (highest priority) by my GP in the surgery. On arrival at the hospital there were 17 ambulances waiting to hand over the patients. I was waiting for a further three and a quarter hours."*

How long did you wait in the ambulance, one it arrived at the hospital, before being admitted into the emergency department?

Over 2 hours
20.16%

1 - 2 hours
7.75%

30 minutes - 1 hour
7.75%

15 - 30 minutes
14.73%

0 - 15 minutes
49.61%
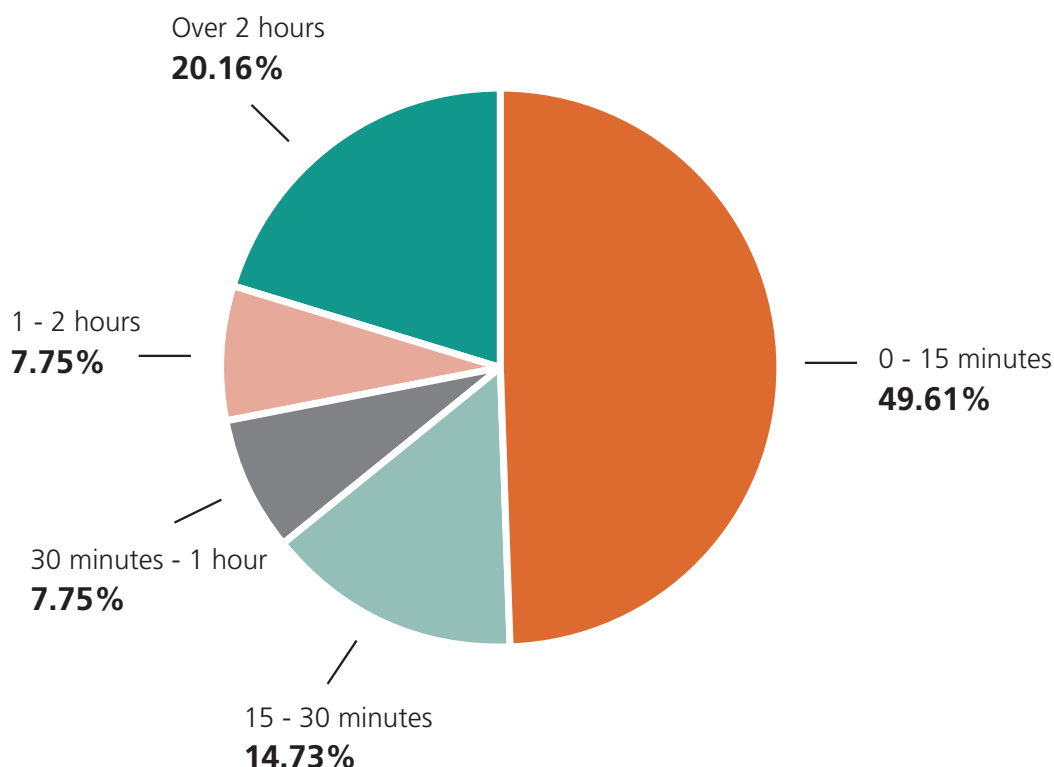
As highlighted earlier in the report, any delay over 60 minutes should be the exception. Prolonged patient waits on board an ambulance are not acceptable, in particular for those who may have already waited for long periods for an ambulance in the community.

Our public survey highlighted that the majority of people who engaged with us were triaged within 30 minutes of arrival at the hospital. This is in line with Welsh Government targets and data available on the NCCU website for its Urgent and Emergency Care Programme. However, around a quarter reported that it took longer than 30 minutes. Whilst most patients were assessed in hospital, 30% reported that assessment took place on board the ambulance. Only a few patients told us they had been assessed in hospital and then taken back to the ambulance.

We received one comment from a patient who reported 17 ambulances were outside the ED at the time that they attended, waiting to handover patients to hospital staff. This is concerning and reflective of the difficulties ambulance crews and ED staff are frequently facing.

A quarter of patients told us they received treatment from ED staff whilst on board the ambulance, but most remained under the care of the ambulance crew. One patient told us that no ED staff assessed them for the duration of their time on board the ambulance, whilst another said:

> *"I was in the ambulance from 8.30am to sometime around 4pm. A doctor paid a number of visits and also nursing staff to take blood and to give me painkillers."*

We asked patients to provide their views on the triage/assessment process upon their arrival at the hospital. Comments we received were mixed, with some stating that it worked efficiently and they were seen immediately, however, there were a number of comments about how long it took to be seen upon their arrival at hospital. One commented included:

> *"After assessment and excellent care and treatment by ambulance personnel I was treated almost immediately after arriving at hospital by a superb team."*

Whilst it is positive that most patients were triaged within 30 minutes, it is concerning that not all patients were assessed by a health board clinician in the appropriate timeframe. This can negatively impact on the patient experience and clinical condition, when they are not reviewed in a timely manner.

As part of our review, we also considered communication with patients' relatives/carers. We found a clear divide, with half stating that relatives were kept updated, and half stating they were not. Comments indicated that ambulance crew communicated well with relatives, to update them on what was happening. However, only half of the survey respondents said they were kept informed about how long the wait on board the ambulance would be. Our survey highlighted that communication once the person was admitted to hospital was experienced as variable.

Our interviews with ambulance crew indicate that they always endeavour to engage with and build a positive rapport with patients. However, they said that during periods of long delays, there are limitations to the number of times they can apologise to patients and their loved ones, either for the delays they experience whilst waiting for an ambulance in the community, delays outside the hospital, or at both locations.

The hospital handover guidance issued by Welsh Government in 2016 is clear, that when delays occur patients and their relatives or carers should be kept fully informed of the reasons and the progress being made in resolving them. We recognise that it may not always be possible to provide accurate timescales to people, since the clinical priority of patients for handover to ED is continuously assessed and changing. However, the importance of clear communication with patients to ensure they are informed of the reasons for delay, is key in alleviating their anxieties or frustration with waiting.

Recommendation

WAST and health boards need to ensure that when delays occur, patients and their relatives or carers should be kept fully informed of the reasons and the progress being made in resolving them.

WAST and health boards across Wales should ensure patient feedback is obtained regularly to understand their experiences of long waits on board an ambulance, in order to inform improvement.

Delayed diagnosis and treatment

Although a minority, several views were communicated to us from people in our public survey regarding ineffective diagnoses made by both ambulance and ED staff. It also included a few dissatisfied comments about ineffective diagnosis and treatment of conditions once admitted.

"If there's a documented history of sepsis. Surely the sepsis protocols could be followed."

We also received comments from ambulance crew relating to the delays in treatment and diagnosis for patients by ED staff. The comments included concerns where a patient's health could deteriorate whilst on board the ambulance, such as a patient experiencing chest pain.
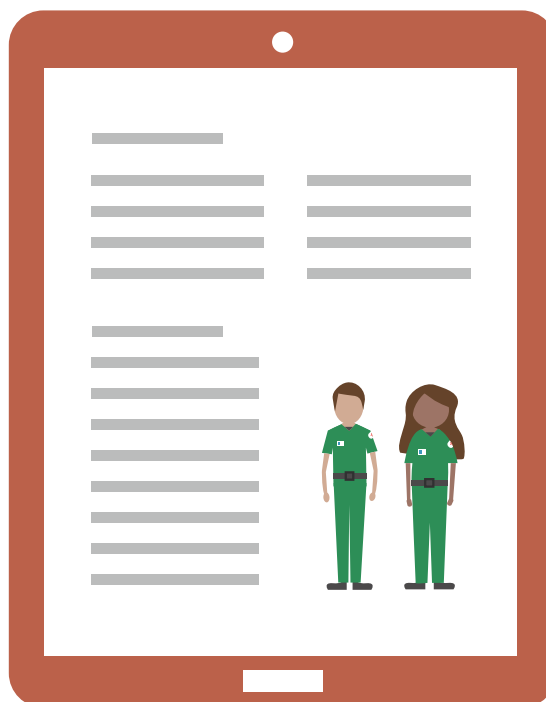
Other comments from WAST staff suggested that they believe diagnosis should commence whilst the patient is waiting on board the ambulance, such as blood tests and x-rays. This somewhat contradicts the self-assessments completed by health boards which suggest that ED staff do commence investigations, diagnosis and treatment while the patient is on board the ambulance. This suggests that the commencement of investigations whilst the patient is on the back of the ambulance does not consistently happen across all EDs. The comments included:

> *"Our patients are left stuck on ambulances without having bloods etc. done which could speed up the process for them to discharge patients. There should be a system for WAST staff to take bloods and take patients for x-rays or appropriate investigations whilst waiting outside hospitals as it benefits the patient and the staff at the hospital."*

We believe that commencing investigations whilst the patient is on board an ambulance has a benefit of earlier diagnosis, admission or even discharge of some patients, which could enable ambulance crews to be released, to undertake their primary role as providing on scene urgent or emergency care, and urgent or emergency transport of patients to hospitals.

Recommendation

WAST and all health boards across Wales must work together to identify a consistent approach in providing timely investigations and treatment for patients on board ambulances, to enable ambulance crews to be released quickly.

Patient privacy and dignity

Standard 4.1 within the Health and Care Standards 2015, states that people's experience of care is one where everyone is treated with dignity, respect, compassion and kindness and which recognises and addresses individual physical, psychological, social, cultural, language and spiritual needs.

In its handover guidance, Welsh Government states that the safety, effectiveness and dignity of care of patients must be at the forefront of systems of emergency care.

As highlighted earlier, our review considered how delayed handovers impacted on the privacy and dignity of patients on board the ambulance. This included the toilet needs of the patient either within the ED, or on board the ambulance.

Overall, our patient survey highlighted that patients were very positive about their experience waiting on board an ambulance due to delayed handovers. We received very positive feedback about ambulance crew, particularly in relation to their kindness, overall communication and managing of distressing situations. Patient comments included:

> *"The ambulance service went above and beyond."*
>
> *"They were excellent, really helped with my mother-in-law's anxiety and kept us fully informed throughout."*

Nearly all who engaged in our public survey said they were treated with dignity and respect by ambulance crew, and felt safe and cared for, and that staff were knowledgeable. Most also said they felt ambulance crew treated their condition effectively. Patients also indicated that they were satisfied by the care and treatment from ED staff.

The results of our staff survey, however, were not as positive in relation to their ability to maintain patients' dignity during delayed handovers. For ED staff, whilst 78% felt that patients were well cared for on board ambulances, only 68% said that the patient's privacy and dignity is maintained. In addition, only 62% of ambulance crew were felt that patient privacy and dignity is maintained.

This was also highlighted in our interviews with ambulance crew, with some specifically raising concerns with their ability to maintain the privacy and dignity of patients. The comments included:

> "Patients never provided with reason as to why they are waiting on an ambulance or have to endure the indignity of using a commode on an ambulance."
>
> "The biggest issue I have come across resulting from patients waiting for many hours on the back of an ambulance is that comfort and dignity is compromised. The ambulance stretcher is not designed for patients, especially elderly patients with thin skin to be laying on them for hours. Also, during long waits patients often need to go to toilet and as a result of very poor mobility end up soiling themselves. So to preserve their dignity we clean them up as best we can with very limited items as it's an ambulance and not a hospital ward."

One area of concern consistently highlighted by ambulance crew, was the difficulty in facilitating patients to access a toilet during their wait. Whilst most patients told us they were able to access a toilet, it is concerning that some patients reported they did not have access to facilities. In addition, during our staff interviews, concerns were highlighted by numerous ambulance crew with the difficulties encountered in assisting patients to use a commode or a bedpan on board an ambulance, due to the limited space available. Some also expressed concern over appropriateness, when two male ambulance crew were required to assist female patients with their toileting needs.

Wherever possible, ambulance crew told us they take patients inside the ED to use the department's toilet facilities, and request nursing staff assistance as appropriate. Overall, staff highlighted the issues with accessing toilet facilities as having a negative impact on patient privacy and dignity. Whilst ambulance crew told us that every effort is made to help maintain patient dignity, they described this as not always possible.

It was positive to note in one ED, that the ED sister attends the ambulance bays to enquire whether patients require the use of a toilet, and ensures staff are available to assist them. Patients are taken inside the ED whenever possible, or assistance is provided on board the ambulance.

Good practice in toilet management can help patients to maintain their dignity. Whilst we acknowledge the efforts made by ambulance crew to protect patient dignity, further efforts are required by both ED staff and ambulance crew to ensure all patients can access appropriate toilet facilities to maintain their privacy and dignity at all times.

Recommendation

Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.

Preventing pressure and tissue damage

It is highlighted within Standard 2.2 of the Health and Care Standards 2015 that people should be helped to look after their skin, and every effort should be made to prevent people from developing pressure and tissue damage.

In response to our staff survey, ambulance crew raised concerns around the suitability of ambulance stretchers for patients who experience long handover waits. In particular, for patients who are immobile and lying on a trolley on board an ambulance are at an increased risk of sustaining skin tissue pressure damage. We received numerous comments from ambulance crew which included:

> "Patients are regularly suffering due to excessive handover delays. Ambulance stretchers are not designed for prolonged use and vulnerable patients are being put at risk of pressure sores and other tissue viability issues despite the efforts of ambulance staff to turn and adjust their positions."
>
> "Often waiting outside with a patient for extended hours anywhere from 2 to 12 hours with a patient on an ambulance stretcher that is not designed for. Hard to give pressure relief to patients especially the heavier ones."

We were told during our interviews with ambulance crew that they are required to undertake an on-line clinical training module on the risk of pressure damage and pressure relief. However, despite their knowledge and understanding of the risks, and crew efforts to mobilise patients where appropriate, staff told us it can be very difficult to prevent skin tissue pressure damage for all patients. This in particular is an issue for patients, such as those with a suspected fractured neck of femur or spinal injury, who cannot be appropriately moved.

In addition, there is an increased risk of skin tissue damage with patients over 70 years of age, as a result of frailty and/or decreased mobility and/or poor nutrition and hydration on board an ambulance. Given the patient demographics provided to us by WAST, the majority of patients taken to EDs by ambulance are aged 65 and above, which highlights additional concerns associated with long patient waits outside ED.

We acknowledge the efforts made by both ambulance crew, and ED staff who support them, to help provide pressure relief and assess patients' skin for signs of pressure damage on arrival to ED. However, we are concerned that the risk of skin tissue damage remains for all patients experiencing long handover delays, in particular older adults, and will continue until prolonged handover delays are resolved.

Recommendation

During prolonged handover delays, WAST and health boards must work collaboratively and consistently, to minimise the risk of skin tissue damage for patients.
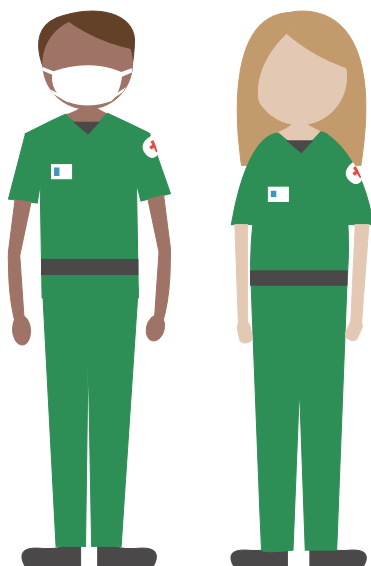
Nutrition and Hydration

Standard 2.5 of the Health and Care Standards highlights that that people should be supported to meet their nutritional and hydration needs, to maximise recovery from illness or injury.

During our review, we considered how patients' nutritional and hydration needs are met whilst they wait on board an ambulance.

As highlighted earlier in the report, the purpose of ambulance crew is to provide urgent or emergency care to patients in the community and where necessary, to transport them to hospital on board an ambulance. Ambulances are therefore not equipped to provide food and drinks to patients. One member of ambulance crew commented:

> "Hospital delays have been allowed to happen without any care or thought to keeping patients hydrated, fed and toileted appropriately whilst in the Ambulance. Ambulance Staff are not provided for, and often left hours without access to food and drink."

In our public survey, it was concerning to find that half of the respondents said they did not receive sufficient food and drink during their wait for handover to the ED. However, we are mindful that there are occasions when patients are designated as 'Nil by Mouth' due to their clinical condition, and therefore cannot consume food or drink, unless assessed as safe to do so. This may include examples with patients with gastric complaints, such as diarrhoea and vomiting, or severe abdominal pain, or for those who are suspected as required urgent surgery.

We found positive examples during our interviews with staff, where the majority told us that patients were supported by British Red Cross workers, who were contracted to work within EDs, who provided assistance to patients with food and drinks, and offered emotional support through engagement with patients.

It is concerning that patients who are waiting on board an ambulance are reliant on others for the provision of food and drink, to ensure their nutritional and hydration needs are met. We also acknowledge the difficulties that ambulance crew and ED staff face in providing food and drink for patients. The uncertainty of when patients may be able to eat and drink will negatively impact on them physically, especially given the uncertainty around timescales of when they may be handed over to hospital staff.

Recommendation

WAST should work with health boards to ensure that patients' nutritional and hydration needs are consistently met whilst waiting in the back of an ambulance due to delayed handovers.

Pain Management

During the review, we considered how patients' pain was managed on board the ambulance during triage and thereafter. Our public survey provided mixed comments, though overall, patients reported that ambulance crew managed their pain well. This is consistent with the findings within the 2018 Amber Review report. There was also a good response from ambulance crew in relation to the management of the patient's pain, with 81% stating they had access to pain relief should the patient require it. However, this was not consistent with their hospital experience, where patient comments indicated that their pain was at times not managed well once admitted to the ED. The comments included:

"The paramedics ensured I received additional pain relief in the ambulance on arrival."

"Unfortunately the hospital left me in a great deal of pain for quite some time."

It is reassuring that ambulance crew are acting positively in managing patients' pain. This is imperative, given the uncertainty of the length of handover delays. This may be reflective of the one to one care patients receive from the ambulance crew in comparison to staff-patient ratio in the ED. Health boards should reflect on these findings, and consider how pain management can be appropriately maintained, for patients experiencing pain once admitted in to the ED.

Infection Prevention and Control (IPC)

Standard 2.4 of the Health and Care Standards 2015, highlights that effective IPC is everybody's business, and must be part of everyday healthcare practice and based on best available evidence, so that people are protected from preventable healthcare associated infections.

Our staff survey highlighted a generally positive response to IPC from ED staff. Whilst 83% said that IPC procedures are followed, almost all said there is a sufficient supply of PPE, and 89% highlighting decontamination arrangements are in place for used equipment and relevant areas.

However, the survey response from ambulance crew was less assuring with 79% saying that IPC procedures were followed, and only 70% highlighting they felt there are adequate decontamination arrangements in place on the vehicle.

During our interviews with ambulance crew, concerns were highlighted by a number of staff regarding their ability to appropriately maintain safe IPC measures on board the ambulance. They provided examples with patients requiring a commode on board the ambulance, and with patients needing to eat and drink within the vehicle during long delays. In addition, crew members who may assist patients with enabling a patient to use a commode or bed pan are unable to change their uniform (if required), and may attend further emergency calls during their shift.

These examples highlight the difficulty in maintaining a safe and infection free clinical environment. The vehicles are a confined environment, and are not appropriate to provide adequate care for patients during periods of long delays with handover. This not only increases the risks with maintaining IPC, but can be considered detrimental to the patient experience.

Recommendation

WAST should consider how ambulance crew and patients can be supported to achieve and maintain high standards of hygiene and IPC, in particular during periods of delayed handovers for patients on board an ambulance.

Safe Care

People's health, safety and welfare actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented.

Within our staff survey, we asked whether staff were satisfied with the quality of care, treatment and diagnosis they give to patients during periods of handover delays. It was positive to find that 89% of ambulance crew said they were satisfied with the care they give to patients, although only 74% of ED staff were satisfied with this.

We asked ambulance crew in our survey if patients were monitored and assessed for acute illness; 87% confirmed they were, and this was also reflected in our findings from the ED staff. In addition, more than three quarters of ambulance crew said there was access to higher clinical support should it be required.

We also asked staff whether patients were involved in decisions about their care. Three quarters of ambulance crew and ED staff confirmed they were, however, we identified some negative comments from ED staff in relation to this question. Once comment included:

> *"There are issues with regards to ongoing care of patients who remain on vehicles for long periods of time; as a department we are trying to look after patient's both physically in and out of the ED, sometimes with little support from the crew."*

Despite receiving positive responses regarding the quality of care provided to patients from ambulance crew, it was very concerning that only 41% of ambulance crew said it was clearly understood who has responsibility for the patient at all times. However, three quarters of ED staff said it is clearly understood who has responsibility for the patient at all times. The hospital handover guidance highlights that ambulance crew should not routinely be responsible for monitoring patients for prolonged periods outside ED.

During our interviews with ambulance crew we identified that the lines of responsibility for patients on board an ambulance are blurred, due to ED staff going on board ambulances to assess and treat patients, and ambulance crews moving patients around hospitals for X-rays, CT scans and other investigations.

Overall, we identified from our interviews and staff survey that ambulance crew are not clear at all times as to who has responsibility for the patient prior to the formal handover taking place to ensure the safety of patients.

Recommendation

WAST and health boards must ensure there is absolute clarity, consistency and understanding between both ambulance crew and ED staff, as to where the responsibility and accountability lies for patient care on board an ambulance following triage, until transferred into the ED.

Discharge planning

During our interviews, a theme emerged from both ambulance crew and senior WAST managers that discharge planning could be improved. We were told that the anticipated date and time of patient discharge often appeared to be a 'last minute' decision in some EDs. The implication of this on the system is that a decision to discharge a patient may not take place until later during the day, which results in less time to obtain patient medication from pharmacy to take home, to arrange take home transport, thus impacting on delayed bed availability for patients in ED.

As referred to earlier within the report, the role of patient flow coordinators at some hospitals is seen as having a positive impact on this issue. On a day to day basis, their role includes co-ordinating a discharge time for a patient to understand the time their bed will become available for patients in ED. Some hospitals also provide the service of a discharge lounge, where patients can wait for their take home medication, and transport home. This means that their hospital bed is made available sooner and helps improve patient flow within the hospital.

Earlier patient discharge planning could result in more timely bed availability within the hospital. This could result in improved patient flow and improved ambulance patient handover times. Consequently this could release more ambulances to respond to emergency calls to patients waiting within the community.

Whilst overall we found that patient privacy and dignity may be compromised when patients are confined to excessive waits on ambulances, people who engaged with our survey were generally positive about their overall experiences. The outcome from our public survey is a positive reflection on the professionalism and caring attitude of the ambulance crews towards their patients.

Workforce

Within the Health and Care Standards, standard 7.1 highlights that healthcare services should ensure there are enough staff with the right knowledge and skills available at the right time to meet needs of patients.

Staff numbers and staff pressures

We received a number of comments from ambulance crew relating to perceptions that EDs are under staffed and under pressure, comments included:

> "Due to low staffing, there can be long delays waiting to hand over. During busy times it feels like the staff aren't listening to us when handing over."
>
> "Slow ... ED staff under too much pressure often short staffed or lack of bed spaces."

This was supported in our findings from ED staff, with only a fifth (23 of 103) of respondents saying there are enough staff for them to carry out their role safely and effectively. This is also consistent with our findings of previous ED inspections across Wales.

These findings are a concern, since insufficient staff numbers within EDs will have an impact on the quality and safety of patient care, and the ability to facilitate a timely ambulance patient handover, thus affecting people waiting for an ambulance in the community. Whilst the scope of our review did not include consideration staffing levels within EDs across Wales, health boards should review, and continue to monitor their staff establishments in EDs, and take action to improve the ongoing issues identified with staffing during our review and in our previous ED inspections.

We identified that during 2020-21, WAST recruited over one hundred additional frontline staff to gain a more timely response to the public's demand on its services. However, it was concerning to find that in response to our survey, only 31% of ambulance crew said there were adequate staff for them to do their job properly. Only 65% said they were able to meet the demands on their time at work. We were informed that there are further plans for WAST to recruit similar additional numbers of staff during 2021-22, however, this may not necessarily result in improved handover times to ED staff. Although, it may help improve the patient experience and staff well-being. It is at present too early to make a judgement on the increase to WAST staff establishments.

Recommendation

WAST and health boards must review and continuously monitor their staff establishments, in order to ensure appropriate levels of staff are maintained at all times.

Impact of hospital handover delays on staff

We asked ambulance crew in our survey whether there was sufficient support available when they wait for long periods on board an ambulance due to delayed handovers. It was disappointing to find that 93% of respondents said there was insufficient support available to them.

Only 36% of ambulance crew said their working pattern allows for appropriate breaks throughout their shift, and that their working pattern allows for a good work life balance. Ambulance crew we interviewed reported that shifts overrunning have become a normal part of their work. The term overruns refers to crews who have no option other than to work beyond their shift end time.

We identified that staff welfare in urban areas is easier to manage than rural areas, since crews are stationed closer to the ED they most often attend with patients, and are therefore able to return to their base station during their breaks and sooner at end of shift times.

In rural areas, we were told that it is not uncommon for shifts to overrun by two to three hours. The impact of delayed handovers is also increased in areas where a high number of tourists arrive during peak holiday times. If ambulance crews are late leaving the ED at the end of their shift whilst awaiting the arrival of a relief crew, at times, crews may be delayed by up to a further two hours before they arrive back at their base station.

These delays mean they have to start their shift the following day at a later time, to ensure they have sufficient down time between shifts. This can have a knock on effect to staff availability in the earlier part of their next shift.

It was positive to find that that 'pool cars' have been implemented at some ambulance stations, to help alleviate the impact of overruns on crew. They are used to transport ambulance crews to return to base for their breaks, and at the end of their shift, once the new crew arrive to take over the patient care on board the ambulance, waiting outside the ED to handover.

As referred to earlier within the report, the role of a Duty Operational Manager (DOM) has been implemented across Wales. The DOM is responsible for the operational leadership and supervision of a defined group of Paramedics, Emergency Medical Technicians and Urgent Care Assistants.

Additionally, they provide proactive and reactive operational leadership as a role model and operational commander at operational incidents, in line with the Civil Contingencies Act 2004[18] and as required to support the wider unscheduled care system. In addition, part of their role is to facilitate crews to take their allocated breaks, and to finish their shift on time wherever possible, by taking over the care of patients, therefore providing relief to crew members. We learned that the role is a relatively new initiative within WAST, and a number of DOMs had only recently been appointed at the time of our fieldwork interviews. The positive impact of this role in supporting ambulance crews is welcomed by those who have experienced this support.

Staff access to food and drink

Our review considered whether ambulance crews have reasonable access to food and drink during their shifts and prolonged waits outside of EDs. Only two in five said they had reasonable access to food and drink.

We established that ambulance crew who attend EDs in rural areas, or those whose ambulance base station is a great distance from their most frequented EDs, have more issues in accessing food and drink, especially during night shifts. This is because they cannot store their food at their base station and return to get it during their breaks, and there are no facilities for them to purchase food, either within the hospital or nearby vicinity. Ambulance crew working within urban areas said access to food was easier, since their base station was near the hospital, which allowed them to return either to their base station, or access food within the vicinity of the hospital, when relieved by Duty Operational Managers. Staff comments included:

"Food or a hot beverage is not available on nights and when working with a less experienced individual you cannot leave the patient when stuck outside hospital for hours on end. Only some hospitals offer the concession of £5. The patient does not get a warm drink or food whilst waiting."

"During night shifts access to food and drink becomes much more difficult and wish this should be addressed."

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18 The Civil Contingencies Act 2004 is an Act of Parliament which provides the framework for emergency and disaster planning and response on local and national levels in the UK.

Staff well-being

Our review has highlighted a number of key issues discussed above, which impact on the health and well-being of ambulance crews, as a direct result of delayed handovers and their knock on effect on crews' working conditions, this was also highlighted within the Amber Review report. During interviews, a number of ambulance crew told us that handover delays have a direct impact on their own health and well-being, comments included:

> "Hospital handover delays are having significant impact not only on patients but on WAST as an organisation, and also on morale, since they [staff] feel they are unable to provide the best service possible to the community that they serve."

In addition to these issues, staff highlighted further concerns regarding the poor ventilation on board an ambulance. We were told this has had a significant impact during the pandemic, where crews have spent prolonged periods on board ambulances waiting to handover to ED, and were required to wear full PPE whilst caring for suspected COVID positive patients. Furthermore, other concerns were highlighted regarding exposure to exhaust emissions from older ambulance vehicles when waiting outside EDs, where engines must run to maintain power to the vehicle.

During interview, some senior WAST staff highlighted their concerns with the impact handover delays have on ambulance crews. Consequently, actions have been implemented to support patients and staff. These include the initiatives highlighted earlier, such as Red Cross teams supporting patients, DOMs and pool vehicles supporting crews and the provision of concessions at hospital canteens for staff meals, when delayed with handover.

The crews we interviewed expressed their support and gratitude for the initiatives, however not all the measures are available consistently across Wales.

In response to our staff survey, 84% of ambulance crew said they were aware of the occupational health support available to them to support their health and well-being, and around 65% said their work place provides support for their mental health. However, it was disappointing to find that only 39% of ambulance crew said their organisation takes positive action on staff health and well-being, and just over 25% said that their employer provides support for their physical health.

Our survey findings also highlighted that just 73% of ambulance crew feel safe at work, and only 47% were content with the efforts of the organisation to keep them and patients safe. Staff repeatedly expressed their frustrations with the impact of handover delays on the experience of patients, and on their own well-being. Further comments in our staff survey included:

> "The effects of waits and frustrations are impacting on staff wellbeing."
>
> "We are expected to have a good level of fitness to perform our roles yet no access to gyms/PTs/ equipment is made."
>
> "WAST have improved in helping with mental well-being but they are very poor at ensuring staff are able to meet the physical requirements of the role. We should have access to gym facilities, discounted gym memberships, a sports club and easy access to physiotherapy. There should be a regular assessment of staff fitness."
>
> "I feel all efforts to improve wellbeing are paper exercises only and there is no real support."

Our staff interviews identified positive comments from ambulance crew regarding access to mental health support at work. The support included referral to TRiM[19], access to the 'Headspace' mindfulness app, and mental health awareness weeks, which promote the services available to staff. Crews also highlighted that following attendance at a serious incident, staff are automatically referred to the TRiM process.

Whilst, in general ambulance crew said that the Trust provides support for their mental health, the majority of DOMs we interviewed said that the support offered to them is limited. They also highlighted that as peers, they provide support to each other, but are not always considered for referral if they have attended the scene of a serious incident, which may have been stressful and upsetting.

Recommendation

WAST should consider how initiatives already introduced can be made consistently available to all ambulance crew across Wales. In addition, consideration should be given to how the welfare and support available to ambulance crews can be further improved.

WAST must ensure that the support for staff mental well-being is consistent across Wales, and that staff are routinely referred when appropriate and aware of how to access support if required.

19 TRiM is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic event.

Training and development

We considered the training and development of WAST staff. 85% of our survey respondents said they had received relevant training to allow them to undertake their role with confidence. Some ambulance crew comments suggested that despite caring for patients for prolonged periods on board an ambulance awaiting handover, training is not provided to support staff with this. This training issue was also highlighted by the ambulance crew we interviewed. Comments included:

"We are not nursing staff, but are expected to look after patients as though they are in the department, this includes having to try and toilet patients."

Recommendation

WAST should ensure that appropriate training is provided to ambulance crew in providing care to patients on board an ambulance, during prolonged periods of handover delays.

Escalation arrangements

Escalating a clinical concern with a deteriorating patient

Our review considered the escalation process in place should a patient's condition deteriorate whilst they are on board an ambulance awaiting handover to the care of ED staff.

In 2018, following the sad death of a patient who had endured a delay with handover from WAST to an ED, the Coroner, issued the Trust with a Regulation 28[20] letter in December 2019 to implement an escalation process for delayed handover. The process was implemented in February 2021 and stipulates circumstances when escalation is required, and what actions must be taken by ambulance crew and ED staff. As part of the escalation process, a Datix incident (electronic incident reporting system) will be completed. This will flag the incident with senior health board and WAST staff to investigate jointly the delay, to help prevent reoccurrence.

In response to our staff survey, only 49% of ambulance crew said that there was a robust system to alert ED staff should a patient's health deteriorate. This was concerning given that a clear process has already been implemented. In addition, not all the staff that we spoke with during our interviews were aware of the process. One comment received by a member of ambulance crew said:

"We have patients who regularly take the turn for the worse and are waiting outside, we raise with hospital staff and management and it's a slow process to get the patient into the department."

20 The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a 'report under regulation 28' or a Preventing Future Deaths report because the power comes from regulation 28 of the Coroners (Inquests) Regulations 2013.

Ambulance crew who had an awareness of the new escalation process told us that it is available on the Trust's intranet which is accessible to all ambulance crew via their iPads.

During our interviews, we spoke with a senior manager within the Trust who said that since its implementation, the impact of the escalation process was being monitored. The process had been presented to the Trust's scrutiny panel and an all Wales audit had commenced with Datix incidents being dip-sampled. The effectiveness of the process is to be gauged within the first six months since its implementation. At the time of our interviews, we were told that it was too early to gauge the effectiveness of the escalation process. As part of HIW's review action plan follow up processes, we will seek an update on the Trust's assessment of the effectiveness of the escalation process.

Recommendation

WAST must ensure all relevant staff are fully aware of the escalation process in place should a patient's health deteriorate, in order to minimise risks to patient safety.

WAST must provide HIW with evidence of its assessment of the effectiveness of the escalation process.

Escalation arrangements at a strategic level

Our review also considered how WAST manages escalation arrangements at a strategic level during periods of high pressure and demand during delayed handovers, and the subsequent lack of vehicle resource. In addition, how risks are identified, managed, and mitigated to ensure patient safety is maintained on board the ambulance during delayed handover.

To explore this, we attended the Trust's Operational Delivery Unit (ODU) in Cwmbran. This is the central hub and support network which provides leadership and co-ordination for the unscheduled care system in Wales. The ODU provides a single point of access for the identification and mitigation of risks in relation to hospital handover delays. Where ambulance crews are delayed, early escalation will occur via the ODU to the site manager and senior manager on call when necessary.

National Delivery Managers located within the ODU work collaboratively with health boards, WAST, Welsh Government and wider organisations and networks. Their role is to monitor WAST's status across all health boards in Wales, which includes the number of ambulances delayed outside each hospital, the hours they have been delayed, and the number of calls from patients who are waiting for an ambulance within the community.

We observed a live intelligence led integrated unscheduled care dashboard, which displays the data highlighted above, and provides a clear visual representation of the situation across Wales. The ODU currently operates seven days a week from 08.00am to 08.00pm or 02.00am during peak periods, and planning is in progress for the ODU to be operational 24 hours a day, 7 days a week.

We observed the daily WAST Risk and Safety Huddle, which is a video call chaired by the National Delivery Manager, with operational management representatives from across each region of Wales and specific service areas. This includes but is not limited to Emergency Medical Service Clinical Contact Centre's, 111 and Non-Emergency Patient Transport Services. Individuals provide an update in relation to identified risks to provide mitigation where required to assess and plan for the day ahead.

We also observed the daily National Risk and Safety Huddle, which is a video call with senior hospital managers within each health board and Welsh Government leads. This is chaired by the WAST Strategic Lead or the Head of the ODU. During the huddle, we observed how intelligence is gathered, performance and risk information is shared nationally, and the regional health system plans for the day are set to maintain the public and patient safety and identify risks, and plan for mitigation of these.

Information is submitted by health boards prior to the meeting which includes hospital escalation status and risk level, hospital bed capacity, and speciality bed numbers, such as those available in critical care. During the call, WAST provides an update on the levels of activity, demand, performance, escalation status and pressures within the unscheduled care system. Areas with significant handover delays, and areas within the community experiencing lengthy patient ambulance response times are prioritised, and health boards report the risks and their plans for mitigation of handover delays. Risks and action plans are agreed and a regional escalation stage is agreed based on demand.

The development of regional escalation protocols has ensured risk is balanced across the healthcare systems. When hospital handover delays are causing issues with vehicle resource and the demand for beds at a hospital has reached maximum capacity, decisions can be made dynamically to divert ambulance resources across geographical borders, to help maintain patient safety. Each health board will take responsibility for ensuring that all appropriate actions have been taken to manage demand within their own boundaries before cross border or regional actions are implemented in line with those defined within their own escalation plans, supported by regional escalation stages.

During periods of high demand on WAST emergency services, ambulance waiting times will inevitably increase. During these periods, WAST utilises the Demand Management Plan (DMP) framework. The DMP is used to deal with real time acute operational issues, which are not likely to have any long term service impact. There are eight DMP levels (DMP-1 to DMP-8) which are reflective of the scale of demand experienced by the service. The DMP aims to reduce demand and increase capacity of the service, which requires decisions at operational, tactical and strategic command level, in-line with the DMP level.

During any handover delay of more than six hours, alerts are automatically generated to the WAST Director of Operations and Chief Executive, to ensure key organisational leads can act on the issues identified and plan to mitigate the risks to patient safety.

During late 2020, WAST commissioned a Quality Governance Report associated with hospital handover delays. The report detailed the background, complexity, and significance of handover delays with the aim to embed robust governance processes, to monitor and manage the issues. The report also provided an account of activities undertaken to promote improvement, an assessment of the likely outcome of improvement actions being undertaken and significance of negative patient experience or patient harm.

WAST also has a Notification and Escalation Procedure, which provides guidance on the incident notification procedures followed within WAST. It also articulates the escalation process for hospital delays and/or patients awaiting an ambulance response within the community. To provide a consistent process, as to when, and to who, hospital handover delays need to be escalated.

In order to ensure the safe handover of patients to secondary care, WAST has developed systems, which identify risks, provide mitigation and escalate concerns, through timely, efficient and safe processes. The development of the ODU has had a significant impact in providing system oversight, and enabling effective management and practice across the healthcare system. The ODU is able to focus on immediate 'red release requests of ambulances from hospitals, hospital diversions to less busy sites, and enabling ambulance crews to handover patients in a timely manner.

Governance Arrangements

The Health and Care Standards stipulate that governance, leadership and accountability should be in keeping with the size and complexity of the healthcare service, are essential for the sustainable delivery of safe, effective person-centred care.

Reporting handover incidents

We found a robust process in place for managing handover incidents which may result in patient harm or death. Daily reviews of the Trust's electronic clinical incident system 'Datix' is undertaken by patient safety officers and managers. The Trust's SCIF, also meets twice weekly to review any serious incident reports, for investigation, and to identify any actions, lessons learnt and themes or trends.

WAST local management teams meet regularly with health board clinical leads to escalate any concerns, present data and discuss local mitigation. A Joint Investigation Framework process is also in place, and guides the Trust and health boards across Wales to review and investigate serious patient safety incidents identified within SCIF.

The process involves a collaborative investigation between WAST and the relevant health board. WAST staff highlighted issues with inconsistency in engagement in the joint process from all health boards, where identifying and sharing of learning from incidents is inconsistent across Wales. However, they did acknowledge that positive steps have been made, to improve engagement from all health boards.

Within our staff survey, only 63% of WAST respondents said they felt secure in raising concerns about unsafe clinical practice, although almost all staff knew how to report it. In relation to patient safety incidents, 64% of WAST respondents said they had seen a patient safety incident, near miss or an error, and of these almost all said they or a colleague had reported it.

It was disappointing to find that only 41% of WAST respondents said they believed their organisation would address their concerns. Our staff interviews supported this finding, with some staff highlighting that any response or feedback they receive as a result of reporting an incident, is a generic response. This therefore does not provide the reporting person with any action plan or learning as the result of a reported incident.

Comments included:

> "Items are reported, there is no feedback and the issue is recurrent."
>
> "Handover delays and long response times are not seen as near misses anymore. They are normal."
>
> "Not confident in reporting any concerns due to backlash."

Despite an overall negative response to incident reporting management, good practice was reported from staff from one ambulance base, which reported a process in place for a designated member of staff to provide feedback to the teams regarding Datix incidents and reports. This has a positive impact on staff, with the feedback encouraging teams to report any incident that occurs.

Our findings highlight the need for WAST to identify more effective processes for sharing feedback from incidents. This was discussed with senior staff who acknowledge improvements can be made to ensure incident investigation outcomes are effectively shared with staff, to help improve the quality and safety of care.

Recommendation

WAST must do more to ensure that its staff feel able to, and are confident in raising concerns. It must also ensure that robust processes are in place to share the learning with staff following incident investigations, in order to improve quality and safety of patient care.

Risk Registers

Hospital handover delays are identified by WAST as a significant corporate risk, which has been assessed at the highest score on its risk register. The risk relates to patients not being able to access secondary care assessment and treatment due to prolonged handover delays. In addition, the consequence of emergency response vehicles unable to attend patients requiring and ambulance in the community.

Such situations place WAST in a position where it is managing the consequence of handover delays. These delays are generally caused by a wider set of factors within the hospital setting including patient flow issues.

It is clear that WAST cannot, alone, improve patient flow through hospitals, to support the prompt transfer of patient care in to EDs. The significant level of risk to patient safety associated with delays handovers including the risk to patients in the community, cannot be one that is accepted any longer. It is essential that WAST, each health board across Wales, including Powys Teaching Health Board, consider whether actions taken to date have gone far enough to resolve this issue.

Conclusion

The aim of our review was to consider the experience of patients, including their safety, care, privacy and dignity whilst waiting on board an ambulance outside EDs during delayed handovers.

Despite finding that patients were, on the whole, positive about their experience, we have identified a wide range of evidence that handover delays have a significant impact on the ability of ambulance crew to provide a positive experience for patients. This included negative impact on the dignity of patients, and potential increased risks to patient safety.

It is clear that the issue of delayed handover has a hugely negative impact on the unscheduled care system as a whole. Each ambulance that encounters a prolonged stay at an ED potentially means fewer ambulances available to respond to emergency situations elsewhere.

National guidance is clear on the targets and expectations regarding handover and there is an apparent clear will to meet and achieve these expectations. However, it is clear that the issues around handover have not been resolved to date, with inconsistency in approaches apparent across Wales introducing risks to patient safety.

Whilst WAST has a role to play in addressing the issues described within this report, it does not have the ability to unilaterally resolve these problems. The whole healthcare system has a role and part to play in addressing the issues that we have highlighted in our report, and it is imperative that a reinvigorated, strengthened and concerted approach is taken to ensure that these problems are overcome.

HIW plans to undertake a National Review during 2021-22 which will focus in more detail on the issue of patient flow, examining in greater depth the cause and impact of patient flow issues.

What next?

We expect the Welsh Ambulance Services NHS Trust, health boards, and Welsh Government to carefully consider the findings from this review and the recommendations set out in Appendix A. We hope that this information will be used to further improve the service being provided by the Trust, and to inform further work and investigation across Wales, as highlighted within the report.

The Trust, health boards and Welsh Government will be required to submit a joint action plan in response to the recommendations highlighted within our report. HIW will undertake follow-up activity on recommendations made. This is to ensure that the Trust, health boards and Welsh Government are being vigilant in addressing the matters raised and taking all necessary action to improve the issues highlighted in our review.

Appendix A – Recommendations

As a result of the findings from this review, we have made the following recommendations in the table below.

Recommendations	Action
Health boards, and Welsh Government should consider what further actions are required to make improvements regarding the patient flow issues impacting on delayed patient handover. This may include consideration of whether a different approach is required by WAST, health boards, and social care services within Wales, to that taken to date in tackling this system-wide problem .	
WAST should engage with health board representatives to ensure there is improvement in practice between ambulance crew and ED staff to ensure the dual pin process is consistently followed, and ensure Welsh Government reporting data is accurate.	
Health boards should consider the benefits of the introduction of specific roles within their EDs that have the aim of improving process of the handover of patients from ambulances.	
Health boards must ensure that appropriate representation is present at WAST Serious Clinical Incident Forum meetings, to aid with the timely management of concerns and service improvement.	
If and where local standard operating procedures are absolutely necessary, WAST and health boards must together ensure that ambulance crew are familiar with the handover policy for that ED.	
WAST and health boards need to ensure that when delays occur, patients and their relatives or carers should be kept fully informed of the reasons and the progress being made in resolving them.	
WAST and health boards across Wales should ensure patient feedback is obtained regularly to understand their experiences of long waits on board an ambulance, in order to inform improvement.	
WAST and all health boards across Wales must work together to identify a consistent approach in providing timely investigations and treatment for patients on board ambulances, to enable ambulance crews to be released quickly.	
Both WAST and health boards must ensure that ambulance crew and ED staff work collaboratively to ensure patient privacy and dignity is maintained, and patients are always provided with the opportunity to use private toilet facilities where appropriate, in a dignified manner whilst waiting on board an ambulance during delayed handovers.	
During prolonged handover delays, WAST and health boards must work collaboratively and consistently, to minimise the risk of skin tissue damage for patients.	
WAST should work with health boards to ensure that patients nutritional and hydration needs are consistently met whilst waiting in the back of an ambulance due to delayed handovers.	

Recommendations	Action
WAST should consider how ambulance crew and patients can be supported to achieve and maintain high standards of hygiene and IPC, in particular during periods of delayed handovers for patients on board an ambulance.	
WAST and health boards must ensure there is absolute clarity, consistency and understanding between both ambulance crew and ED staff, as to where the responsibility and accountability lies for patient care on board an ambulance following triage, until transferred into the ED.	
WAST and health boards must review and continuously monitor their staff establishments, in order to ensure appropriate levels of staff are maintained at all times.	
WAST should consider how initiatives already introduced can be made consistently available to all ambulance crew across Wales. In addition, consideration should be given to how the welfare and support available to ambulance crews can be further improved.	
WAST must ensure that the support for staff mental well-being is consistent across Wales, and that staff are routinely referred when appropriate and aware of how to access support if required.	
WAST should ensure that appropriate training is provided to ambulance crew in providing care to patients on board an ambulance, during prolonged periods of handover delays.	
WAST must ensure all relevant staff are fully aware of the escalation process in place should a patient's health deteriorate, in order to minimise risks to patient safety.	
Recommendation – WAST must provide HIW with evidence of its assessment of the effectiveness of the escalation process.	
WAST must do more to ensure that its staff feel able to, and are confident in raising concerns. It must also ensure that robust processes are in place to share the learning with staff following incident investigations, in order to improve quality and safety of patient care.	

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Healthcare Inspectorate Wales

National Review of Mental Health Crisis Prevention in the Community

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Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

Content

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

Provide assurance:
Provide an independent view on the quality of care

Promote improvement:
Encourage improvement through reporting and sharing of good practice

Influence policy and standards:
Use what we find to influence policy, standards and practice

01 | Foreword

Foreword

Alun Jones
Interim Chief Executive

I am pleased to be publishing this report which presents the findings from our National Review of Mental Health Crisis Prevention in the Community. The focus of this work was to identify how people at risk of, or facing a mental health crisis are supported in the community and how easily support can be accessed.

One of the seven well-being goals at the heart of The Well-being of Future Generations Act[1] is *a society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood,* this comes with a need to ensure that public services make a shift towards prevention and wellness in how interventions are funded and delivered.

The COVID-19 pandemic has been a significant challenge to society, and has presented logistical challenges to the delivery of healthcare services as we know them. Our work during this time has highlighted, more than once, that the way people access services has changed significantly. Whilst this has been necessary to reduce the risks of COVID-19 transmission, in some areas and for some health conditions, these changes may have caused complexities in accessing care and treatment to become even more difficult.

In such challenging times, maintaining good mental health and well-being has arguably never been more important. This review is important in that it provides a timely spotlight on what measures are in place to help prevent mental health crisis, and whether the provision of care is timely and appropriate.

I am pleased that our work has enabled us to identify areas for improvement, and to highlight areas of good practice. In this piece of work we again demonstrate how critical it is that all parts of a health service work together as seamlessly as possible and that opportunities to work with third sector partners are maximised to deliver better outcomes for people who need care and support. Prevention of mental health crisis and the availability of strong support to those who are in crisis, and immediately after a crisis has passed, is best achieved when services work closely together.

To close, I must once again take this opportunity to pay tribute to the staff working within the mental health sector in Wales. The tireless dedication and positivity of those we encountered during this work, is heartening and provides a strong and positive basis upon which to improve.

Alun Jones
Interim Chief Executive
Healthcare Inspectorate Wales

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[1] See: A Healthier Wales – The Future Generations Commissioner for Wales

02 | Summary

Summary

This report sets out the findings from our National Review of Mental Health Crisis Prevention in the Community, which explored the experiences of people with mental health needs, and the adequacy of services available to support their mental health and well-being at the earliest opportunity.

The most effective method to prevent an individual from reaching mental health crisis is to ensure that adequate, timely and appropriate support services are available to that person at the onset of their mental health issues. This represents the greatest opportunity to avoid deterioration and lessen the risk of an individual reaching mental health crisis.

However, our review has found challenges across Wales inhibiting the ability of people to access timely mental health support. The absence of timely care or support when a person encounters a crisis in their mental health may lead to an increase in risk to their safety (or to others), which may result in a hospital admission or at worst; self-harm, suicide attempts or loss of life.

Those working within healthcare, emergency and third sector services and across Wales are committed and dedicated to providing support and care to people with mental health needs. It is clear that the various professionals working in primary care and community services, emergency services and within the third sector take great pride in what they do to support people with their mental health needs.

In general, we found that when a person is adequately supported by one service, such as a General Practitioner (GP), the risks associated with an individual's mental health needs are manageable. However, when a GP requires support from more specialist mental health services, this introduces complexity, uncertainty and risk, particularly if assessment by a specialist service is not completed in a timely manner. Whilst GPs endeavour to meet the mental health needs of an individual, when more specialist support is required, it is not always apparent whether suitable services are available, or exist, to refer into.

This is particularly relevant for those individuals who require an enhanced level of support above that which can be offered by a GP, but perhaps do not meet the criteria for the service being provided by their Local Primary Mental Health Support Services (LPMHSS) or the Community Mental Health Team (CMHT). GPs are not always aware of, or have been adequately informed of, the alternative services that may be able to provide enhanced support for these individuals.

Furthermore, referral processes into services can be cumbersome, with potentially lengthy waiting times, impairing the ability to ensure timely support to the individual. More needs to be done to address this gap in provision between services, with strengthened engagement between GPs and other primary and community care services and secondary mental health services.

Better engagement and communication is also required between services, to ensure clarity and consistency over what may constitute an 'urgent' referral, with the aim to minimise referrals being refused or passed back to the GP. This scenario can result in a patient not being assessed by another mental health service in a timely manner, potentially increasing the risk of deterioration in their mental well-being.

For those individuals who have reached the point of mental health crisis, more needs to be done to ensure that timely care, support and treatment is provided. Whilst we generally found that the initial response to crisis is adequate, with Crisis Teams responding promptly to provide care and support, ongoing support following intervention is perceived as less positive by both staff and patients. There are often delays in appropriate support and care being provided following a period of crisis,

sometimes resulting in referral back to the GP, and starting the referral process once again.

Inefficiencies in process, or lack of ability to directly refer into services, is a key issue highlighted by our review, and can result in an individual being caught in a cycle, having to access their GP repeatedly in order to re-commence the referral process. For instance, some emergency services can directly access mental health crisis teams when necessary, which is a positive step in gaining timely assessments, care and/or treatment for people who require urgent support, however, others cannot. This may lead to additional demand being placed on already busy and highly pressured emergency departments, and most significantly delaying the urgent mental health care and support a person may need.

We found positive examples within emergency services call handling teams (Welsh Ambulance Services NHS Trust (WAST) and the police), where mental health professionals have been recruited to manage incoming calls from people needing support with their mental health. It was highlighted to us from staff that this allows for more timely support to people through prompt telephone advice for those struggling with their mental health, and who call emergency services in times of urgent mental health need.

This can have a positive impact by removing the need to dispatch emergency service resources to a person calling for crisis support, as a caller can be supported over the phone or signposted immediately to the most suitable resource to support them.

The service and support that can be offered by third sector organisations to individuals with mental health issues can be invaluable, and potentially lessen the likelihood of significant or rapid deterioration into mental health crisis, and may ease the demand on NHS services. There are clear opportunities to strengthen linkages and collaboration with the third sector in relation to crisis prevention, in particular for those individuals who require a greater level of support than a GP is able to provide. However, third sector support services are not able to refer directly into specialist mental health services when necessary, and this can make processes inefficient. The heavy reliance on GP involvement in referral processes may mean that the best interests of the individual arenot always met in a timely way.

We found that in some areas there are no defined processes in place to ensure that physical health assessments and monitoring of patients with a mental health condition is undertaken. The Mental Health (Wales) Measure 2010[2,3] sets out a requirement to undertake physical health monitoring for relevant patients. During our review we heard differing views from health board and primary care representatives on whether physical health assessment and monitoring should be undertaken by a Community Mental Health Team (CMHT), or whether this was the responsibility of primary care. During our interviews we heard concerns across Wales that there were no defined processes in place to ensure that these were undertaken.

Lack of clarity around responsibility for physical health monitoring can have significant consequences for a person's health, if monitoring is missed or not prioritised where required. For example, some psychiatric medication requires regular monitoring of a patient's blood pressure and heart monitoring, or blood tests for liver or kidney function. Clear processes must be in place to ensure that physical timely health monitoring is undertaken, and communicated appropriately between teams.

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[2] https://www.legislation.gov.uk/mwa/2010/7/part/1
[3] https://gov.wales/sites/default/files/publications/2019-03/the-mental-health-wales-measure-2010.pdf

Our review has noted several positive initiatives across Wales. For example the implementation of a single point of access to ensure specialist mental health professionals are available to provide clinical triage, onward referral and effective signposting to individuals in crisis. We also found positive steps being taken with the introduction of local Mental Health Practitioner roles, Local Primary Care Mental Health Support Services that are located within or near healthcare services, and usage of 'safe places' to provide short term support, from a few hours or with some services enabling the person to stay overnight. However, many of these initiatives are either early in their introduction or not available in all areas of Wales. The benefits of such approaches need to be evaluated, with learning shared across Wales to ensure that health boards can adopt the most effective approach.

Whilst it is clear that those working within services are committed and dedicated to helping those individuals in need of support at all stages of their mental health illness, it is also apparent from our review that services are not always designed or working in the best interests of the individual, heightening the risk to that person of reaching mental health crisis.

03 | Context

Context

In our Operational Plan 2019-2020[4], we committed to a programme of national reviews, which included crisis prevention in mental health. The decision to undertake this review was based on concerns relating to people's ability to access timely care to prevent them reaching a crisis with their mental health.

Providing services to support people with urgent mental health needs, or to prevent people falling into crisis, is often not the responsibility of any one service or professional, and can require a number of professionals and/or a multi-agency response.

We have previously identified that initial access to mental health services is an area that requires improvement. Our report Joint Thematic Review of Community Mental Health Teams published in 2019[5], highlighted a lack of knowledge by some primary healthcare professionals of the range of referral services available for people suffering with mental health issues.

Our joint review on Substance Misuse Services in 2018[6], also identified significant challenges around holistic working within mental health services. The review identified issues of long waiting lists after referral to mental health services, and staff working in substance misuse services highlighting concerns that referral processes were sometimes overly complicated and inconsistent. In addition, it was recommended that improved co-ordination between substance misuse services and mental health teams was required in some areas of Wales.

What is mental health crisis?

A mental health crisis can mean a rapid deterioration of a person's mental or emotional state, such that a person no longer feels able to cope or be in control of their situation. They may experience or feel many emotions, although this may be different for each individual. This can include moderate to severe emotional distress or anxiety, to an extent that a person cannot cope with day-to-day life or work, or that a person may think about suicide or self-harm, or may experience hallucinations or hear voices.

A key challenge in defining mental health or well-being crisis is that each person's perception of crisis is individual to them. What one person may perceive as manageable problems, may cause another to feel completely overwhelmed. People may seek support for their mental health needs at different points of time, and as such, the required response from organisations supporting that person may vary and need to be individualised to the person, and their presentation at that time. Some will seek support for the first time when developing mild symptoms, such as anxiety, and others when they feel unable to cope, or even when they are at significant risk of harm to themselves or to others. Services should respond swiftly to enable the person to receive support appropriate to their needs and symptoms, and from the most appropriate professionals in the most appropriate place.

When someone requires support in a less urgent situation, they need to be reviewed by the most appropriate professional or service in a timely manner to prevent any further deterioration. Without early support, this may lead to them falling into a situation where they require more urgent and immediate support.

This review sets out to identify whether mental health crisis is being prevented in the community through timely and appropriate care. We considered the experiences of individuals who have accessed support for their mental health.

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[4] https://hiw.org.uk/sites/default/files/2019-06/190412operationalplan1920en.pdf
[5] https://hiw.org.uk/sites/default/files/2019-06/190207joint-thematic-review-community-mental-health-en.pdf
[6] https://hiw.org.uk/sites/default/files/2019-06/180725smen.pdf

We also explored the views of service providers on what services they provide, how they commission or access additional support from other services, and their experiences in doing so. Our review focused on mental health crisis, where the timeliness of support from one or many services is paramount to preventing further deterioration in people's mental health and well-being.

Mental health services available in NHS Wales

There are seven local health boards in Wales, and each plan, commission and deliver healthcare services in their localities, including mental health services. These are highlighted, along with a map of the localities, in Annex B.

The mental health services in each health board area provide a range of services to care for and support individuals according to their needs. Each has a set criteria to identify which service is most appropriate to treat or support a person, and are based on the severity of their condition and urgency of need.

The way in which health boards manage and deliver mental health services across Wales varies according to the locality and the population needs. However, regardless of how the services are managed locally, the services available are generally consistent, and include:

- **Tier 0/1 open access**, which provide non-clinical mental health support without the need of referral. This includes provision commissioned at a national level and support commissioned locally by health boards. This level of support incudes 24/7 access to the mental health advice line CALL (Community Advice and Listening Line)[7] and online resources.

- **Primary care services**, such as GP services, who manage mild or moderate mental health needs

- **Local Primary Mental Health Support Services (LPMHSS)**, which provide care and support for mild to moderate mental health symptoms, which usually require more support than can be offered from a GP service. Patient access to LPMHSS is through GP referral, and the service operates either within or alongside GP practices

- **Community Mental Health Teams**, which provide services for people diagnosed with, or are suspected of having moderate to severe mental illness or mental disorders, who for complex reasons, severity of condition and/or poor treatment response, will require specialist secondary care services with multidisciplinary team input

- **Crisis teams**, who provide short term rapid support in the community to help prevent hospital admission. They may also support those people attending emergency departments or have been brought to a Section 136 Suite[8].

- **Hospital teams**, who provide inpatient care for individuals needed more intensive support than is available in the community. People may receive care in hospital voluntarily or be detained under the Mental Health Act.

- **Liaison psychiatry** provide psychiatric care to medical patients. These include those people attending emergency departments, general hospital, they may also cover community and primary care medical services.

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[7] https://www.callhelpline.org.uk/
[8] A Section 136 Suite is a designated 'place of safety' under the Mental Health Act that the police can take a person to receive a psychiatric assessment.

How do people access services for their mental health needs?

Primary care is usually the first point in the healthcare system where a person will seek support for their mental health. The GP is often the first point of contact for mental health concerns, and the care which they provide in local settings helps to treat mental health issues. The King's Fund study *Understanding Pressures in General Practice*[9] published in 2016, states that 90% of adults with mental health problems are supported in primary care. In 2011, Welsh Government published the *National Model for Local Primary Mental Health Support Services*[10], highlighting the aim of these services is to improve access and patient outcomes for mental health care within primary care settings.

90%
of adults

with mental health problems are supported in primary care

Additional mental health services available in the community

In addition to NHS services, there are numerous services provided by third sector organisations available to people in Wales, to support those who may be experiencing mental health problems or need urgent support. Further details of these organisations can be found in Annex C.

The third sector is a term used to describe a range of organisations that are neither public sector nor private sector. It includes voluntary and not-for-profit organisations such as charities, associations, self-help groups and social enterprises[11].

In Wales, many of these third sector organisations are members of the Wales Alliance for Mental Health, which has been the 'collective voice' in the field of mental health for many years[12]. Many members of the Alliance work directly with people in crisis, or with people seeking support or advice, as well as providing care services, undertaking research and surveys, working with families and carers and advocating for people with 'lived experiences'.

Mental health law

The main piece of legislation that covers the assessment, treatment and rights of people with a mental health illness is the Mental Health Act 1983[13]. The Act provides a framework for the compulsory hospitalisation and treatment of certain people with a mental disorder. However, only a very small minority of people with mental health problems need compulsorily treatment, and the majority of people never need to be treated compulsorily, and instead voluntarily seek treatment.

[9] Understanding pressures in general practice | The King's Fund (kingsfund.org.uk)
[10] http://www.wales.nhs.uk/sitesplus/documents/863/Mental%20Health%20Measure%20-%20Primary%20Care%20Model.pdf
[11] https://www.nao.org.uk/successful-commissioning/introduction/what-are-civil-society-organisations-and-their-benefits-for-commissioners/
[12] http://www.mentalhealthwales.net/voluntary-sector/#:~:text=The%20Wales%20Alliance%20for%20
[13] https://www.legislation.gov.uk/ukpga/1983/20/contents

The Mental Health (Wales) Measure 2010

The Mental Health (Wales) Measure is different to the Mental Health Act, as it does not provide for the compulsory hospitalisation or treatment of people with mental health conditions. The Measure is a law made by the National Assembly for Wales, now Senedd Cymru, which introduced important changes to the support available for people with mental health conditions in Wales. It places legal duties on health boards and local authorities to improve support for people with mental ill-health, and also made provision for the expansion and strengthening of mental health services at primary care level. This includes the introduction of local primary mental health support services, which are delivered in partnership by health boards and local authorities, and which operate alongside existing GP practices.

In addition, the Measure:

- Requires a care and treatment plan be in place for all service users aged 18 and over needing care and treatment within secondary mental health services

- Allows people who have been discharged from secondary care mental health services, who believe that their mental health is deteriorating to such a point as needing care and treatment again, to refer themselves back to secondary services directly, without necessarily needing to first attend their GP or elsewhere for a referral.

The Measure also allows all inpatients in Wales, who are receiving assessment or treatment for a mental disorder are entitled to request support from an Independent Mental Health Advocate. Advocacy can lead to an improved experience of mental health services for individuals; it can create choice, improve involvement in decision making, and promote access to a range of different services.
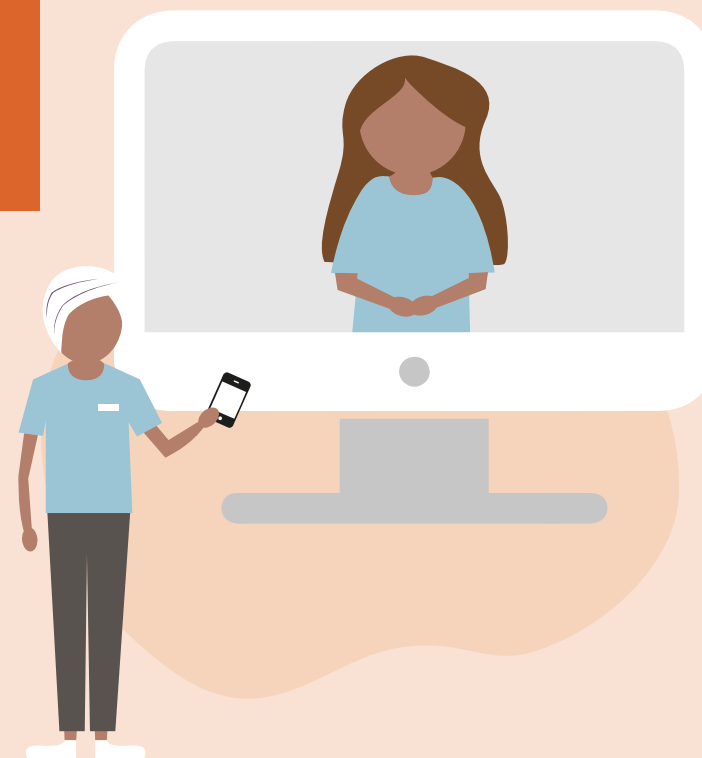
Together for Mental Health

Within its *Together for Mental Health Delivery Plan 2019-22*[14], Welsh Government highlights a number of priorities, which includes improved access to preventative measures and early intervention to promote recovery. In developing the delivery plan, the approach taken reflects the requirements of the *Well-being of Future Generations (Wales) Act 2015*[15] by emphasising the importance of preventative and integrated services whilst recognising the importance of taking a longer term approach. The emphasis in the plan is on early intervention so that longer-term harms are prevented before they occur, and also includes preventing exposure to adverse childhood experiences.

Mental Health Crisis Care Concordat

The Mental Health Crisis Care Concordat[16], is a national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations can work together to deliver a quality response when people with acute mental health crisis have contact with the Police and are likely to be detained under section 135 or section 136[17] of the Mental Health Act 1983. It is under-pinned by Welsh Government's commitment to mental health policy, set out within its strategy and supported through its Code of Practice for the Mental Health Act 1983.

The Mental Health Crisis Care Concordat published by the Welsh Government and its partners in 2015, highlights a shared statement of commitment to improving mental health services in primary care, and is endorsed by senior leaders from organisations who are most involved in responding to those in mental health crisis.

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[14] https://gov.wales/sites/default/files/publications/2020-10/review-of-the-together-for-mental-health-delivery-plan-20192022-in-response-to-covid-19_0.pdf
[15] Well-being of Future Generations (Wales) Act 2015
[16] https://gov.wales/sites/default/files/publications/2019-03/mental-health-crisis-care-concordat.pdf
[17] https://www.mind.org.uk/information-support/legal-rights/police-and-mental-health/sections-135-136/#WhatIsSection135

04 | What we did

What we did

Focus of Review

The focus of our review was to understand the adequacy of the measures in place across Wales, to help mental health crisis being prevented in the community, through timely and appropriate care.

Throughout the review we explored:

- **The experiences of people who access care and treatment** - to understand how services help people to manage their mental health condition and prevent crisis

- **Safe and effective care** - how GP and other NHS services available within the communities across Wales provide safe and effective services to help prevent mental health crisis, and what third sector organisations do to support this

- **Collaborative working** – how mental health crisis is being prevented in the community and across teams, to ensure care and support is provided by the right services, in the right place, and at the right time
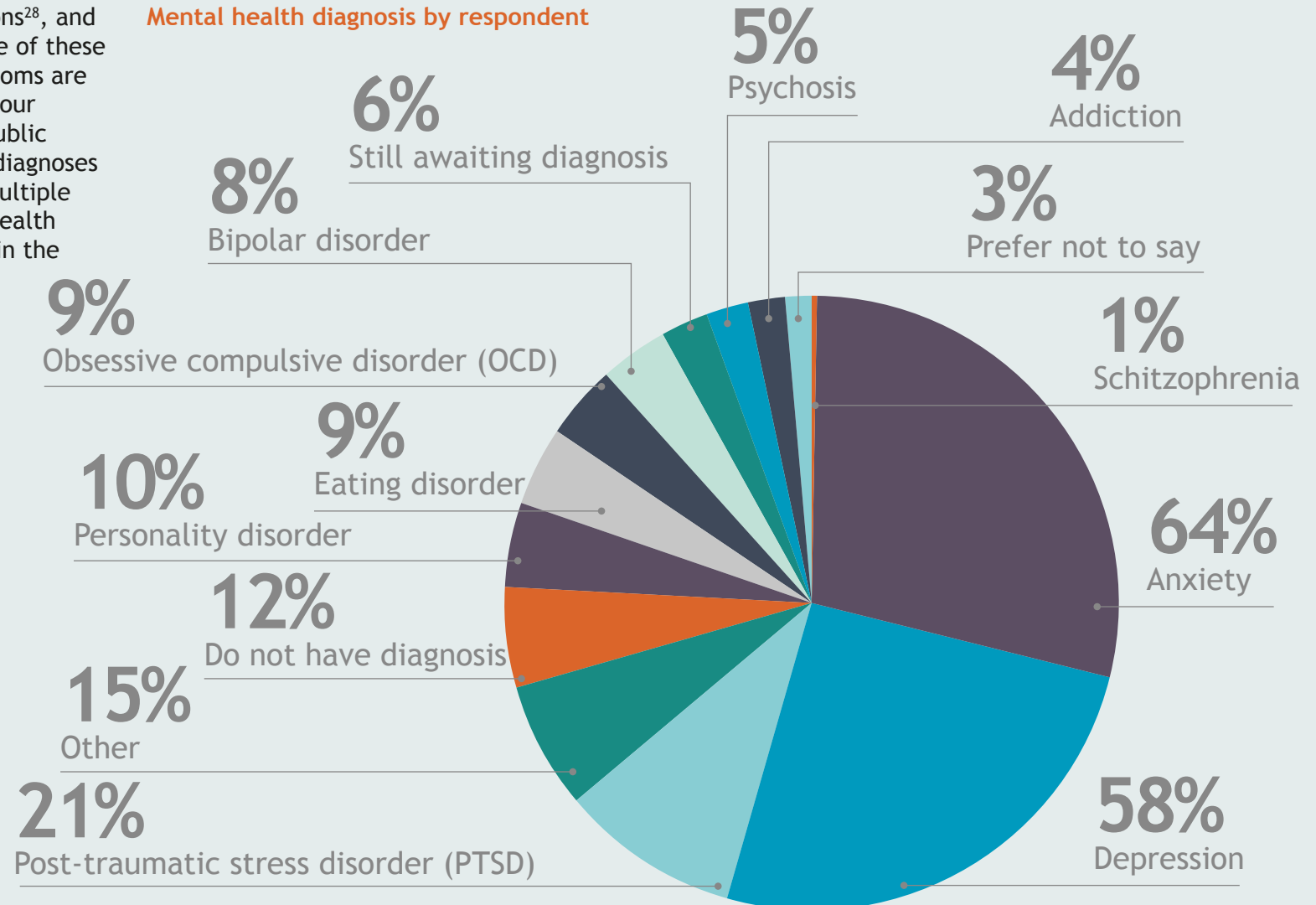
Throughout, we considered the following key questions:

- Are there adequate services available in the community across Wales to help prevent people reaching mental health crisis?

- Are people in Wales receiving timely, safe and effective mental health care or support from multi-professional teams?

- Are mental health services in the community effective and sustainable?

Whilst planning our review, we considered mental health policy within Wales and reviewed a number of published documents, which included; The Mental Health (Wales) Measure 2010 and Mental Health Crisis Care Concordat highlighted earlier; *Together for Mental Health: A Strategy for Mental Health and Well-being in Wales*[18], which is a 10 year strategy for improving the lives of people using mental health services and of their carers and/or families; and the *Mental Health Delivery Plan 2019-2022*[19], implemented to improve mental health and well-being.

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[18] https://gov.wales/sites/default/files/publications/2019-03/together-for-mental-health-a-strategy-for-mental-health-and-wellbeing-in-wales.pdf
[19] https://gov.wales/sites/default/files/publications/2020-10/review-of-the-together-for-mental-health-delivery-plan-20192022-in-response-to-covid-19_0.pdf

Scope and methodology

To review the areas outlined above, we requested relevant documents and key information regarding the services provided from each health board. We also considered local and national initiatives and developments and performance data and statistics, which included:

- Public Health Network Cymru[20]
- Mental Health Improvement Cymru[21]
- StatsWales data[22].

In addition, we coordinated with the NHS National Collaborative Commissioning Unit (NCCU), who carried out the review *Mental Health Urgent Care Access* and Conveyance Review concluding in the review *Beyond the Call*[23] published in 2020. We also engaged with the NHS Delivery Unit, who is undertaking an *All Wales Psychiatric Liaison and Crisis Care Review,* which is scheduled for completion around February 2022.

Understanding the planned and ongoing work by other stakeholders and partners within mental health crisis services was a key consideration in shaping the focus of our national review. This was to ensure our work could add value, and to prevent duplication of any ongoing or planned work in the area of urgent care or mental health crisis.

Over the course of our review we undertook a programme of interviews with a variety of staff within services which provide care and support to people with their mental health needs, and conducted an online national survey for both NHS and third sector staff. In addition, we conducted a national public survey jointly with the NCCU, to help inform both reviews.

Professional staff survey

We developed and launched a survey of professionals to obtain the views of health board, emergency services and third sector staff on the mental health services they provide to people across Wales. This was to help us understand the services in place, staff perception of the services available (or not), and to help identify good practice or any areas for improvement.

We asked health boards, WAST, the Royal College of General Practitioners (Wales)[24], and the Wales Alliance for Mental Health[25] to distribute our online smart survey details to relevant staff, and we also promoted the survey through our social media channels.

We received a total of 222 responses across Wales, which included:

71
Mental health staff

52
GP and primary care staff

39
Third Sector staff

45
'Other' staff

15
Emergency services staff (999, WAST and Police)

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[20] https://publichealthnetwork.cymru/category/mental-wellbeing/
[21] https://phw.nhs.wales/services-and-teams/improvement-cymru/our-work/mental-health/
[22] https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Mental-Health
[23] beyond-the-call.pdf (gov.wales)
[24] https://www.rcgp.org.uk/rcgp-near-you/rcgp-nations/rcgp-wales.aspx
[25] http://www.mentalhealthwales.net/voluntary-sector/#:~:text=Voluntary%20sector%20The%20Wales%20Alliance%20for%20Mental%20Health,
Wales%20working%20in%20the%20field%20of%20mental%20health

Breakdown of staff responses per staff type:*

27.27%
Other (please specify)

7.66%
Non-emergency phone line

0.90%
999 emergency phone line

1.35%
Police

12.16%
Ambulance service

17.57%
Third sector organisation

23.42%
GP Practice

25.68%
Mental Health Team (Community)

6.76%
Mental Health Team (Inpatient)
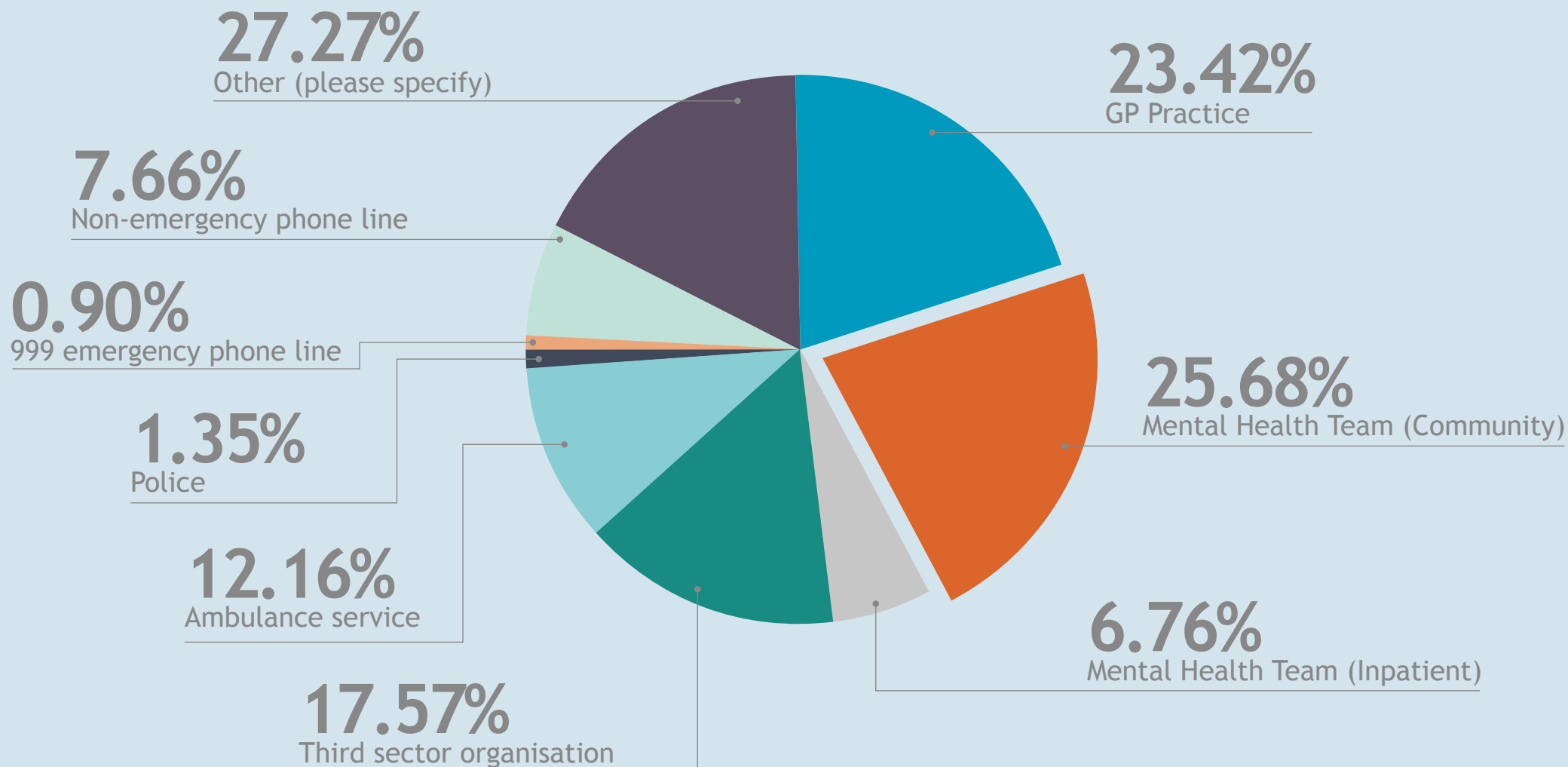
*multiple choice

Public survey

In addition to the survey of professionals, we also launched a national public survey to capture the views of people who have experienced mental health concerns. This was to gain an understanding of their perception and experiences of the services available to them.

The survey was jointly commissioned by HIW, NCCU and the charity Mind Cymru[26] and was appointed to, developed and analysed by Picker[27] (an international health and social care charity), to investigate service users' lived experience of accessing urgent mental health services in Wales.

We received a total of 1,265 responses from people across Wales, with 16% identifying as male, 79% as female and 5% of other identifications.

79%   **5%**   **16%**

This included understanding:

- **Access to and effectiveness of crisis planning:** service users with a mental health diagnosis should be aware of an individualised crisis plan that they can activate in an urgent situation. Whether these are common within self-identified service users and what have been their experiences of the urgent care services that they have accessed?

- **Awareness and experience of support services that can be accessed in an urgent situation:** who or what is 'front-of-mind' as a contact point in an urgent mental health crisis situation?

- **Prioritisation of what is important to service users when accessing mental health services:** what do people value most when trying to access urgent mental health support?

The survey was hosted on a third-party online survey portal Qualtrics. It was administered through an open link, and was distributed via social media channels and promoted by HIW. Paper surveys were also available upon request, as were easy read and alternative language versions.

The survey was available to complete between 4 March and 19 April 2021. It is therefore important to note that this period was during the COVID-19 pandemic, and could have potentially affected response rates and may have influenced how people responded to the survey questions. We received a total of 1,265 responses from people across Wales, with 16% identifying as male, 79% as female and 5% of other identifications. The ethnicity of respondents included; White 93%, Mixed/ Multiple ethnicity 1%, Asian/ British Asian 1%, and other ethnicity 3%. Respondents comprised of people who were receiving care or treatment for their mental health by their GP or mental health service, others not receiving treatment, and some who may have been experiencing anxiety disorders, but without a diagnosis.

[26] https://www.mind.org.uk/about-us/mind-cymru/
[27] https://www.picker.org/

We received responses from across Wales and each health board, and this is highlighted in the chart below:

Public responses per Health Board

8%
Swansea Bay University Health Board

6%
Powys Teaching Health Board

17%
Hywel Dda University Health Board

14%
Cwm Taf Morgannwg University Health Board

16%
Aneurin Bevan University Health Board

14%
Betsi Cadwaladr University Health Board

25%
Cardiff and Vale University Health Board
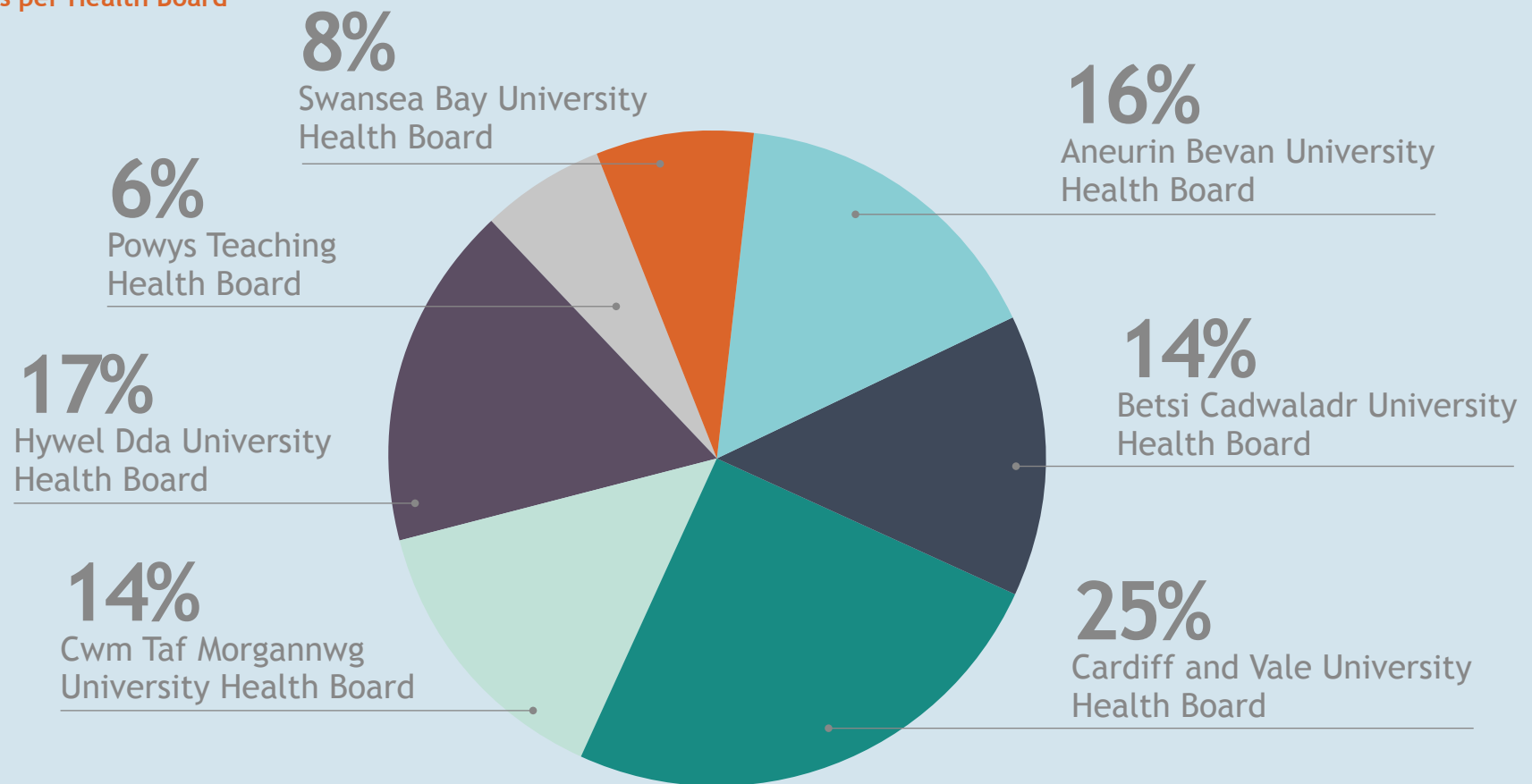
People from a range of age groups responded
to the survey, as highlighted in the chart below:

Responses by Age

1%
75-84

5%
65-74

19%
55-64

27%
45-54

3%
17 and under

9%
18-24

14%
25-34

21%
35-44
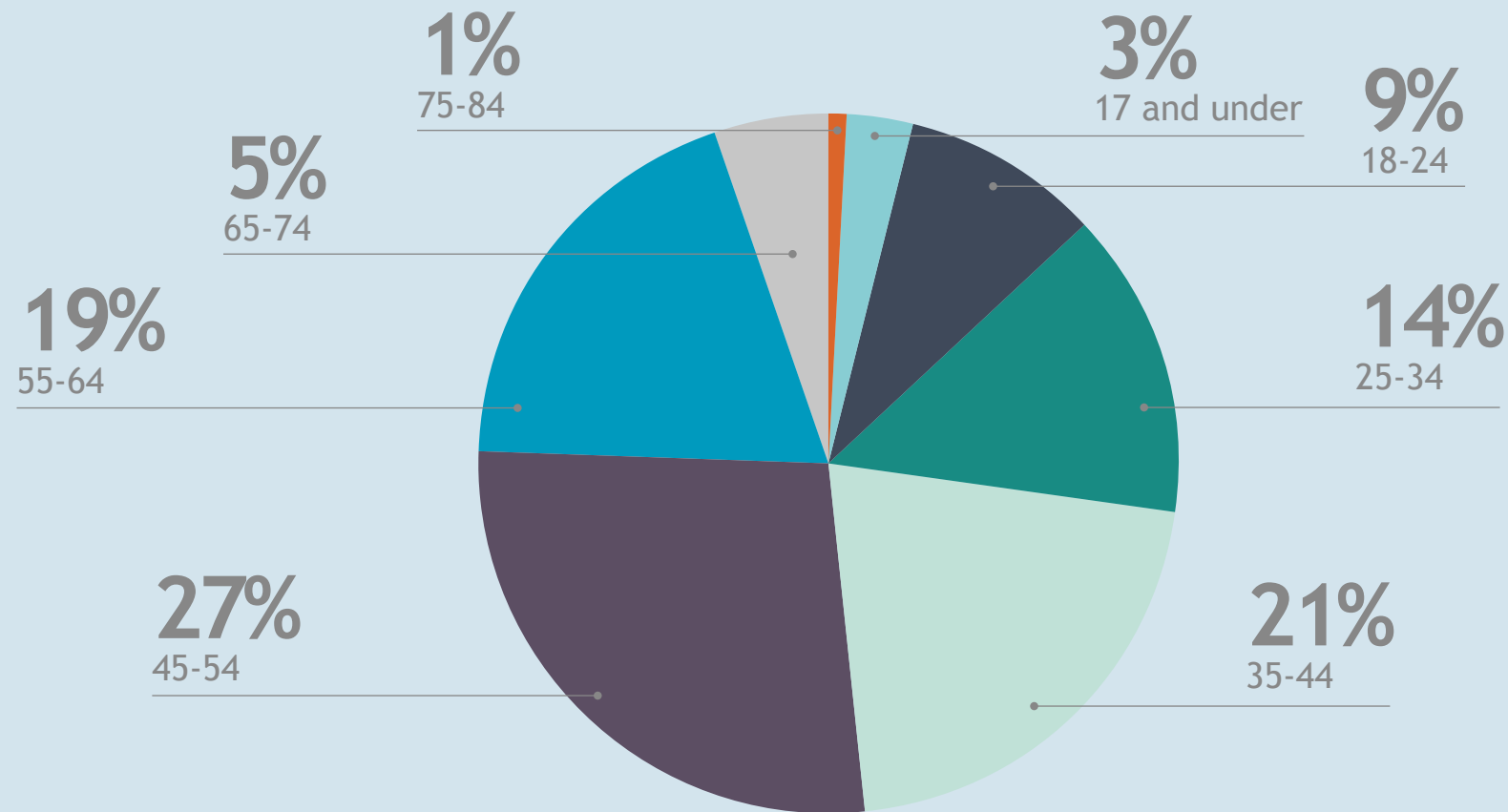
Staff Interviews

Due to restrictions in place relating to the COVID-19 pandemic, our fieldwork was completed remotely. This was to help minimise the risk of exposure to the virus to our team or those working within healthcare and third sector services across Wales.

We held 45 interviews with staff from acros Wales. This included staff from:

- Health boards
- General Practitioners
- Police
- WAST
- Third sector.

The staff we interviewed shared their views and experiences of working within the services providing mental health care or support, and the main challenges they faced in their day-to-day work. We also discussed their organisation's service provision, current service provision and plans for future developments to improve access to services, and discussions around the findings of both our public and professionals surveys.

Children and young people

Whilst this review has focused on adult services, we have also gathered intelligence around children and young people's mental health services. This information will be used for planning future HIW activity. Whilst arrangements for children and young people will differ from that of adult services, there are clear messages and learning from this review that are also relevant to services for children and young people.

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Are there adequate services available in the community across Wales to help prevent people reaching mental health crisis?

There are many mental health conditions[28], and the term 'crisis' can cover a wide range of these conditions and situations, where symptoms are exacerbated for the person. As part of our review, we asked respondents to our public survey to identify their mental health diagnoses (the respondent was able to identify multiple diagnoses, as is common with mental health conditions), and these are highlighted in the chart to the right.

Mental health diagnosis by respondent

- 6% Still awaiting diagnosis
- 5% Psychosis
- 4% Addiction
- 8% Bipolar disorder
- 3% Prefer not to say
- 9% Obsessive compulsive disorder (OCD)
- 1% Schitzophrenia
- 9% Eating disorder
- 64% Anxiety
- 10% Personality disorder
- 12% Do not have diagnosis
- 15% Other
- 58% Depression
- 21% Post-traumatic stress disorder (PTSD)

[28] https://www.nhs.uk/mental-health/conditions/

The chart clearly highlights that anxiety and depression are the main mental health conditions highlighted by the respondents in our survey, and the more complex conditions were less reported. This is consistent with the Mental Health Foundation[29], which suggests that anxiety disorders and depression are two of the most common mental health disorders in Britain, with anxiety affecting 16% of people in the UK. These are mental health conditions that can typically be managed within the community from services in primary care and/or third sector organisations.

Whilst the chart shows that 18% of people 'do not have' or 'are awaiting a diagnosis', we cannot determine whether this means that people have a suspected condition, are under mental health or GP services for this, or are self-diagnosing a condition, which has not been confirmed by a medical professional.

Focusing on prevention

The *Talk to me 2: Suicide and Self-harm Prevention Strategy for Wales 2015-2022*[30], suggests that mental health crisis, self-harm and suicide are largely preventable, if an individual's risk factors are effectively addressed.

Suicide is typically in response to a complex series of factors that are both personal and related to wider social and community influences.

There is no single reason why someone may try to take their own life, and suicide is more likely best understood by looking at each individual, their life and their circumstances. This, however, requires a public health approach, which is broader than focussing on services for mental health service provision. It demands a collective action by individuals, communities, services, organisations, government and society as a whole.

Prevention and promotion of positive mental well-being are key features in the *Together for Mental Health Delivery Plan*, highlighting actions at both individual and community level. The delivery plan also includes a specific focus on preventing suicide and self-harm through the *Talk to Me 2 Strategy*, through early intervention to prevent longer-term harms, which includes preventing exposure to adverse childhood experiences.

In our public survey, we asked whether respondents had a crisis plan in place to deal with an urgent mental health need.

Under Part 2 of the Mental Health Measure, a care and treatment plan should be in place for all service users aged 18 and over who need or receive care and treatment within secondary mental health services. However, whilst a crisis plan may be developed as a requirement of specific legislation, it may also be a document that has been developed by a person with services that may include health services and/or third sector organisations.

69%   **23%**   **8%**

Over two thirds indicated that they did not have a plan in place (69%), compared to only 23% that did and 8% that were not sure.

29 https://www.mentalhealth.org.uk/
30 https://gov.wales/suicide-and-self-harm-prevention-strategy-2015-2020

Respondents that had a crisis plan

8%
Don't know

23%
Yes

69%
No
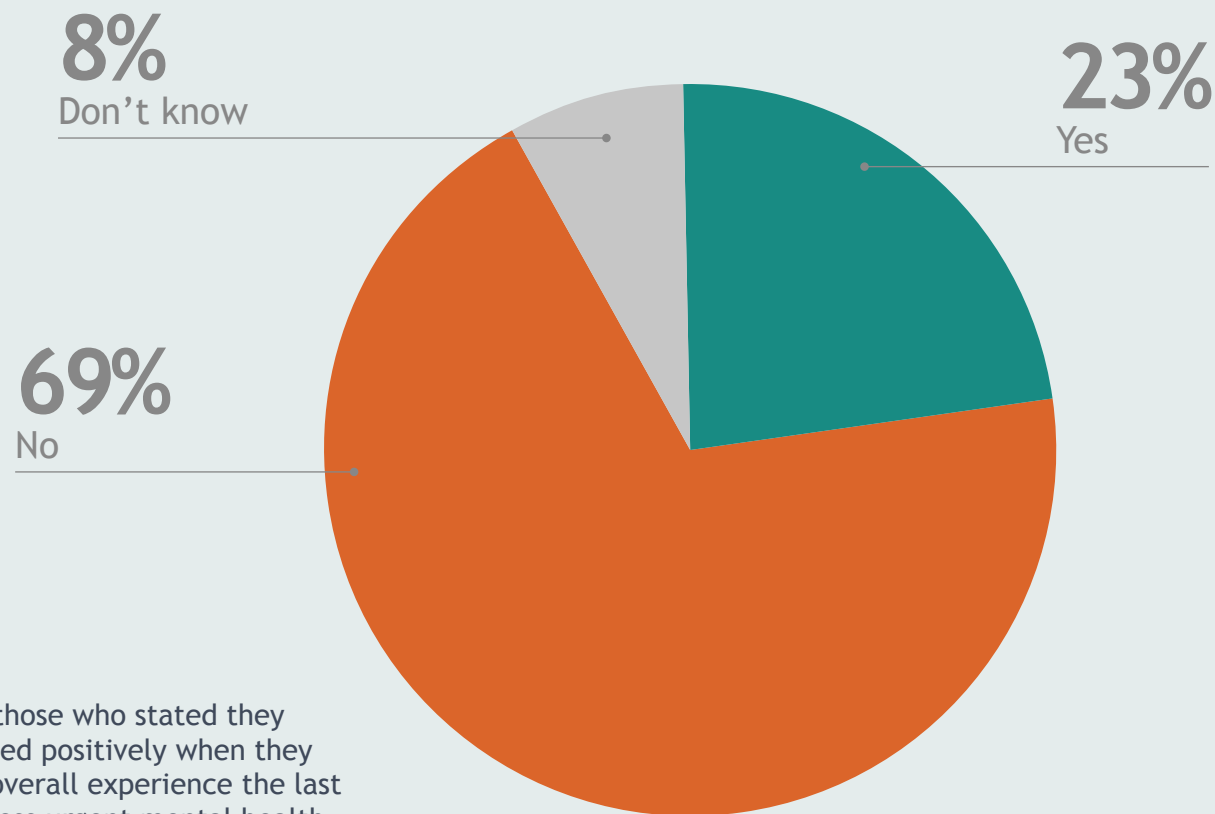
It is of note that 50% of those who stated they had a crisis plan responded positively when they were asked about their overall experience the last time they needed to access urgent mental health support. This compares with 21% of those who didn't have a crisis plan or unaware if they did.

Recommendation 1

Health boards must support people to develop an individual crisis plan to aid them in seeking further support when required.

From where do people access urgent mental health support?

Our review identified that people who attend services within the community for support with their mental health condition, may have a wide range of needs, and in some cases will require urgent support. Support or care can be sought through services, such as GP Surgeries, LPMHSS, local CMHTs and third sector organisations.

In our public survey, we asked people who or what service they would contact when requiring urgent care and support for their mental health needs. The chart highlights the responses:

Service which people contacted when requiring urgent care and support:[*]

Service	Percentage
A walk in service run by volunteers/charity such as twilight sanctuary/café	1%
Social Services	5%
Ambulance	6%
NHS Direct/ NHS 111	8%
Police either 999 or non-emergency 101	9%
A&E Department	11%
Other	13%
A help & listening service	17%
Family	21%
Your community NHS mental health services	33%
GP Practice	45%
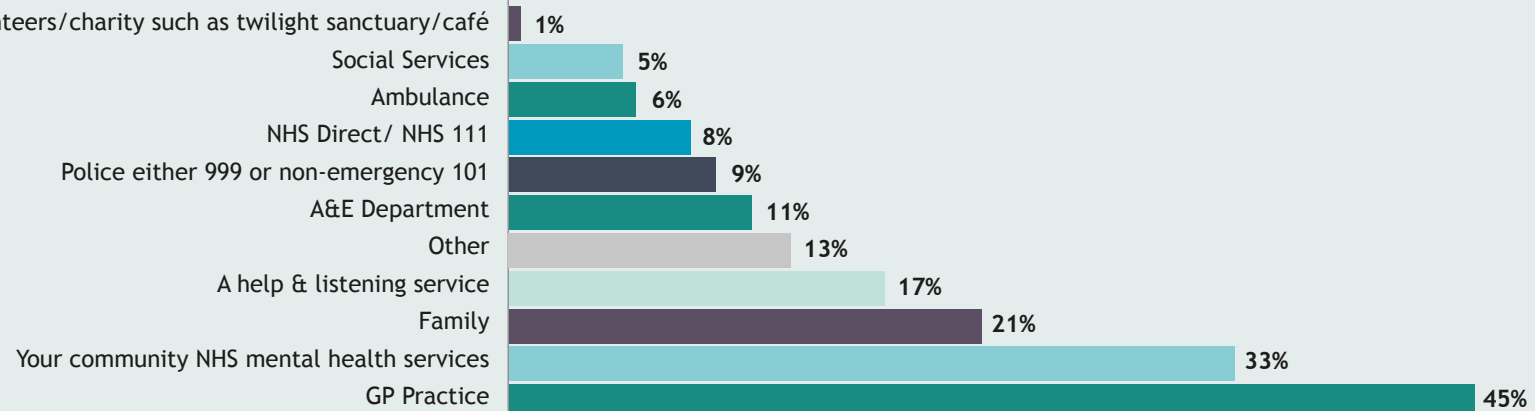
The chart above indicates that 45% of respondents would seek urgent care and support from their GP in the first instance.

In line with the response to the above question, the survey then prompted the respondent to state the reason why they contacted the service that they did.

The responses presented in the chart below highlight the most common five reasons.

*multiple choice

The five most cited reasons given for accessing the GP (in the free text responses):

Reason	Percentage
Part of care plan	5%
Referral	7%
Immediate/Easy support	11%
Confidence in their abilities	28%
Unable/Unaware of other services	49%
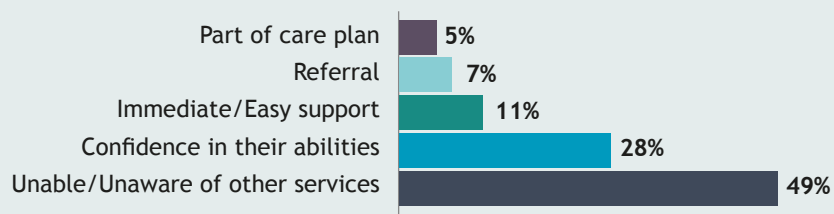
This chart illustrates that whilst 5% accessed their GP as part of their care plan, almost half (49%) were unaware or unable to access support from other services. It suggests that greater public awareness to alternative support to GP services is needed.

Some examples of comments explaining why respondents accessed a GP practice the last time they needed urgent mental health support are displayed below, by the themes highlighted above.

Unable/Unaware of other services:

"Because each one I called sent me somewhere else"

"Because it's the only steps I knew how and it wasn't urgent enough to call 999 or A&E due to Covid."

"No idea who to turn to during Covid"

Confidence in their abilities:

"Because I feel they could help me and understand me"

"Our GP is amazing and helped so much. Also currently seen through CAHMS"

Immediate/Easy support – many people perceived the GP practice as being the quickest and easiest to arrange support available in an urgent situation.

"I needed urgent help"

"Desperate for help"

Referred – relates to those that were referred to the GP practice or who hoped to be referred to another service and identified this service as the way to gain that referral.

"So they could refer but told to go to Emergency Unit"

"I went to see my GP as I wanted to be referred for a mental health assessment"

Part of care plan – many considered this the first step on their care plan.

"Outlined in the plan we have in times of urgent need"

"Was told had to speak to GP first"
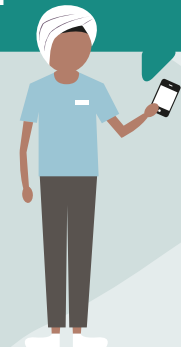
Through our national public and professional surveys we identified a number of views regarding the experience of accessing support from GPs. Overall, the consensus is that GPs endeavour to meet the mental health needs of an individual, albeit with very limited time available during a GP consultation appointment[31]. In such consultations, there is often insufficient time to fully explore the mental health needs of a person.

It was also highlighted that mental health needs are not always the main reason for a person attending a GP consultation. During our interviews, staff reported that patients often request a consultation with a physical or medical concern, and their mental health needs may only become apparent to a GP during their conversation with the patient.

We also found that it is not uncommon for people to attend a GP consultation to seek support for their mental health quite late into their symptoms, and often at a point when they feel no longer able to manage themselves without additional support.

As highlighted earlier, there are also social factors that can contribute to a person's mental ill-health, which cannot be addressed by a GP or other healthcare services, but which impact upon people's mental well-being; these can be varied and numerous, and include personal or family issues with finance, housing, relationship and addiction.

Local Primary Mental Health Support Service (LPMHSS)

Another service that people may use for their mental health needs is the LPMHSS which provides care and support to people with mild to moderate mental health symptoms. Access to LPMHSS is through primary care services, and the service operates either within or alongside GP practices. LPMHSS undertake assessments and offer the provision of structured short-term mental health therapy and support for people in the community, along with information and advice. The provision of LPMHSS services across Wales varies between each health board, where teams are configured differently; some are hosted in GP practices, some in community hubs and others on health board premises.

The referral to assessment times from GPs to LPMHSS are monitored by each health board, and the data is submitted to Welsh Government. This is one of three Mental Health Measures monitored by Welsh Government. Part 1 relates to a referral to assessment target time of 28 days. Part 2 refers to a 28 day target monitored for LPMHSS assessment to the start of a therapeutic intervention, and Part 3 relates to the assessment of former users of secondary mental health services, and measures the percentage of outcome of assessment reports which were sent within 10 working days and over 10 working days, after the Part 3 assessment had taken place.

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[31] The average GP appointment is eight minutes.

LPMHSS National Performance across each health board

Percentage of LPMHSS assessments undertaken within 28 days of referral.

Wales average

Highest (blue) and lowest (green) performing health board per month
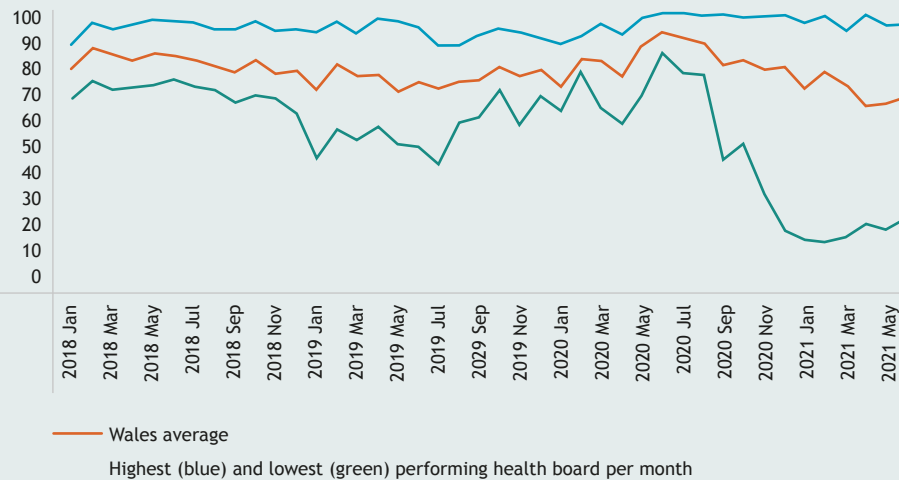
Percentage of therapeutic interventions started within 28 days following a LPMHSS assessment

Wales average

Highest (blue) and lowest (green) performing health board per month
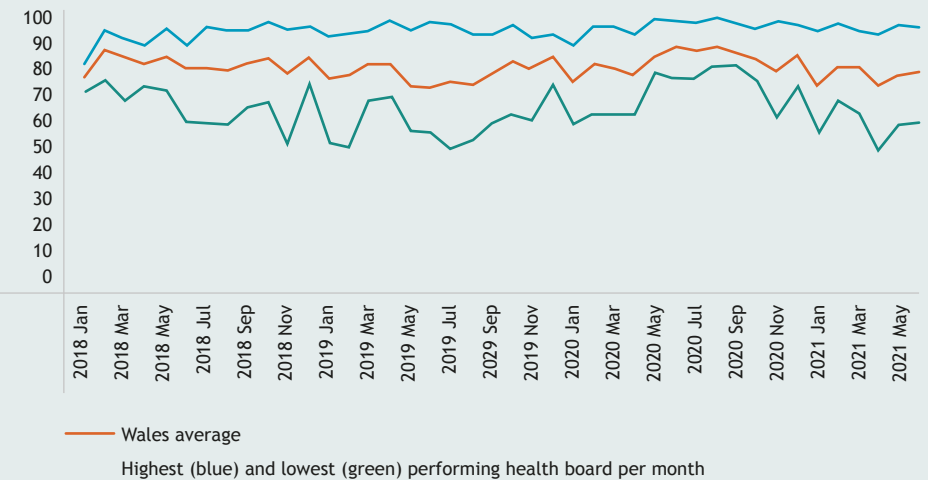
Compliance with these targets fluctuates for each of the health boards depending on demand and capacity of the services. The data demonstrates a significant impact during the COVID-19 pandemic as lockdown requirements were implemented and referrals to LPMHSS reduced significantly during the first wave in spring of 2020. As a result, whilst activity continued in LPMHSS, health boards had to adapt the priorities and workforce to meet the challenges of the pandemic and the effect it had on the availability of the workforce.

That said, even prior to the pandemic there was a large variation of compliance with both the LPMHSS assessment and intervention timescales. With assessments within 28 days typically varying between 60-100% and interventions starting within 28 days typically ranging between 50-100%. This highlights a variation in assessment times and in commencing interventions, and this is dependent on the geographical location across Wales.

Whilst feedback from healthcare staff suggests that referrals to LPMHSS and subsequent interventions were reasonable, we heard some concerns around these timescales from a patient perspective. As highlighted earlier, it is not uncommon for people to attend a GP to seek support for their mental health after struggling for some time, and subsequently may need a referral to other services, such as LPMHSS. The negative comments we heard were related to further waits for LPMHSS assessment and intervention of between four and eight weeks respectively, therefore prolonging a person's waiting time to seek specialist care or support.

Following our review of the national LPMHSS data, we found that on average there are 6,000 referrals each month for assessments across Wales. Of these, around 3,000 assessments are ultimately completed, and of these, 1,700 therapeutic interventions are started. The data therefore highlights that from referral to assessment, the number undertaken is halved, and again almost halved for intervention. Therefore almost three quarter of referrals to LMPHSS do not result in the uptake of interventions, and people are either referred back to the GP for ongoing support or they may disengage from services.

Community Mental Health Teams (CMHT)

Referrals to a CMHT are generally made for people who have been diagnosed with or are suspected of having moderate to severe mental illness or mental disorder, who for complex reasons, severity, or lack of treatment response, will require specialist secondary care with multidisciplinary team input. Unless a person is already engaged with NHS secondary mental health services, referrals must be made by a GP into the CMHT.

Our *Joint Thematic Review of Community Mental Health Teams*[32], published in 2019, identified a lack of clarity amongst healthcare teams regarding the referral criteria into CMHTs, and also a lack of knowledge of the range of other, alternative mental health support referral services available to GPs. This was again highlighted during this review through our staff interviews and our national survey of professionals. One comment included:

> "CMHTs don't provide a service, they will only see people if they are actively suicidal. They have required a GP to provide very specific details regarding patient's suicidal intention."

[32] https://hiw.org.uk/sites/default/files/2019-06/190207joint-thematic-review-community-mental-health-en.pdf

Through discussions undertaken as part of our review, we identified that caseloads in some CMHTs across Wales are very high, and consequently responses to referrals and assessment times vary considerably. This issue was also identified during our Joint Thematic Review of CMHTs, suggesting little progress in improvement. Within that review we found response times varied from same day assessment (within four hours), up to the Welsh Government target of within 28 days. Just over half the respondents to our survey in the joint CMHT thematic review said they waited four weeks or longer to be seen by a CMHT following referral.

Within our public survey, we noted mixed views regarding CMHT services, with comments stating:

Recommendation 2

Health boards must take steps to improve the timeliness of assessment or intervention following referral to mental health statutory service (such as LMPHSS and CMHT) whilst also considering how people are supported in the community whilst awaiting assessment or intervention.

Outside of this review, we have previously received concerns from a small number of people discharged from their CMHT without knowledge of the arrangements in place for any continued needs or prescribed medication. During our interviews with primary care representatives we found similar concerns regarding ongoing prescribed psychiatric medication, and the lack of clarity on how to proceed with these specialist medications post-discharge from CMHTs, which can be unfamiliar to GPs.

"I've had extremely good support overall from my CMHT during the last year, and it's been a massive help."

"CMHT have technically 'ceased' my treatment as I've finished the DBT course so need to be re-referred via the GP. These appointments take months."

Comments from our primary care staff interviews include:

"Patients can get discharged from secondary care on high volume of medication with no follow up. It leaves GPs uncertain on how to manage any changes in the medication in relation to the needs of the individual."

"It is difficult to get medication advice from mental health doctors. With physical conditions then would be able to get advice easily either by phone or email."

In addition, within our public survey we found comments that include:

"The last time I tried to discuss my meds with the CMHT psychiatrist he just wrote back to the GP saying 'no need to see her…she knows what to do'"

"I hate that my CMHT and GP are so separate on prescribing. Any medication change always involves CMHT saying they will contact my GP, me ringing my GP Surgery a week later to ask about my new medication only to have them say they haven't heard anything. So I end up contacting CMHT to chase this up and end up on new medication about 7 days later than needs be."

For patients subject to the Mental Health Measure, specific arrangements need to be in place to support and manage relevant patients of all ages with mental health needs complicated by a physical health problem, sensory impairment or a physical or learning disability. This also includes a requirement to undertake physical health assessment and monitoring. Through our interviews, we found differences across Wales in the provision of ongoing physical health monitoring, and whether this was undertaken by CMHT teams or primary care teams.

Our review has highlighted concerns that there was not always a clear process in place to ensure that physical health assessments and monitoring of patients is undertaken. Some health board representatives we interviewed were unable to provide assurance that arrangements were in place to ensure that these were undertaken. Other professionals we interviewed stated that physical health checks were not being undertaken as required.

Lack of physical health monitoring can have significant consequences to a person's health. For example, some psychiatric medication requires regular monitoring of a patient's physical health, and this may include blood pressure and heart monitoring, along with the need for blood tests for liver or kidney function. It is therefore essential that clear processes are in place to ensure that physical health assessment and monitoring is undertaken.

Recommendation 3

Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.

Throughout our review we found inconsistency in the communication processes and relationships between primary care services and CMHT services. In some areas we heard communications and relations were weak, often resulting in slow advice and slow uptake of referrals. However, in others this was reported as good, and allowed the fostering of good working relationships and a better experience for patients. We found examples where primary care staff who had experience of working in mental health services, had developed good relations between the teams, and in turn aided communication for advice and referrals.

One positive initiative for developing good working relationships amongst different teams was highlighted by Cardiff and Vale University Health Board, where a psychiatrist working within a CMHT allocates time each week to offer advice and support to GPs within their area. This has allowed for the development of a stronger work relationship between teams, in the interest of both patients and staff.

Where health services are cooperative or interlinked with each other, it has been highlighted how this aids the individual by strengthening the provision of services available in the communities across Wales to help prevent people reaching mental health crisis. Health services across Wales must review their own service provision and reflect on how to improve joint working and wrap-around services with other health colleagues and organisations.

Recommendation 4

Health boards and GP services must consider how communication between different teams in primary care can be improved and strengthened, to ensure prompt mental health advice and efficient and timely referral processes.

Recommendation 5

Health boards must consider how arrangements can be strengthened to ensure primary care professionals are able to access timely specialist advice on mental health conditions, appropriate treatments and medication.

Recommendation 6

Health boards need to consider how they can strengthen links between services to improve access and provision for individuals needing support for their mental health and well-being.

Mental Health Crisis Teams

For people who feel that they may have reached a crisis point with their mental health and therefore need urgent support, there are a number of services that may be contacted. In our public survey, 505 respondents were able to report a service that they would contact in an urgent situation. Just under a third (30%) of these respondents listed a community NHS mental health service or their GP Practice (including out of hours services), as who they would contact in an urgent situation. The responses are highlighted in the chart below:

In situations where any healthcare or emergency service feels that referral to a mental health team is very urgent and requires immediate support, they would usually contact the health board Mental Health Crisis Team for advice, guidance or support. We found overall that Crisis Teams respond promptly, and will provide care and support to the person in need, to address the immediate concerns.
Whilst the referral process and prompt treatment from Crisis Teams are positive steps in the process, the ongoing support following the crisis team intervention is perceived by service

users as less positive. For example, following the period of crisis, if a patient is not admitted to hospital and they instead require mental health support within the community, there was not always a structured pathway to facilitate this. This process, instead of admission to hospital, was described by one mental health professional as "a lottery", meaning the level of support they may receive back in the community is inconsistent.

We found that in some circumstances, a patient may be referred from the Crisis Team to a community mental health service, and others may be advised to attend their GP for them to identify what ongoing mental health support the person may need. However, where a person is referred back to the GP, we heard examples where because the GP is not a specialist in mental health that they are not always best placed to assess what ongoing mental health support is required, or what alternative options are available.

Services contacted by respondents when seeking urgent support:*

Service	%
Social services	1%
A walk-in service	1%
Police	2%
Family, friends or carers	2%
Hospital	4%
NHS Direct/ NHS 111	3%
Other	5%
999	11%
A&E Department, Emergency Department (ED) or Minor Injuries Unit (MIU)	14%
A help and listening service	14%
GP Practice	30%
A community NHS mental health service, such as Crisis Resolution & Home Treatment	30%

*multiple choice

When exploring this in our public survey, one person noted:

> "Crisis team are useless, they didn't take any details and said to go to my GP in the morning. When I explained I was under CMHT and gave them my care coordinators name, they said that there was no point contacting them as they were off work."

We also found that in some instances, where a person is referred by a Crisis Team on to a community mental health service, there are often prolonged waiting times to access these services. This subsequently places the pressure back on to the patient and the GP to manage their ongoing mental health concern whilst awaiting support by specialist teams in the community.

Recommendation 7

Health boards and GP services must ensure that there are clear and robust follow up processes in place to ensure timely and appropriate follow up for people who have received crisis intervention, and are not subsequently admitted in to hospital.

Alternative services to the NHS

In addition to the care and support offered by NHS healthcare services, there is a significant opportunity to make greater and more efficient use of the range of other resources available to people through third sector organisations. Services provided by the third sector can help manage and provide timely support for an individual's mental health and well-being, and can be beneficial in supporting someone to prevent further deterioration or exacerbation of their symptoms.

It is essential that people can clearly identify how they can access mental health support to meet their needs, and it is also essential that healthcare services are able to respond promptly with a *No Wrong Door*[33] approach, to ensure that a person gets the right support from the right people at the right time.

There are many third sector services in Wales and across the UK, where people can access support for their mental health, such as Samaritans or Mind Cymru. Our interviews with third sector, healthcare and other staff, highlighted the importance of third sector services, and how such organisations can provide a responsive service for people who require support for their mental health needs, and also provide support to NHS mental health services.

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[33] No Wrong Door approach means that every door in the public support service system should be the right door with a range of services being accessible to everyone from multiple points of entry. This commits all services to respond to the individual's needs through either providing direct services or linkage and case co-ordination, rather than sending a person from one service to another.

Within our national public survey, we asked people who or what service they contacted when they last required urgent support for their mental health, by providing options for the respondent to choose from. Only 95 out of 872 responses said they contacted a third sector organisation. This suggests that people are less likely to seek urgent support from third sector organisation when requiring more urgent support. Instead, the results were that 751 people used their GP, community mental health services, or in more extreme circumstances, emergency services, when seeking urgent or crisis support. Their reason(s) for choosing these services when they needed urgent mental health support, was access to medical professional (64%), a quick response (59%), access to support 24 hours a day (47%).

Some third sector services can provide crisis support for individuals when they are staffed by mental health professionals, however,

understandably going to a third sector organisation may not be appropriate if the individual also required significant medical support, such as following an incident of self-harm. We believe that greater use of third sector services can play a role at an earlier stage of a person's mental health issues, potentially averting any rapid deterioration into a mental health crisis. We will expand on this later in the report.

As highlighted earlier, where services have strong working partnerships better outcomes for the person accessing support have been demonstrated. A key challenge for services, is how they identify whether preventative measures are in place and if they are successful. Taken in isolation, it is difficult to identify whether the support accessed has prevented a person requiring any further support, either short term or long term.

Recommendation 8

Health boards need to consider how they can strengthen the role and involvement of the third sector to improve the range of provision for individuals needing support for their mental health and well-being.

only
95
out of 872 responses said they contacted a third sector organisation

Are people in Wales receiving timely, safe and effective mental health care or support from multi-professional teams?

Challenges in referring to other services

During our review we spoke with professionals from a range of services, including GPs. It was evident that whilst there are a range of options available to support people with their mental health needs, this often required separate referrals and assessments to different mental health teams or services.

We also found that some GPs have less experience than others in managing the mental health needs of people, and therefore may not be able to effectively meet a patient's needs, and may not always possess knowledge of all the services available to refer a patient to.

In addition, even once an appropriate service is identified, the referral processes can vary depending upon the location of the service within Wales which further complicates matters for GPs. This is not a helpful situation and more needs to be done to ensure that GPs are aware of the services available to refer to in their areas, and that referring into those services is efficient and timely.

We identified that the typical options available to GPs in managing people's mental health needs are to prescribe medication to ease symptoms, such as antidepressant or anxiolytic[34] medications, and/or to refer to mental health services if a greater level of support is required, such as a LPMHSS or CMHT, or to therapies, such as psychotherapy or counselling services. However, referrals to services such as these may result in prolonged waits for assessment(s) and any subsequent care or treatment. Our interviews with staff across Wales, and some responses to our public survey, highlighted a level of discontent in relation to the outcome of a GP appointment. There were two prominent themes with this, which included the GP consultation not meeting the patient's expectations for support with their mental health, and if a referral is made to other mental health services then the length of wait for assessment and support from these services was very long.

Understandably it is common for a person to attend a GP appointment with an expectation of the outcome, which may be a prescription for medication and/or referral to mental health services. A GP will seek to identify the most suitable option for the person, and in doing this they should consider the views and expectations of the patient. Whilst the outcome of the GP appointment may not meet the person's original expectations, it is important that GPs explain the reason for their decision.

Recommendation 9

To prevent the requirement for multiple referrals, health boards must ensure that referral processes are clear to all services, and when appropriate, a single point of access to the range of health board mental health services is implemented to support referral and patient options.

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[34] Medication that reduces anxiety.

Gaps in provision and inefficient process

Whilst our review has found some positive developments between primary care and mental health services, some GPs and senior primary care managers we spoke with suggested that when a referral was considered 'not required' by a mental health team (for instance by the LPMHSS or CMHT), this would be referred back to the GP with limited or no information on alternative options for the GP to manage a person in need of further mental health support. This was also a finding in our Joint Thematic Review of Community Mental Health Teams in 2017-18,

suggesting a lack of improvement over the last three to four years.

We also found that in some cases, where referrals are declined with advice that a referral to a different service should be made, the process then requires the GP to make yet another referral to the advised team, rather than an onward referral process. This impacts further on timely access to additional support to services, pointing clearly to gap in provision and inefficient process. This can negatively affect a person's experience and impact significantly upon their mental well-being.

Within our public survey, one comment included:

This differing of professional opinion and referral back to the GP can result in a patient not being assessed by other mental health services in a timely manner, and potentially increases the risk for deterioration in a patient's mental well-being, during which time a GP may feel unable to appropriately support them. This is not acceptable and improvement in this area is required. This interface between GPs and other mental health services requires attention, to ensure that there a clear understanding of acceptance criteria, and a smooth and seamless process of onward referral into alternative options, should it be necessary. Addressing both of these issues would result in a better experience for the individual awaiting care and treatment.

"After experiencing extreme high and low moods along with many other bipolar symptoms for some time I hit extremely low to where I was seriously considering suicide but reached out to my GP who was great and saw me immediately, gave me medication and referred me to my local community mental health team to be assessed. After 6 months waiting I was told they put me back to the bottom of the waiting list as they needed more information from my GP. Another 6 months go by heard nothing so contacted CMHT who said they won't be assessing me but with no reason given as to why, have referred me back to my GP and advised them to what medication to prescribe me; antipsychotics, mood stabilisers and antidepressants! "

The majority (65%) of respondents to our public survey highlighted a poor or very poor experience, with only a quarter stating it had been positive. The comments included:

"I have found the services I have used to be extremely helpful and find my personal surgery very supportive around issues of mental health and a quick, appropriate response has been given."

"Mental health assessment done, no contact since. Was told would make contact within a week, that was months ago, I'm still waiting."

"I've been very lucky to speak to the same doctor regularly throughout my crisis. He has also rung me to follow up, if I haven't rung the surgery. This has made a huge difference, meaning I haven't had to explain my issues to multiple people and he has been able to monitor and assess my progress. This has helped build my confidence. I think this is an important offer to patients, as long as they are not building a dependency on one person."

"Initial contact with my GP has been brilliant, with an excellent level of support and understanding. However, there is an 8 week wait to be able to access counselling support and during this time there is nothing able to be offered, leaving my situation to deteriorate."

Our discussions across Wales identified a number of frustrations held by staff, such as GPs, regarding the delays in the referral process to other services.

We explored this dissatisfaction further with GPs and other healthcare staff during our interviews. We heard mixed views from professionals within primary care of their experience when requesting urgent support from mental health services. We were told by some staff of the difficulties they often encountered when requesting support, with staff often required to contact a number of different mental health teams within their health board, to identify which team would be best placed to support the person in need. In addition, our interviews with primary care staff and responses to our professional staff survey highlighted negative views. This included the perception that when requesting further care and support from mental health teams, that those services were looking for a reason to exclude a person from their service. This was based upon the experiences of specific cases where some mental health services have strict acceptance criteria with no flexibility to meet the current situation, therefore if a person did not quite meet the service criteria they would be excluded.

Our interviews at Cardiff and Vale University Health Board highlighted a positive initiative aimed at preventing issues around assessment criteria, with the implementation of a multidisciplinary Primary Care Liaison Service. We were told that this service provides an invaluable resource to aid the connection between primary care and mental health services. GPs and other primary care professionals can have direct access to the service, including for advice, guidance and support. One member of primary care spoke positively about its introduction, and stated that it has *"been a life saver"*. We believe that initiatives such as this should be considered across other areas of Wales.

Recommendation 10

Health boards should review the community mental health services available in their localities, to ensure that services focus on individualised needs of people to prevent a deterioration in mental health, and to provide timely care and support in all community services when required.

Recommendation 11

Health boards and Welsh Government should consider benchmarking mental health services across Wales to identify good practice and positive initiatives and to share learning.

Emergency Services

In 2019 Welsh Government commissioned the National Collaborative Commissioning Unit (NCCU) to undertake a national review of access to emergency services for those experiencing mental health or welfare concerns. The NCCU review's scope was to achieve greater understanding of the issues leading the public to access emergency services when experiencing mental health and/or welfare concerns.

The review *Beyond the Call* highlighted that emergency services (999 call handlers) across Wales receive, on average, 300 calls a day from individuals requiring mental health support. Separately, research by the Royal College of Psychiatrists[35] also found that two-fifths of patients across the UK, who are waiting for mental health treatment, contact emergency services or crisis services for support, with one-in-nine (11%) ending up in Emergency Departments (EDs). This is also highlighted in our review's public survey, where 13% of respondents contacted emergency services and 14% contacted or attended an ED or Minor Injury Unit. EDs may not be the most suitable place to access mental health support, but can be where individuals present once in a crisis, often not knowing how else accesssupport, or as a consequence of not having had more support before their crisis developed.

Direct referral by emergency services

Emergency service staff from the police and WAST can also be the first point of contact for a person in crisis. We interviewed staff from WAST and each of the four police forces across Wales. Our discussions identified variation across Wales in the arrangements in place for emergency services to assist a person to seek urgent support for their mental health.

We were provided with some positive examples where police and WAST staff in some areas are able to directly contact mental health crisis teams, when there are significant concerns for an individual's mental well-being. This enables emergency service teams to establish whether the person is already known to mental health services, and if so, allows them to discuss the current situation with mental health professionals and help identify the most appropriate actions to take.

We were also informed that emergency services within Aneurin Bevan, and the police within Cwm Taf Morgannwg are able to directly take a person to the local NHS mental health team for support

even if they are not known to these teams rather than into an ED which has historically been the required pathway across Wales. This was highlighted as a positive step in gaining timely assessments, care and/or treatment for people who require appropriate urgent support for their presenting mental health condition.

Our review also found examples where crisis teams in some health boards offer advice to emergency service workers and/or speak to the person in mental health crisis over the phone. This process allows for the crisis services, in some instances, to provide sufficient support to prevent the person being transported to a Crisis Team or hospital at all.

These processes allow for good working relationships between emergency services and mental health teams. Such positive measures can have a favourable impact for a person requiring urgent support, and help healthcare services involved with the person to provide a more timely and smoother passage to the most appropriate service for the individual.

999 call handlers across Wales receive, on average,

300 calls a day

from individuals requiring mental health support.

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[35] Two-fifths of patients waiting for mental health treatment forced to resort to emergency or crisis services (rcpsych.ac.uk)

Unfortunately the good examples set out above were not seen across Wales. In some health board areas, the police cannot directly access mental health crisis teams. Therefore, the police may need to transfer a person to an ED or to an Out Of Hours GP[36] service. This may add an additional burden to an already busy and highly pressured ED and delay the urgent mental health care and support a person may need. This impacts negatively upon the individual in crisis along with EDs and other services and professional engagement required during this process.

We found that an inability to gain direct access to mental health crisis teams is further complicated when a police service covers a number of local health boards. Where this is the case, there may be different processes in place across different boundaries. For instance, South Wales Police aligns with three health boards and it can directly access Cwm Taf Morgannwg University Health Board crisis teams, however, it cannot directly access the teams in Cardiff and Vale or Swansea Bay University Health Boards.

On the occasions when people require transportation to EDs, we found concerns from some healthcare and third sector staff that a person's dignity may be compromised. This is because of the stigma associated with people being transported in marked police vehicles, and also with them being escorted through hospital buildings by uniformed police, particularly within public areas of a hospital.

In many instances, the police will usually remain present with a person (in a public area), until they are assessed by a mental health team. In addition, this can impact upon police resource within the community, when they are required to remain with a patient for many hours until assessment or allocation to a bed (or discharge) has taken place. This may further add to the distress of the person requiring urgent mental health assessment or intervention.

This was also highlighted as an issue in a comment within our national public survey, which included:

"When a person is in crisis, the last thing they need is the police... It is disgusting sending police to a person in mental health distress. This just makes a person be seen by the police and others as though they are criminals."

Whilst the aim of services is to prevent someone reaching a crisis, there will unfortunately be situations where this occurs. We have seen clear examples where health boards and emergency services can co-ordinate to provide an easier passage for the person and the services involved.

Recommendation 12

All health boards should consider how mental health crisis teams can be more accessible to emergency services, to help provide advice and/or timely care and support to people with urgent mental health needs.

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[36] Out of Hours GP services provide urgent primary care when GP surgeries are typically closed.

Skills and knowledge of emergency service staff

Our interviews with emergency service staff also highlighted concerns around their skills and knowledge in assisting people in mental health crisis. Whilst they receive training in how to provide support to people in crisis, they cannot be experts in this area, and do not always have the appropriate or more specialist skills to fully support all people, and manage their risks in the most effective way.

To help mitigate against such situations, police and WAST staff highlighted the positive measures in place with the introduction of experienced mental health professionals available within their call handling teams (when people dial 999). There are different models across Wales, where the post holders can be employed by either a health board, WAST or police forces.

This role allows for appropriate mental health professionals to provide telephone support and advice to people contacting emergency services who are seeking urgent care or support for their mental health. This can have a positive impact for the caller, who can be supported over the phone and/or signposted immediately to the most suitable resource to support them. In such

instances, this could prevent a delay in seeking the help required, reduce the demand for emergency ambulances, or remove the need to transport a person to other mental health services (or EDs), to improve outcomes and experience for the public.

In some health boards mental health call handlers within emergency services have access to some electronic health board and local authority records. This enables them to access the background information of a caller with urgent mental health needs, or in crisis, such as crisis plan or medical history. This can often have positive outcomes in managing people promptly, particularly when they are already known to mental health services.

Whilst this was highlighted to us as a positive measure, there was a consensus nationally that the resources within each organisation are very limited, and are not sufficient for the demand.

Recommendations 13

Health boards, emergency services and primary care services should consider how mental health staff can be incorporated within emergency call handling teams across Wales, to enable early advice and support to people who need urgent care or support for their mental health.

Engaging with third sector organisations more effectively

As highlighted earlier, we believe there are opportunities for NHS healthcare services to better engage with third sector organisations to help ensure timely care and support for people with mental health needs. This could help minimise the incidences of people reaching a crisis with their mental health, by providing early support to some people to manage the symptoms of their mental health condition(s). However, at times, people will require more intensive support, therefore it is important for third sector services to have effective links into specialist mental health services when necessary.

When more specialist support is required, third sector organisations across Wales cannot directly refer individuals into health board mental health teams. During our review, we found examples where registered mental health professionals within third sector organisations have supported people through their service, sometimes for many months, and later identified a deterioration in their mental well-being which requires further support from other specialist health board mental health teams. However, with no direct access to refer in to health board

mental health teams, third sector staff are forced to direct a person to contact their GP to facilitate access to health board mental health services, to attend ED, Out of Hours GP services, or to call 111 (or even emergency services in severe cases of urgent need). This is a cumbersome process that may delay timely access to the right team, and also negatively impact on ED and or emergency services.

Our interviews identified concerns from some staff around the commissioning arrangements between health boards and the third sector. We were told that contracts were often only short term which impacted negatively upon third sector organisations in recruiting and retaining staff for their service because people would prefer to seek employment opportunities affording longer term security.

It is clear that third sector mental health services are an invaluable resource for people seeking help, support or advice when living with mental health illness. Therefore, all health boards should consider how they build on their current third sector partnerships to improve and strengthen arrangements for more effective and productive collaboration. This would benefit both the people using the services and staff working

within mental health care, as well as potentially allowing more timely provision of mental health and well-being support to people, and lessening the likelihood of deterioration into a mental health crisis.

Recommendation 14

Health boards should ensure clear advice and information is available and promoted to people with mental health needs, to help maximise their knowledge about additional support services available within the community including the third sector.

Recommendation 15

Health boards should consider how they can strengthen collaboration with third sector organisations to enable appropriate direct referrals in to NHS mental health services when required.

Management of risk

The process of managing and balancing risk for an individual with mental health needs can be complex. Each person's symptoms can vary significantly and as a result each situation will require a tailored response to manage the risk and meet that person's needs. Our review found that staff who are experienced in managing more risky behaviours are able to draw on their expertise to enable them to manage a situation without fully removing the risk. However, for staff who do not routinely support people with higher risks, a more risk adverse approach is sometimes taken.

During our interviews we were informed of examples where a person's mental health has resulted in risky behaviours, however, staff seeking support from specialist services (such as from primary care to specialised mental health professionals) may receive a slow response, or be informed that the situation did not meet the referral criteria. In these situations, the professional(s) supporting the person may not be those with the greatest expertise in how best to manage the person's risks.

This re-affirms and supports our earlier findings regarding the need to improve referral arrangements between organisations so that the risk is managed by the most appropriate service at the earliest stage.

Are mental health services in the community effective and sustainable?

Developments and initiatives

Single Point of Access

Within the *Beyond the Call* review, it is highlighted that implementing a single point of access can ensure specialist mental health professionals are available to provide clinical triage, onward referral and effective signposting to individuals in crisis, and also provide authoritative advice to primary care staff, the police and ambulance crews.

The review recommended that NHS Wales should facilitate access to specialist mental health professionals through a single point of entry, such as the NHS Wales 111 Service. Additionally, that the service should have robust links to the third sector and self-help support as well as providing referral pathways to primary care, police and emergency medical personnel. In addition, the review recommends that all organisations should engage with the 111 pilots, to ensure that people of all ages with an urgent need have 24/7 access to mental health support, and that clear referral or signpost pathways are available for people where required, such as 'out of hours' social services, welfare support, finance/debt support and domestic abuse support.

We support this approach, and through our review, we discussed the current plans in progress to implement a single point of access service across Wales. The service is currently being piloted in some health boards to address issues with different healthcare teams needing to navigate different contact arrangements for a range of support or referral services. The aim is to simplify the process of contacting the most appropriate support or other service in a timely manner. Once the pilot is complete, the service will be implemented across Wales, which is planned for winter 2021-2022.

The majority of staff we interviewed were positive about this new process. We were provided with positive examples by GPs who had used the service allowing them to contact or refer to the most appropriate mental health team in a timely manner. Overall, feedback from staff was positive, indicating that these arrangement help in identifying the most appropriate referral pathway promptly.

In addition to supporting staff, the single point of access will also be accessible to anybody requiring mental health support, to help guide them promptly to the most appropriate service.

Within our public survey, we asked people what their priority is when seeking help or support.

The top three responses were to have 'a quick response',

'to speak with a medical professional',

or 'to speak with a caring, reassuring person'.

The implementation of a single point of access could provide 'a quick response' from 'a medical professional' with 'access to support 24 hours a day'.

People's priorities when seeking help or support:*

Priority	Percentage
A quick response	58%
A Medical professional	54%
A caring, reassuring person to speak to	47%
Access to face-to-face support	43%
Access to support 24hrs a day	43%
A mental health practioner	37%
Access to a walk-in centre/crisis house	31%
Advice that avoids the need to visit A&E	25%
Support that allows me to self-manage	22%
Access to telephone support	19%
Local knowledge of things that may help	13%
Access to online support	10%
Support in your first language	5%

*Respondents were able to choose up to five options.

Our public survey also asked people who they would contact in an urgent situation. 45% of the respondents indicated that they were not sure of who to contact, with comments including:

> "I don't know who to contact"

> "It would be helpful to know who to contact in a mental health crisis"

Other respondents indicated that they would contact a range of services, including primary care teams, mental health services, third sector organisations, emergency services, or that they would attend an ED.

Whilst we generally received positive views about single point of access, we heard concerns regarding whether the single point of access service has the capacity to meet the demand,

> "I don't know who to contact, despite being suicidal on my last contact with psychiatrist, medication was changed and I was referred back to GP"

> "Wouldn't know who to contact"

and without significant resources it is therefore likely that a large proportion of public calls will still continue to progress to emergency services call handlers.

As highlighted earlier, the third sector cannot refer directly into NHS mental health services. However, the implementation of a single point of access, supported by improved and strengthened joint working arrangements, may help to simplify transition from third sector organisation support, to NHS mental health services, without the requirement for review or referral by a GP or attending EDs. This could be beneficial for both the patient and healthcare services involved. It is too early at present to make a judgment on how effective this service is until it is fully implemented across Wales and is operational to all professionals and public.

Recommendation 16

Health boards should ensure that single point of access services are implemented across Wales and is accessible to all professionals and public to help facilitate prompt support and care for people with mental health needs.

Local Mental Health Practitioners

Another development highlighted to us during our review is the development and implementation of the local Mental Health Practitioner role (albeit with a variation in title across Wales), with the purpose of implementing mental health expertise closer to primary care. The practitioner is typically responsible for carrying out comprehensive mental health assessments with patients in surgeries and community mental health units, and identifying patient needs. The practitioner also works closely with multidisciplinary teams, and can receive referrals directly from GPs, and sometimes self-referral from a person known to mental health services. The role provides short term interventions for individuals with mild to moderate mental health illness, and additionally they work closely with teams within secondary care and other specialist mental health services, as well as third sector organisations and statutory agencies.

Across Wales we found variation in the role and how it has been established into primary care teams. Some health boards have recruited registered mental health practitioners and others mental health support workers. In some health boards, we also found the support available from practitioners was not solely healthcare orientated, and included help and advice on social factors, allowing for a more holistic approach to addressing a person's concerns and social circumstances which may be impacting upon their mental well-being. In utilising this type of approach, the practitioner can utilise their expert knowledge and skills and socially prescribe[36], and/or signpost to other services appropriate to the individual's needs.

The way in which this role was accessed also varied across Wales. In some health boards, people can make a direct appointment with a practitioner, however, others would need a referral through their GP. Direct access into practitioners can be more beneficial for the person, and may ease demand for GP appointments relating to ongoing mental health needs.

In some health boards, the service is co-located within GP practices, whilst in others they are located in other community facilities or services. We noted positive feedback where the service is co-located with a GP, with ease of working relationships between GPs and the mental health practitioners and patients having familiarity and easy access to the service. However, whilst we heard the benefits of the mental health practitioner being co-located with the GP service, this was not always possible or practical due to the physical space or office availability. We found examples where the location of services in some community locations allowed an improved access to that service, since their operating hours were not tied to those of a GP practice.

However, in contrast to this, during some interviews there was a suggestion that patients may perceive themselves as not having equitable services when the appointment is with a practitioner not located within their GP practice. In addition, some staff suggested that the risk of non-attendance at appointments may increase if people have to attend an appointment at a different location after consultation with the GP, due to anxiety about finding and attending an unfamiliar location.

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[37] Social prescribing is a means of enabling health professionals to refer people to a range of local, non-clinical services. The referrals generally, but not exclusively, come from professionals working in primary care settings, for example, GPs or practice nurses. Recognising that people's health and well-being are determined mostly by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health. What is social prescribing? | The King's Fund (kingsfund.org.uk)

A response in our public survey echoed this and stated:

> "Please don't just give a person a leaflet and send them on their way, I felt like I was wasting their time and I was told to attend a well-being course which meant 3 buses there and 3 back when my very being was I can't deal or interact with people. I was crying out for help and all I was worth was two sheets of paper and an address and time for a well-being course, I couldn't think of anything worse."

This highlights the importance of including the person in the decision about what support they can or are able to engage with.

Whilst local mental health practitioners in general are having a positive impact, the practitioners had no authorisation to refer into other heath board mental health services for those people with more complex or severe mental health needs. Therefore, if a person requires additional psychiatric support or intervention above that provided from the local mental health practitioner, a person would be required to have a consultation with a GP for an onward referral to other services. This is again time consuming for a patient and may place them at the beginning of the process for seeking more specialist support or care, which may have a significant or detrimental impact on their mental well-being.

We believe that the mental health practitioner roles are providing beneficial support to individuals within the community, and health boards must consider how to support and embed these roles further and ensure that the role can link directly into a seamless mental health pathway.

Recommendation 17

Health boards must consider how to support and embed mental health practitioner roles further and ensure that they can link directly into a seamless mental health pathway.

Safe Places

During our review we learnt of a number of initiatives being established or piloted in some health boards across Wales to provide an alternative and/or additional range of services for people who require urgent support with their mental health. As highlighted earlier, in some urgent cases of crisis, people may need transportation to EDs or by police to a Section 136 suite in hospital. However, the provision of alternative services in the community, such as a 'crisis house', 'sanctuary', 'safe haven' or 'crisis café', has in some instances minimised the need to attend a hospital in these circumstances.

The aim of these safe places is to provide a calm, safe space in a less clinical setting for adults experiencing mental distress, as an alternative to hospital admission. The safe places would typically provide short term support, usually for a few hours, to enable a person in crisis to talk through their concerns, and if required, to be supported to take appropriate action. Some services can offer overnight accommodation, although numbers are minimal.

Whilst these services are not always open 24/7, the focus is on specific times of the day or days of the week where health board data suggests people are more likely to access their services in times of mental health crisis. Within *'Beyond the Call'*, the authors found that people seek help for their mental health at all times of day.

However, the majority seek help outside of normal office hours, and that different crisis triggers had certain patterns of demand. The review presented evidence that providing dedicated advice and support at these times, and providing support for issues such as relationships, housing, debt, and substance misuse, may avoid the use of emergency response services, and attendances at EDs or at Section 136 detention suites.

Our review noted that safe places may be managed by the NHS, independent organisations such as charities, or both of these together, although in most cases they are commissioned by health boards and operated by third sector organisations. Overall, the safe places were regarded by staff as a positive resource for people with acute mental health needs.

The usual criteria to access these services is that the person is not a risk of harming themselves or others, and that they do not require medical assistance or treatment. Whilst these services would not exclude someone if they had consumed alcohol and/or illicit substances, the person would need to be compliant and have the ability to engage with the service.

The way in which these safe places are accessed varies across Wales. Some provide open access, allowing people to self-present, whereas in others, a person would require a referral by their GP or other service to gain access, or must already be known to the safe place.

Some of the safe places were implemented prior to, or during, early stages of the COVID-19 pandemic, and people could access these face-to-face. However, as a result of increased impact of the pandemic, the operational model had been adjusted in some to offer a more remote access service, through video or telephone calls. However, the intention is for these services to resume face-to-face access when safe to do so.

Overall, our review identified positive feedback regarding the implementation of safe places. However, some concerns were raised about their accessibility, particularly for those living in more rural locations across Wales. We also found that at present, WAST staff are unable to take someone to these safe places, although some safe place premises are looking at how this could happen in the future.

When we interviewed police working in localities that offered safe places, the feedback was again positive. However, not all health board localities allowed for the police to support a person in accessing a safe place, and in those areas the police would be required to access more traditional NHS options to support the person.

Whilst most of these services were being piloted and developed at the time of our review, it was

not possible for those third sector organisations that provide safe places, which may be staffed by mental health professionals, to access direct support from NHS mental health teams. As highlighted earlier, there was no specific pathway for the third sector to directly refer into some mental health teams or a Crisis Team, therefore they would need to follow the same process as a member of the public in order to gain access to further support.

It is important that clear pathways are established to enable people to access safe places, with or without support from other services, rather than a mental health crisis team or an ED. It is equally important that if staff at a safe place identify that a person requires more specialist mental health support, they are able to access this in the most effective manner.

Our review also identified another project which was developed by the South East Wales Shared Lives Scheme in partnership with Aneurin Bevan University Health Board, and is known as the Shared Lives for Mental health Project. The project has been praised by the World Health Organisation (WHO) for its best practice.

The programme operates by matching someone who needs care with an approved carer, so as to support them with their mental health needs.

The carer shares their family and community life with someone who needs support to live independently, and was piloted as an alternative to hospital admission, or to facilitate early discharge from in-patient psychiatric care.

Whilst some programmes across the UK offer daily visits for a few hours, others allow people to stay with a carer overnight and for a longer set period of time. In Aneurin Bevan, the programme offers arrangement for up to two weeks which provide the person with homely support in the community. This is a positive initiative and consideration should be given to replicating this arrangement across Wales.

Recommendation 18

Health boards should consider how adults with urgent mental health needs, and who are experiencing mental distress, can easily access safe places in the community, which can provide a calm and safe space in a less clinical setting as an alternative to hospital admission or contacting emergency services.

Engagement with the male population

Only 16% of those responding to our national public survey identified themselves as male. In 2020, data published by Samaritans[38] regarding suicides in Wales, highlighted that males are almost four times more likely to take their own life compared to females.

During staff interviews across Wales, we discussed the low male response rate to our survey, and whether it may be reflective of engagement with GP or mental health support services. The overwhelming consensus is that male engagement within healthcare and third sector services is consistently lower when seeking support or help for their mental health.

Our review considered the measures undertaken across Wales to engage with males who may be, or are, suffering with mental ill health, to encourage them to engage and seek support from services or talk about their mental health needs. We identified a number of initiatives to help males (and others), to open up and seek help with their mental well-being in more relaxed and informal circumstances. These included healthcare and third sector staff targeting

specific areas, and implementing regular social groups which included sporting activities and craftwork.

For instance we found examples of health board and third sector organisations identifying some work places and offering to target these areas to offer support, such as industrial settings, or places where people may work in more isolated locations, such as agriculture, and being available and visible to people like farmers at agricultural markets. In addition, we noted third sector services, such as the David Cotterill Foundation[39] (based in Wales), which has professional footballers and a life coach and motivational speaker as ambassadors, and aims to promote mental health well-being through football associations and clubs, which is a male dominated sport.

We also found developments in the use of social media and mobile phone apps. There is an ever increasing number of options available to the public to use these resources to help monitor and support their own needs. In Betsi Cadwaladr and Powys health boards, working in conjunction with the third sector, have developed an app for those who can access a smart phone or tablet, which provides links with established online services to provide self-help resources for individuals.

In addition, we found examples where training is provided in workplaces or to members of the public to help people identify mental health distress in other people. Some examples included training people, such as barbers or hair stylists, which may at times be a person that an individual is likely to share issues with around their mental health rather than with someone from a medical or clinical background. Such initiatives highlight the positive measures in place to help support people with their mental health needs, and to help signpost people on how to seek support for their mental health and well-being.

Recommendation 19

Health boards, and Public Health Wales, should consider what additional steps can be taken to raise mental health support awareness in men, to support their mental well-being and signposting to support services.

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[38] Suicide_Stats_Wales_2020_FINAL.pdf (samaritans.org)
[39] https://www.thedavidcotterillfoundation.com/

06 | Conclusion

It is clear from our findings that those working within primary care and community services, emergency services and third sector services across Wales, are committed and dedicated to providing support and care to people with mental health needs. It is also clear that they take great pride in what they do to support people.

For over a decade, Welsh Government policy and guidance has set out clear expectations for health boards and local authorities to improve support for people suffering with mental health problems across Wales; there is a clear will to meet and achieve these expectations across primary and community care services.

However, it is evident that there are continuing issues across Wales in relation to people accessing timely care and support, to prevent a deterioration in mental well-being, and reduce instances of mental health crisis.

Services need to be designed and focussed around the needs of the individual with prevention being the most effective way for services to avert mental health crisis. Whilst avoiding mental health crisis can never be guaranteed, it is clear from our review that there is a need to ensure that more is done at an

earlier stage to ensure that people receive appropriate, and timely care suited to their needs. These needs aren't always directly health related. There is a significant opportunity for the NHS and third sector to work more closely, effectively and efficiently to provide support for individuals, the benefit of which would be to enable people to maximise their well-being.

Our review has highlighted the 'gap' that can exist between primary care and secondary mental health services, with people falling between the criteria of different services that can provide support. Similarly, there is a need to strengthen understanding of alternative services that provide support for individuals to prevent their mental health and well-being from deterioration.

Furthermore, it is clear that there are efficiencies to be gained in ensuring that professionals, the third sector and emergency services, are able to directly refer into the service most appropriate to the individual's needs. The 'hub and spoke' route which currently has to be taken, whereby nearly all paths lead back to the GP for onward referral, needs to be addressed in order to ensure that those in need of timely care and treatment are able to receive it.

Our review identifies several positive initiatives and approaches that are being taken to improve the provision of mental health services, and there is learning for health boards, emergency services and third sector organisations in considering the benefits of these. We also endorse the benefits of introducing a single point of access for the public and professionals attempting to access services.

Whilst it is clear that there are positive experiences for some people when accessing support for their mental health or well-being, we also heard frustration about timeliness and ease of access to services, particularly when a referral is required from one service to another. It is clear that more can be done to ensure that mental health services work together effectively in order to provide the appropriate support to people at the earliest opportunity, and prevent mental health crisis through timely and effective care.

07 | What next

We expect all health boards to carefully consider the findings from this review and our recommendations set out in Appendix A.

We hope that this review will be used to further improve mental health services being provided across Wales, and to help inform further work in this important area of health care.

Our recommendations are also highlighted throughout the report and can be found within Annex A.

Organisations are required to submit an improvement plan in response to the review's recommendations. This is to ensure that the matters raised by our review are being addressed.

The findings throughout our review and highlighted in the report will enable us to consider what further work HIW will undertake.

08 | Annex

Annex A: Recommendations

Recommendations

1	Health boards must support people to develop an individual crisis plan to aid them in seeking further support when required.
2	Health boards must take steps to improve the timeliness of assessment or intervention following referral to mental health statutory service (such as LMPHSS and CMHT) whilst also considering how people are supported in the community whilst awaiting assessment or intervention.
3	Health boards must ensure that clear processes are in place to ensure that physical health assessments and monitoring is undertaken for relevant patients under the Mental Health (Wales) Measure 2010.
4	Health boards and GP services must consider how communication between different teams in primary care can be improved and strengthened, to ensure prompt mental health advice and efficient and timely referral processes.
5	Health boards must consider how arrangements can be strengthened to ensure primary care professionals are able to access timely specialist advice on mental health conditions, appropriate treatments and medication.
6	Health boards need to consider how they can strengthen links between services to improve access and provision for individuals needing support for their mental health and well-being.
7	Health boards and GP services must ensure that there are clear and robust follow up processes in place to ensure timely and appropriate follow up for people who have received crisis intervention, and are not subsequently admitted in to hospital.
8	Health boards need to consider how they can strengthen the role and involvement of the third sector to improve the range of provision for individuals needing support for their mental health and well-being.
9	To prevent the requirement for multiple referrals, health boards must ensure that referral processes are clear to all services, and when appropriate, a single point of access to the range of health board mental health services is implemented to support referral and patient options.
10	Health boards should review the community mental health services available in their localities, to ensure that services focus on individualised needs of people to prevent a deterioration in mental health, and to provide timely care and support in all community services when required.
11	Health boards and Welsh Government should consider benchmarking mental health services across Wales to identify good practice and positive initiatives and to share learning.

Annex A: Recommendations

12	All health boards should consider how mental health crisis teams can be more accessible to emergency services, to help provide advice and/or timely care and support to people with urgent mental health needs.
13	Health boards, emergency services and primary care services should consider how mental health staff can be incorporated within emergency call handling teams across Wales, to enable early advice and support to people who need urgent care or support for their mental health.
14	Health boards should ensure clear advice and information is available and promoted to people with mental health needs, to help maximise their knowledge about additional support services available within the community including the third sector.
15	Health boards should consider how they can strengthen collaboration with third sector organisations to enable appropriate direct referrals in to NHS mental health services when required.
16	Health boards should ensure that single point of access services are implemented across Wales and is accessible to all professionals and public to help facilitate prompt support and care for people with mental health needs.
17	Health boards must consider how to support and embed the mental health practitioner roles further and ensure that they can link directly into a seamless mental health pathway.
18	Health boards should consider how adults with urgent mental health needs, and who are experiencing mental distress, can easily access safe places in the community, which can provide a calm and safe space in a less clinical setting as an alternative to hospital admission or contacting emergency services.
19	Health boards, and Public Health Wales, should consider what additional steps can be taken to raise mental health support awareness in men, to support their mental well-being and signposting to support services.

Annex B – Further context to the review

What do we know about mental health and well-being in Wales?

In the 2015 Welsh Health Survey, 13% of adults (aged 16 and over) living in Wales were found to be currently receiving treatment for a mental health problem[40].

Within its Together for Mental Health Strategy[41], Welsh Government highlights a number of mental health statistics that includes the following:

- 1 in 4 adults experience mental health problems or illness at some point during their lifetime
- 1 in 6 of us will be experiencing symptoms at any one time. At a time of recession when levels of stress and anxiety inevitably rise, more people will be affected and suicide rates are likely to increase
- 2 in 100 people will have a severe mental illness such as schizophrenia or bipolar disorder at any one time
- 1 in 10 children between the ages of 5 and 16 have a mental health problem and many more have behavioural issues. There is evidence this is increasing
- Approximately 50% of people with enduring mental health problems will have symptoms by the time they are 14 and many at a much younger age, demonstrating that mental

illness can affect people across the course of their lives

- Between 1 in 10 and 1 in 15 new mothers experience post-natal depression
- 1 in 16 people over 65, and 1 in 6 over the age of 80, will be affected by dementia. Current estimates are that approximately 43,000 people in Wales are experiencing dementia and this is predicted to increase by over 30% in the next 10 years
- 9 in 10 prisoners have a diagnosable mental health and/or substance misuse problem.

The strategy also highlights that mental illness has a significant impact on life expectancy and is a key cause of health inequalities. The most deprived communities have the poorest mental health and well-being. Many mental health problems can start early in life, often as a result of deprivation, and can include poverty, trauma, loss or abuse. Not only can the impact of mental health illness be distressing to the individuals, but also to their families, friends and carers.

The Welsh Government document *Talk to me 2: Suicide and Self-harm Prevention Strategy for Wales 2015-2020*, highlights that there is a stigma associated with mental health conditions, and this is a cause for concern, and is also an area where improvement is needed.

The stigma around mental illness can cause isolation, and may stop those struggling with their mental health or those in crisis from seeking help, which in turn may result in self-harm or even suicide, consequently preventing those affected by suicide from accessing appropriate services and post-suicide bereavement support.

Who manages NHS mental health services in the communities across Wales?

There are seven local health boards in Wales, and each plan, commission and deliver healthcare services in their localities, including mental health services. These are listed below and highlighted on the map.

Local Health Board Mental Health Services:

- Aneurin Bevan University Health Board
- Betsi Cadwaladr University Health Board
- Cardiff and Vale University Health Board
- Cwm Taf Morgannwg University Health Board
- Hywel Dda University Health Board
- Powys Teaching Health Board
- Swansea Bay University Health Board.

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[40] http://gov.wales/statistics-and-research/welsh-health-survey/?lang=en
[41] https://gov.wales/sites/default/files/publications/2019-03/together-for-mental-health-a-strategy-for-mental-health-and-wellbeing-in-wales.pdf

Annex B – Further context to the review

There are also three NHS Trusts in Wales, each with an all Wales focus, and who also engage with patents who have mental health needs. These are Public Health Wales[42], Welsh Ambulance Services NHS Trust[43] and Velindre NHS Trust[44].

The provision of NHS mental health services in the community can include the following:

- GP practices
- Local Primary Mental Health Support Services
- Community Mental Health Teams (CMHT)
- Social services (such as joint services with CMHTs)
- Clinical Psychologist
- Psychiatrist
- Psychotherapists
- Counsellors
- Occupational Therapists
- Social Workers
- Approved Mental Health Professionals
- Crisis Resolution and Home Treatment Teams
- Early Intervention in Psychosis Teams
- Third sector (when commissioned by the NHS)

Betsi Cadwaladr University Health Board

Powys Teaching Health Board

Hywel Dda University Health Board

Aneurin Bevan University Health Board

Swansea Bay University Health Board

Cardiff and Vale University Health Board

Cwm Taf Morgannwg University Health Board

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[42] https://phw.nhs.wales/
[43] https://www.ambulance.wales.nhs.uk/
[44] https://velindre.nhs.wales/
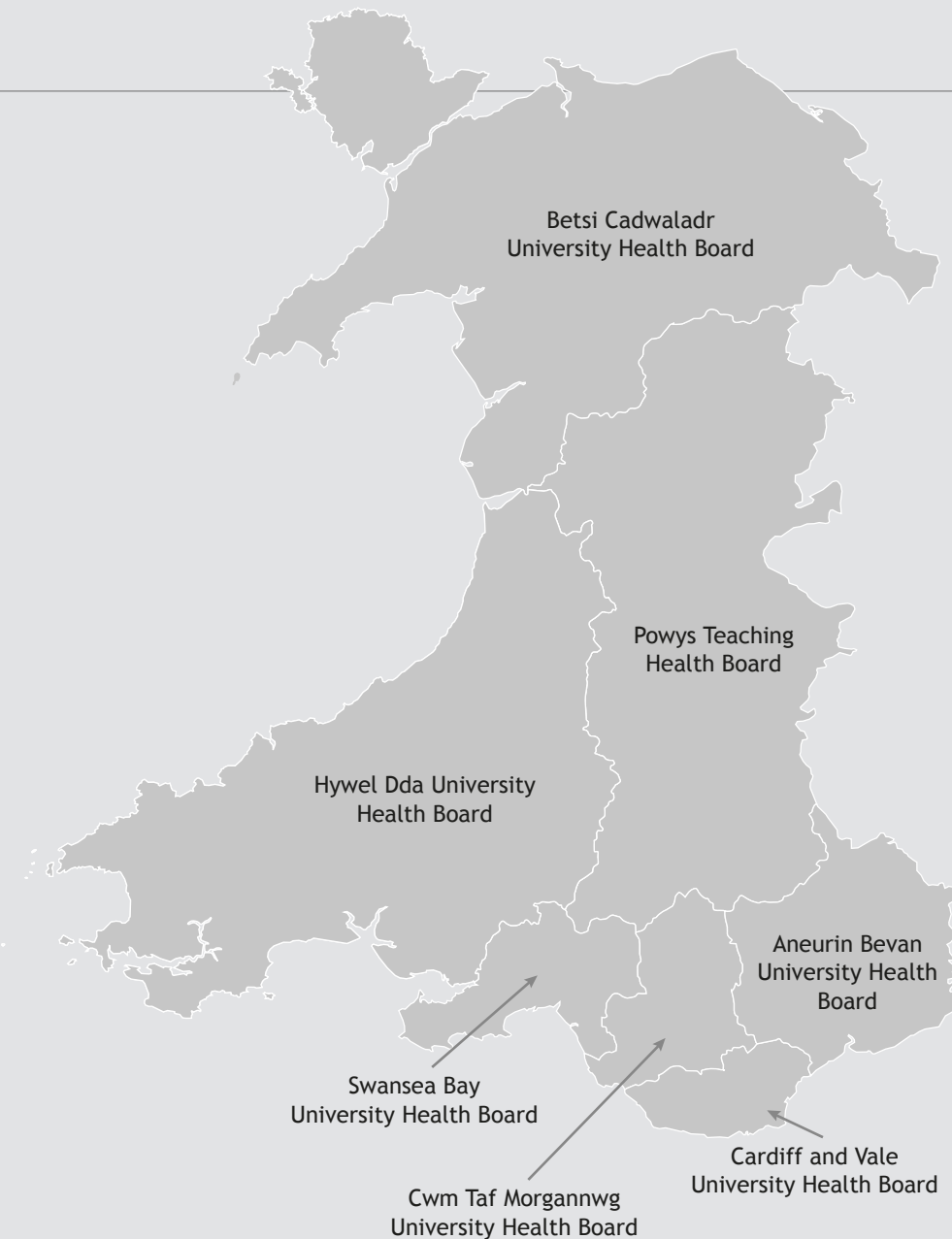
Annex C - Tier 0/1 and Third Sector services supporting people mental health

There are numerous services in Wales where people can access support for their mental health, and these include those listed within the NHS 111 (Wales) helpline leaflet[45], and those listed below.

- NHS 111 Wales[46]
- Hafal[47]
- Samaritans[48]
- CALL (Community Advice and Listening Line)[49]
- Mind Infoline[50]
- SANE[51]
- Meic Cymru[52]
- Childline[53]

There is also a service available for healthcare professionals; Health for Health Professionals (HHP) Wales[54]. HHP Wales offers a free, confidential service that provides NHS staff, students and volunteers in Wales with access to various mental health support. The service offers self-help, guided self-help, peer support, and virtual face-to-face therapies with accredited specialists.

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[45] https://111.wales.nhs.uk/pdfs/Helplines_leaflet.pdf
[46] https://111.wales.nhs.uk/encyclopaedia/m/article/mentalhealthandwellbeing/
[47] https://www.hafal.org/
[48] https://www.samaritans.org/
[49] https://www.callhelpline.org.uk/
[50] https://www.mind.org.uk/
[51] http://www.sane.org.uk/
[52] http://www.meiccymru.org/
[53] http://www.childline.org.uk/
[54] https://hhpwales.nhs.wales/

Annex D: Acknowledgements and Stakeholders

HIW is grateful for the public and staff that completed our national surveys and all those met with us during the national review. Our stakeholder group included representation from:

Care Inspectorate Wales

Community Health Councils Wales

NHS Wales Delivery Unit

NHS National Collaborative Commissioning Unit

Welsh Government

Health Board

Welsh Ambulance Service NHS Trust

Police

Local Authority

Third Sector

Royal College of General Practitioners

Royal College of Psychiatrists

National Coordinator for the Crisis Care Concordat

agic
hiw

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Quality Check Summary
Mesen Fach, Bryn Y Neuadd
27 May 2021

Publication date: 2 July 2021

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Mesen Fach ward, Bryn y Neuadd Hospital as part of its programme of assurance work. The ward is one of three inpatient wards situated in Bryn y Neuadd Hospital. It provides assessment and treatment, and therapeutic support services for up to nine patients with learning disabilities.

HIW's quality checks form part of a new tailored approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks are a snapshot of the standards of care within healthcare services. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to assurance and inspections can be found here.

We spoke to the Ward Manager on 26 May 2021 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How are you ensuring that the environment is safe and suitable for the needs of patients at this time? What changes, if any, have been made as a result of COVID-19 to the following:
    - Physical environment
    - Routines, visiting arrangements and contact with loved ones
    - Behaviour management
    - Patient access to community/leave, activities and social networks (including formal leave where the Mental Health Act applies)?

- How is the risk of infection assessed and managed to keep patients, visitors and staff safe?

- How are you ensuring that there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider health and care professionals where needed?

Considering the impact of COVID-19, how are you discharging your duty of care against the Mental Health Act and DOLS legislation, and how are patients' rights being safeguarded?

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors.

The key documents we reviewed included:

- The most recent environmental risk assessments / audits
- Patient voice data
- Hospital passport / profiles
- Details of incidents; specifically incidents of challenging behaviour, restraint and seclusion

We also questioned the service representatives on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

The ward has single en-suite patient bedrooms and two lounge areas, which we were told supports effective self-isolation and social distancing. Staff added that patients are also able to benefit from access to well-presented and spacious outdoor areas.

We were told that visiting and access to community based activities had been restricted to prevent the transmission of COVID-19. Staff told us that this initially led to a drop in motivation and a slight increase in challenging behaviours. However, it was positive to note that staff had continued to provide a nurse-led therapeutic service in an effort to replicate activities that were usually accessed within the community. This included frequent use of the outdoor space, risk-assessed use of a vehicle and making pizzas to replicate the take-away experience.

Staff told us that ward routines, such as meal times, had remained consistent throughout the pandemic. Staff added that all patients have their own routines and that each patient has an individualised plan based on the activities that they prefer to undertake. Staff added that this plan is created with the input of families wherever possible and that behaviour is monitored to assess how patients are responding to certain activities.

We found that MDT meetings had continued throughout the pandemic on a virtual basis. Staff commented that this had worked well and that there had been positive input from all specialisms. Staff confirmed that MDT meetings would be increased if required and that specialist teams are encouraged to attend weekly ward rounds to support patient needs.

We were told that the patient feedback group had been stopped during the pandemic due to infection control reasons. However, it was positive to note that the ward had used an alternative method to capture the patient voice. We saw an example of a brief questionnaire that is completed weekly by each patient. This asks the patient to write what makes them happy, sad and what things they wish to tell their doctor. Staff confirmed that this feeds into each patient's MDT meeting, which helps to provide individualised care.

We confirmed that all patients had received a physical health check upon admission to the ward. This ensures that the overall health and well-being needs of patients are being met. Staff told us that this service is provided by a local GP practice and that the input from the practice had been very beneficial. It was positive to note that the GP has an active role, attending the ward weekly and MDT meetings as required.

We confirmed that each patient had a hospital passport[1] in place. We saw an example of this and found it to be comprehensive and individualised to the patient. This helps to ensure that the needs of the patients are fully described should they require admission to another ward.

The unit provides assessment and treatment for adults who are admitted with acute needs and, as such, patients can sometimes display challenging behaviours. Staff told us that a positive behaviour support (PBS) model is followed and confirmed that the methods used to manage these behaviours are part of each patient's individual care or PBS plan.

We reviewed restraint data and found that restraint had been used on an infrequent basis. Where restraint had been used, we found that this had been done for minimal durations. We reviewed one incident with the ward manager who was knowledgeable of the incident and provided details of the debriefing and learning that had taken place. We confirmed that relatives and the MDT had been involved throughout.

Staff confirmed that a ligature risk assessment had been recently undertaken and told us that this is reviewed twice each year. Staff added that individual risk assessments are completed for patients who are considered to be at risk of self-harm.

We found that a health and safety risk assessment and self-assessment audit had been completed in response to the pandemic. These had been recently reviewed and contained updated actions. However, we found that there had been a significant length of time between the reporting of some historical maintenance issues and their completion. Whilst the maintenance issues had since been completed, the health board is advised to review and monitor timescales on other wards to assure itself that similar delays are not being experienced at this site.

No areas for improvements were identified.

[1]

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19, and how well it manages and controls the risk of infection to help keep patients, visitors and staff safe.

The key documents we reviewed included:

- Generic infection control policies and Covid-19 specific policies
- Current data on infection rates
- Most recent infection control risk assessments / audits

The following positive evidence was received:

The ward manager described how staff are kept up-to-date with the latest infection prevention and control (IPC) information, which included attendance at a daily safety meeting and through a staff bulletin.

The ward manager confirmed that training in how to correctly apply and remove PPE had been provided to staff and that there were donning and doffing champions on the ward whose role is to encourage good practice. It was positive to note that additional training and support from the IPC team had been provided, which were told had promoted a good awareness of IPC procedures amongst staff.

We were told that PPE usage had been difficult for some patients. However, it was positive to note that clear face masks were being trialled on the ward. It is hoped that this trial will help to promote clear communication between staff and patients.

Staff confirmed that visiting to the ward had been managed on a cautious basis. We were told that all professional visitors are pre-planned and that staff are expected to wear an appropriate uniform and PPE. For family visitors, we were told that a checklist is used to risk assess each visit and that designated spaces are used to maintain social distancing.

We found that IPC considerations had been assessed as part of the health and safety risk assessment and self-assessment audit. This had been supplemented by a recent positively scored audit from the health board IPC team. Staff told us that there had been regular input from the IPC team throughout the pandemic.

We were told that one COVID-19 positive patient had been cared for on the ward. Staff confirmed that this patient was successfully isolated in a designated en-suite room on the ward and that a separate staff team was allocated to provide care. Staff told us that a review by the IPC team had been undertaken and we confirmed that relatives were involved in the care and treatment of this patient.

We confirmed that regular COVID-19 testing of staff was being undertaken and that all staff had received their vaccination. We confirmed that patients who had been on the ward for a period of time had also received their vaccination. Staff described how patients were supported to understand COVID-19 and the need for the vaccine, which included use of stories and picture books.

No areas for improvements were identified.

Governance / Staffing

As part of this standard, HIW questioned the service representatives about how, in the light of the impact of COVID-19, they have adapted their service. We explored whether management arrangements ensure there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider health professionals where needed.

The key documents we reviewed included:
- Escalation policies
- The most recent audit/review of the detention paperwork for patients subject to the Mental Health Act 1983, along with an action plan of how any areas identified will be addressed
- Corporate policies/processes to ensure preparedness for future pandemic emergency
- Mandatory training records for all staff
- The current percentage completion rates for mandatory training
- Risk assessments undertaken in relation to infection prevention and control, environment and staff health and safety
- The number of safeguarding referrals

The following positive evidence was received:

The ward manager demonstrated a clear knowledge of the ward, its patients and they were complimentary about the way in which staff had responded to meeting the needs of patients during the pandemic.

We found that there were agreed staffing levels across the ward and that staff were aware of the procedure to follow should any staffing concerns need to be escalated. The ward manager noted that there was good engagement from senior management when reviewing staffing needs.

We were provided with the mandatory training statistics and found an overall good level of compliance. The ward manager described what plans were in place to source additional training to meet the needs of learning disability staff. It was positive to be told that disciplines, such as speech and language therapy and psychology, were working closely with the directorate to meet this need.

We confirmed that the five patients who were detained under the Mental Health Act had access to virtual tribunal hearings and were able to access advocacy services if required. This helps to ensure that the rights of patients are protected.

The following area for improvement was identified:

The aim of an assessment and treatment service is to provide treatment on a short term basis for patients with a learning disability. We found that there had been four discharges within the last three months and it was positive to hear that staff placed emphasis on ensuring the lasting success of these. We were provided with examples in which ward staff had temporarily moved with new staff teams to help integrate the patient into their new environment. We also heard positive examples of close working with community and complex needs teams to further support the patient.

However, we found that one patient had been admitted to the ward for a significant period of time and another patient who had been admitted in September 2020. Staff explained that there had been previous attempts to discharge the first patient into suitable placement and that the on-going delay is due to the lack of a suitable therapeutic and social provision within the locality.

Whilst we were assured that safe care is being provided, the health board must provide HIW with additional assurance in relation to the discharge planning progress of patients who have been admitted for lengths of stay beyond the purpose of an assessment and treatment unit.

What next?

Where we have identified areas for improvements during our quality check and require the service to tell us about the actions taken to address these, an improvement plan providing details will be provided at the end of this quality check summary.

Where an improvement plan is required, it should:

- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the areas for improvements identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the quality check.

As a result of the findings from this quality check, the service should:

- Ensure that the areas for improvements are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

If no areas for improvement were identified during this quality check, an improvement plan will not be required, and only the quality check summary report will be published on HIW's website.

Improvement plan

Setting: Bryn y Neaudd Hospital

Ward: Mesen Fach

Date of activity: 27 May 2021

The table below includes improvements identified during the Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/	Service Action	Responsible Officer	Timescale
1	The health board must provide HIW with additional assurance in relation to the discharge planning progress of patients who have been admitted for lengths of stay beyond the purpose of an assessment and treatment unit.	Health and Care Standards, 5.1	**Operational A&T Pathway.** On admission, the inpatient team will be working closely with the external community LD teams to identify suitable, person centred placements. Early planning for discharge will form part of the A&T pathway. MDT meetings will be held fortnightly including care coordinator, advocacy and external MDT & family to ensure that	Head of Operations Head of Nursing Community Ops Manager Ward Manager	1 Month

| | | planning for discharge is a continuous process aligned with the A&T pathway.

Monthly clinical commissioning groups have been established. Membership includes Head of Nursing, Clinical operational Managers and Operational lead for CHC. All complex cases are discussed at this forum and provide a platform for escalation and mitigation of any potential barriers for discharge. This forum will be opened up to LA partners to promote collaborative planning for discharge. | | |

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Name: William Haydn Williams – Head of Operations and Service Delivery
Date: 23.06.2021

Ionising Radiation (Medical Exposure) Regulations Inspection (Announced)

Diagnostic Imaging Department, Wrexham Maelor Hospital, Betsi Cadwaladr University Health Board

Inspection date: 19 / 20 October 2021

Publication date: 25 January 2022

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

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Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance: Provide an independent view on the quality of care

Promote improvement: Encourage improvement through reporting and sharing of good practice

Influence policy and standards: Use what we find to influence policy, standards and practice

1. What we did

Healthcare Inspectorate Wales (HIW) completed an announced Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection of the Diagnostic Imaging Department of Wrexham Maelor Hospital within Betsi Cadwaladr University Health Board on 19th and 20th October 2021.

Our team, for the inspection comprised of two HIW Inspectors and a Senior Clinical Diagnostic Officer from the Medical Exposures Group, United Kingdom Health Security Agency, who acted in an advisory capacity.

HIW explored how the service:

- Complied with the Ionising Radiation (Medical Exposure) Regulations 2017

- Met the Health and Care Standards (2015).

Further details about how we conduct Ionising Radiation (Medical Exposure) Regulations inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall, from the evidence we examined, we found that compliance with IR(ME)R 2017 was good. Discussions with staff demonstrated that awareness of responsibilities in line with IR(ME)R was also generally good.

Policies and written procedures required under IR(ME)R 2017 were available and up to date. These helped the department to comply with the requirements of the regulations as they apply to radiology.

Both patients and staff who completed the survey were positive about their experiences whilst in the department.

Discussions with managers and department staff throughout our inspection provided assurance that arrangements were in place to ensure examinations were being undertaken safely.

Some areas for improvement were identified.

This is what we found the service did well:

- Staff treated patients with dignity, respect and kindness

- Feedback from patients indicated that they were highly satisfied with the service provided

- Overall, we found good compliance with the Ionising Radiation (Medical Exposure) Regulations 2017

- The training process for non-medical referrers

- Good working links between Medical Physics Experts (MPEs)[1] and staff working within the department

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[1] An MPE is a person having knowledge, training and experience to act or give advice on matters relating to radiation physics applied to medical exposure in diagnostic radiology, nuclear medicine

- Information provided indicated that appropriate arrangements had been implemented to allow for effective infection prevention and control

- Senior staff were receptive to our inspection and demonstrated a willingness to make improvements as a result

- Mandatory training and IR(ME)R training compliance was good.

This is what we recommend the service could improve:

- Ensure staff consistently check on a patients' pregnancy status prior to exposure to ionising radiation and document the check

- Implementing arrangements to routinely collate patient feedback on the services provided within the department

- Ensure staff appraisals are being carried out, to allow for training and development needs to be identified and monitored

- Eliminate any potential areas of discrimination.

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and radiotherapy, whose competence in this respect is recognised by a competent authority. All employers who carry out medical exposures are required in IR(ME)R to appoint a suitable medical physics expert.

3. What we found

Background of the service

Betsi Cadwaladr University Health Board was established on 1 October 2009 and provides primary, community, mental health and acute hospital services for a population of around 690,000 people, across the six counties of North Wales (Anglesey, Gwynedd, Conwy, Denbighshire, Flintshire, and Wrexham).

The health board has three main hospitals (Ysbyty Gwynedd in Bangor, Ysbyty Glan Clwyd in Bodelwyddan and Wrexham Maelor Hospital), along with a network of community hospitals, health centres, clinics and mental health units.

The department equipment included diagnostic general radiography, mobile X-ray equipment including mobile C-arm[2], general fluoroscopy[3] equipment, dedicated interventional equipment, computed tomography (CT)[4] scanners and dental equipment.

The department employs a number of staff including advanced practice reporting radiographers, radiographers, consultant radiologists, radiology department assistants as well as domestic, administrative and clerical staff. There were also 21 rotational student radiographers in the department who worked under the direct supervision of the radiographers.

The department provided an out-of-hours service staffed by radiographers and was also supported by a third-party provider providing justification and clinical evaluation of out of hours CT scans. There was also back up cover from the health board radiologists, when required.

The department also had advice and support provided by Medical Physics Experts (MPE) employed by the health board.

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[2] A C-arm is an imaging scanner intensifier. The name derives from the C-shaped arm used to connect the X-ray source and X-ray detector to one another. C-arms have radiographic capabilities, they are used primarily for fluoroscopic intraoperative imaging during surgical, orthopedic and emergency care procedures.
[3] Fluoroscopy is a type of medical imaging that shows a continuous X-ray image on a monitor,
[4] A CT scanner is a large, donut-shaped machine with a tunnel in the middle where the scanning takes place. A person lies on a flat table that slides in and out of the tunnel.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective was at the centre of our approach to inspection.

Feedback from patients indicated that they were highly satisfied with the service provided by staff within the radiology department.

We saw that arrangements were in place to promote the privacy and dignity of patients and found that staff treated patients in a kind and respectful manner.

Information provided indicated that overall there were adequate arrangements in place to meet the communication needs of patients attending the department.

The service needs to implement a process to routinely collate patient experience feedback and ensure that subsequent findings and actions are shared with patients and staff.

HIW issued both online and paper surveys to obtain patient views on the Diagnostic Imaging Department at the hospital. In total, we received 28 responses, all online. Not all respondents answered all of the questions. Patients made a number of positive comments about the service, but elected not to have their comments published.

Patients were asked in the questionnaire to rate their overall experience of the service. Over 96 percent of the patients who answered the question rated the service as 'very good' or 'good'.

We also issued an online survey to obtain staff views on the diagnostic imaging department at the hospital. In total, we received 62 responses from staff at the hospital. Again, not all respondents answered all of the questions.

Staying healthy

Senior managers that we spoke with confirmed that all leaflets had been removed and destroyed as a result of COVID-19. We saw one leaflet in the department main waiting area which related to cancer support. However, we did notice a smoking cessation poster displayed next to the main reception desk.

We also saw a number of posters displayed throughout the department advising patients to notify staff if they were, or there was a chance that they could be pregnant. Posters were also displayed throughout the department relating to benefits and risks associated with the radiation dose from the exposure. Additionally, we noted other information on posters, including advice for patients on receiving the results following their procedure.

Dignified care

Patients were greeted by reception staff and the radiographer would collect them from the waiting area, when ready. During our time in the department we observed staff speaking to patients in a polite, sensitive and professional manner. We did not overhear any sensitive conversations taking place within the department during our visit. Almost all of the patients who answered the question said they were able to speak to staff about their examination or procedure without being overheard by other people. Similarly, almost all of the patients said they were listened to by staff during their appointment.

The department's main waiting area had been reorganised to allow for social distancing between waiting patients. The number of seats available within the department appeared appropriate for the number of patients attending, during our visit. The secondary waiting room immediately outside the examination rooms also had chairs arranged to ensure social distancing.

There were changing cubicles available adjacent to treatment areas throughout the department. Each cubicle had a curtain which could be closed to allow patients to change clothing in private, when required. Within the cubicles there was a mirror and posters about the relevant procedure, as well as pregnancy posters. The curtains on each cubicle seen, had a no entry sign stating 'do not disturb' which was visible when the curtains were closed. Almost all of the patients who completed the survey said that they had been treated with dignity and respect by staff. Almost all staff who completed the questionnaire said that patients' privacy and dignity was 'always' or 'usually' maintained.

Patient information

As described above, we saw posters throughout the department, including the main reception, sub-waiting areas and within changing cubicles, making information available to patients about their examination. Bilingual signage and information was seen throughout the department. The vast majority of patients (96 percent) said that:

- They felt involved as much as they wanted to be in any decisions made about their treatment

- They had received clear information to understand the benefits and risks of their examination

- They had been given information on how to care for themselves following their procedure or treatment.

There was an employer's procedure in place that described how the benefits and risks of an exposure to ionising radiation should be communicated to patients. This procedure set out the information that should be given to the patient in a consistent format. Staff told us that information on the benefits and risks of the exposure would be sent out to patients in advance of their examination, in addition to posters being displayed in the department.

However, it could not be confirmed if theatre patients received benefit and risk information prior to the exposure. Evidence of the check must be added to the consent form to allow for compliance with this regulatory requirement.

Improvement needed

The employer must ensure that there is a documented process for informing patients of the benefits and risks of the radiation exposure when undergoing all radiological examination including during theatre procedures. This must include who will deliver the information and how this is recorded.

Communicating effectively

We were informed by staff that there was a hearing loop installed within the main reception area, to assist patients wearing hearing aids, when communicating with staff. Reception staff confirmed that it was turned on as and when required to help patients with hearing impairments, and for those who wear a hearing aid. There was a bilingual sign displayed on the main reception desk advising patients to notify reception staff if they would like to use the hearing loop. Signage throughout the department was bilingual. All the posters displayed relating to pregnancy enquiries, radiology procedures and feedback mechanisms were also bilingual.

Staff informed us that access was available to telephone translation services, should a patient attend the unit who was unable to communicate in English. We were also informed that there were Welsh speaking staff available in the

department, should a patient prefer to communicate in Welsh. However, there was no sign displayed with regards to the 'Active Offer'[5].

> **Improvement needed**
>
> The health board is required to ensure that action is taken to promote the availability of Welsh speaking staff or support within the department to help deliver the 'Active Offer'.

Timely care

We spent some time in the main reception observing the patients and the area. Whilst we did not hear patients being told of waiting times by reception staff on arrival to the department, we did not observe any patients waiting excessively long periods for their examination. Only four percent of patients, who responded to the question on the questionnaire, said they had to wait over 30 minutes. 70 percent of patients said they were not told on arrival how long they would likely to wait before having their examination. However, staff we spoke with said that if there were any delays they would inform the main reception desk. Staff also said that, typically they would not tell patients about normal waiting times but they would communicate any excessive waiting times. We also noted that there were sub-waiting areas for each speciality.

We asked patients in the survey various questions relating to timely care and 93 percent said it was 'very easy' or 'fairly easy' to find their way to the department. Additionally, 89 percent told us it was 'very easy' or 'fairly easy' to get an appointment for their procedure or treatment.

Staff responses to the survey were also positive in this area with 95 percent, who expressed an opinion, saying they were at least 'usually' satisfied with the quality of care they gave to patients. Similarly, 97 percent said patients were 'always' or 'usually' involved in decisions about their care. Additionally, 85 percent of staff said senior managers were committed to patient care.

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[5] An 'Active Offer' simply means providing a service in Welsh without someone having to ask for it. The Welsh language should be as visible as the English language.

Individual Care

Peoples Rights

The department was located off the main corridor of the hospital. There were also corridors linking the department to the accident and emergency unit, to allow easy access to patients, when required. There was level access throughout the department to enable individuals with mobility issues to attend the department. 90 percent of patients said they felt they could access the right healthcare at the right time regardless of any protected characteristics[6]. Two patients said they had faced discrimination when accessing or using this health service. This area is referenced further, later in this report.

All the patients said their preferred language was English, that they were able to communicate with staff in their preferred language and that healthcare information was available in their preferred language.

Listening and learning from feedback

Staff told us that on the occasions where verbal concerns were raised by patients, attempts were made, where possible, to speak with the patient immediately, to try to resolve any issues or concerns quickly and efficiently. We were told that there was a complaints process that should be followed. Where it was not possible to deal with a complaint at a departmental level, we were told that patients were signposted to the health board's patient advisory service, who managed these concerns. There were also posters displayed within the department on the all Wales NHS complaints procedure, known as Putting Things Right (PTR)[7].

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[6] Protected characteristics are specific aspects of a person's identity defined by the Equality Act 2010, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation). The 'protection' relates to protection from discrimination.

[7] 'Putting Things Right' (PTR), is the integrated process for the raising, investigation of and learning from concerns. Concerns are issues identified from patient safety incidents, complaints and, in respect of Welsh NHS bodies, claims about services provided by a Responsible body in Wales.

There were posters displayed throughout the department advertising the 'Gwrando / Listen' health board feedback system. A quick response[8] (QR) code was displayed on the poster for patients to access the online feedback form. However, when the inspection team tried to access the form, it stated that the survey was closed. Adjacent to the department reception desk there were paper 'Gwrando / Listen' feedback forms and a box for individuals to put their completed forms.

Staff we spoke with confirmed that previously the service had a method for allowing patients to provide their feedback on a specific question. Tokens were provided to them and the individual had to put their token into the box linked to their answer. Questions previously included, was a staff member bare below the elbow, were patients happy with their appointment and was the department clean and tidy. Information was displayed on the wall along the main entrance corridor to the department relating to previous feedback received from patients. Staff confirmed that this was done on a monthly basis for a period during 2017/18. The most recent information displayed was from 2018. All the results of the questions were generally positive.

Staff responses in the questionnaire relating to the patient and service user experience within their department were:

- 81 percent said feedback was collected

- 62 percent said they received regular updates on the feedback

- 45 percent said that feedback was used to make informed decisions, although 47 percent answered to say they did not know.

The health board must consider having a standardised approach to collating patient feedback for the department. Findings, analysis and any subsequent action should be fed back to patients and department staff.

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[8] QR Code is a two-dimensional version of the barcode, typically made up of black and white pixel patterns.

Improvement needed

The health board must ensure that:

- There is a system in place to ensure feedback is requested from patients, and staff, on a regular basis

- Results of the feedback are made know to patients and staff

- Staff understand how patient feedback is used to make improvements.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

Overall, we found that compliance with IR(ME)R 2017 was good from the evidence available and discussions undertaken with staff.

Staff awareness of their IR(ME)R 2017 roles and responsibilities was also good. We found arrangements were in place to provide patients visiting the department with safe and effective care.

Information provided indicated that appropriate arrangements had been implemented by the service to allow for effective infection prevention and control within the department.

Policies and written employer's procedures required under IR(ME)R were available. These helped the department to comply with the requirements of the regulations as they applied to radiology.

We identified some areas for improvement including the need to ensure pregnancy checks were carried out appropriately and that these checks were documented.

Compliance with Ionising Radiation (Medical Exposure) Regulations

Prior to our inspection, HIW required senior staff within the department to complete and submit a self-assessment form (SAF). This was to provide HIW with detailed information about the department and the employer's key policies and procedures in respect of IR(ME)R 2017. This document was used to inform the inspection approach.

The SAF was returned to HIW within the agreed timescale and was comprehensive. Where we required additional information or clarification in respect of the responses within the self-assessment, senior staff provided this promptly.

Duties of employer

Patient identification

The employer had an up to date employer's procedure for staff to follow to correctly identify patients prior to their exposure. This aimed to ensure that the correct patient had the correct exposure in accordance with the requirements of the procedure. The procedure set out that staff were expected to confirm the patient's full name, home address and date of birth. This approach was in keeping with current UK guidance[9]. The procedure also described alternative approaches that staff must use, should patients be unable to verbally confirm their identity themselves.

Staff we spoke with were able to describe the correct procedure to identify patients. Also, all patients who completed our questionnaire told us that they were asked to confirm their personal details by staff before starting their examination.

Individuals of childbearing potential (pregnancy enquiries)

During the inspection we found evidence that the pregnancy enquiry was not being carried out in all relevant cases. We checked online records and there were clear gaps in the recording of pregnancy status. For the pregnancy enquiry a yes or no answer was required. If the operator obtained additional information, this would be written on the form but there was not a specific place for this information. However, we did note two instances where the pregnancy check had not been recorded on the relevant paperwork.

Also, the internal IR(ME)R audit highlighted this issue and there was little evidence to show this had being acted upon as the numbers are getting worse since the last audit.

There was an employer's procedure in place in relation to the process for carrying out pregnancy enquiries for individuals of childbearing potential, prior to any exposures. This procedure aimed to ensure that such enquiries were made in a standard and consistent manner. The procedure identified the staff responsible for making the relevant enquiries and set out the process to follow, depending on the individual's response. Whilst the procedure included the age range of patients

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[9] Department of Health and Social Care (2018); Guidance to the Ionising Radiation (Medical Exposure) Regulations 2017.

who should be asked about pregnancy, in accordance with UK guidance, the flow chart included as an appendix did not include the age range.

We also noted that posters were displayed within the department advising individuals to speak with staff if they either pregnant or thought they may be pregnant. This was important to minimise potential harm to an unborn child from the exposure to ionising radiation.

Staff we spoke with were able to describe their responsibilities in regard to the pregnancy enquiries, which were in line with the written employer's procedure described above. We were also informed that pregnancy status would be verbally checked with carers and comforters prior to any exposure. A record of the carers or comforters that were present with the patients during exposures was kept locally in a book. The use of this book should be further extended to include that pregnancy checks were completed on the carer or comforter. Staff we spoke with were able to describe the process used when carers or comforters accompanied a patient receiving treatment. This was in accordance with the employer's procedure for carers and comforters.

Non-medical imaging exposures

The employer had a written procedure in place which set out the criteria for carrying out non-medical imaging exposures[10]. Referrals for non-medical imaging examinations would only be accepted from registered healthcare professionals.

The list of current non-medical imaging performed included suspected inflicted injury (also termed non medical imaging or suspected physical abuse). This is not generally classified as a non-medical imaging under IR(ME)R as there will be a direct health benefit to the individual being exposed. Additionally, included in the list of non-medical imaging were sports performance and physical development. As these are not currently included in the list of non-medical imaging within section 4 table 1 of the employer's procedure, consideration should be given to updating this list to reflect current examination being provided.

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[10] Non-medical imaging exposures include those for health assessment for employment purposes, immigration purposes and insurance purposes. These may also be performed to identify concealed objects within the body.

Referral guidelines

The referral guidelines used by the employer were the Royal College of Radiologist (RCR) iRefer[11] publication, which set out the referral criteria and also provide an indication of the radiation dose. Information provided indicated that referrals are accepted from entitled referrers, who have been registered on the system on condition that it is in accordance with the set guidance for referral.

The information required included the relevant patient details, the referrer identity and signature, the examination required and sufficient medical data to allow the practitioner to justify the exposure.

The SAF also described how diagnostic imaging and interventional radiology referrals were made to this department. Referrals were made using a standard paper template which is sent to the department either with the patient, in the post, or the referrer may bring the request directly to the department. Some primary care practices send the paper form scanned via e-mail to a standard address box.

Referral forms in theatres were completed by the operating surgeon. The radiographer is responsible for justifying referrals in theatres.

A project had just been commenced to introduce electronic requesting into the department.

Incomplete request forms are returned to the referrer with a proforma identifying the reason for the return. A radiation physics audit report identified issues with the process of incomplete referrals and how patients could miss out on an appointment, when forms were returned to the referrer. Management representatives we spoke with during the inspection were confident that the current process in place, would ensure that this would not occur.

The SAF stated that non-medically qualified referrers had to complete a training programme and formally request entitlement. This is reviewed via a radiology panel who provide formal entitlement, if the application was accepted. The non-medical referrer would then be added to the non-medical referrer register. In view

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[11] iRefer is widely accepted as a major tool to promote evidence-based imaging. iRefer evaluates clinical evidence from diverse sources and uses a network of clinical experts to validate information. It reflects current best practice.

of this evidence of good practice, the health board should consider extending this training to medical referrers where areas of non-compliance are identified.

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Improvement needed

The employer must ensure that the:

- Pregnancy checks are carried out for every individual of childbearing potential where relevant and the record of this check is documented

- Age range of patients who should be asked about pregnancy is included in the flowchart as described in the relevant employer's procedure

- Non-medical imaging employer's procedure is update to in line with current examinations being provided

- Record of pregnancy checks carried out on carers and comforters is recorded in the relevant book in the examination rooms.

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Duties of practitioner, operator and referrer

The employer had a system in place to identify the different roles and responsibilities of the professionals involved in referring and performing radiology examinations. The employer's procedure on how IR(ME)R 2017 was implemented within the department identified, by staff group, who were entitled to be referrers[12], practitioners[13] and operators[14] (known as duty holders).

Staff we spoke with had a clear understanding of their relevant duty holder roles and scope of entitlement under IR(ME)R. Staff confirmed that they were able to

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[12] Under IR(ME)R a referrer is a registered healthcare professional who is entitled, in accordance with the employer's procedures, to refer individuals for medical exposures.

[13] Under IR(ME)R a practitioner is registered healthcare professional who is entitled, in accordance with the employer's procedures, to take responsibility for an individual medical exposure. The primary role of the practitioner is to justify medical exposures.

[14] Under IR(ME)R an operator is any person who is entitled, in accordance with the employer's procedures, to carry out the practical aspects of a medical exposure.

access up to date electronic versions of policies and procedures via the health board online shared drive.

Training records were provided for a range of staff grades and groups. The evidence provided of the training matrix that held records for entitlement and scope of practice was seen and no issues were noted. The equipment training for radiologists consisted of refresher training dated September 2021. The induction and training records checked did not have all the relevant columns completed including trainer initials. Additionally, not all training records included signatures and dates to show that the competency had been completed.

> Improvement needed
>
> The employer must ensure that all induction and training records are completed in full, with signatures and dates to show the training has been completed.

Justification of Individual Medical Exposures

Staff we spoke with had a clear understanding of the justification process. Justification of individual medical exposures was recorded on the radiology referral forms, with the date and signature of the practitioner.

Out of hours provision was supplied by Everlight Radiology and we were satisfied the process was compliant.

The process for authorisation was described in the SAF. The practitioner has delegated the task of authorisation to the IR(ME)R operator, through the use of authorisation guidelines. The guidelines detailed the authorisation criteria for each examination listed. However, it was not clear from the authorisation guidelines provided, who the named practitioner was. Additionally, for the trauma CT authorisation guidelines it was not clear who the practitioner was that took responsibility for referrals authorised under these guidelines. We were told that the clinical director would be the practitioner. This needs to be added to the authorisation guidelines to ensure the operators authorising to them know who the individual practitioner is, that they are working under.

We were provided with results of an IR(ME)R audit, on a retrospective review of referral forms for justification of examinations dated March 2021. This was one of the five rolling audits to ensure compliance with IR(ME)R. The sample was individually checked to see if the justification box had been signed by the radiographer or radiologists. If it was found to be missing from the referral form RadIS2 was also checked. The audit results showed almost 100 percent compliance. We checked a sample of referrals and noted that the relevant clinical information was seen to justify the referral. There was also evidence of

authorisation, from an appropriately entitled practitioner, confirming the justification process had taken place.

> **Improvement needed**
>
> The employer must ensure that the authorisation guidelines have an identifiable practitioner named.

Optimisation

Optimisation is the process of keeping exposures as low as reasonably practicable (ALARP) while achieving the best image quality to answer the clinical question. The employer had arrangements in place for the optimisation of exposures. The SAF stated that practitioners and operators ensured doses were ALARP[15] via a number of factors. Staff we spoke with were able to describe the process that they used to ensure the doses were optimised.

Diagnostic reference levels (DRLs)[16]

There was an employer's procedure in place for determining, implementing and reviewing diagnostic reference levels (DRLs). We were told this was under revision at the time of the inspection. During our tour of the department, we noted that local and national DRLs were clearly displayed in each area visited. The local DRLs were all equal to, or less than, the national DRLs. The department should consider setting local DRLs for paediatrics, when there is sufficient data available.

The SAF showed that the task of DRL review was included in the terms of reference for the relevant Radiology Image Optimisation Team (RIOT). It was described that a review of DRLs would take place annually at the first quarter RIOT meeting. This check would include a review of the preceding years' median doses, including how this data was trending. Additionally, we were told that as

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[15] ALARP ("as low as reasonably practicable), is a principle in the regulation and management of safety-critical and safety-involved systems. The principle is that the residual risk shall be reduced as far as reasonably practicable.

[16] DRLs are a level used in medical imaging to indicate whether, in routine conditions, the dose to the patient or the amount of radiopharmaceuticals administered in a specified radiological procedure for medical imaging is unusually high or unusually low for that procedure.

part of the computed tomography (CT) RIOT, the research radiographer looked at doses across the three main sites in the health board. It was stated that this achieved a significant dose reduction in some CT examinations. This showed evidence of collaborative working across the health board assisted by RIOTs, and providing an area of facilitating shared learning. It was also positive to note that there was an intention for a RIOT in the future for interventional radiology.

Paediatrics

The SAF provided stated that staff would deploy a variety of techniques to prevent movement of children during X-ray examinations to reduce the need for repeat exposures. These included feed and wrap[17] and various distraction techniques. The SAF further referred to the CT scanner having specific programmes for imaging children that optimised the dose. In addition, for general X-ray and fluoroscopy, the equipment had anatomical programme setting optimised for the imaging of children based on age ranges.

We were also told that a post for a paediatric lead radiographer has been introduced in the general X-ray department to support the imaging of paediatrics, to ensure exposures were optimised. Additionally, a research radiographer had completed and published research on the optimisation of neonatal incubator X-ray imaging. This work was being used to standardise techniques and protocols. It had also been used to support the purchase of incubators that facilitated dose optimisation.

Clinical evaluation

There was a procedure in place which described the process regarding clinical evaluation. The purpose of this procedure was to ensure that each medical exposure was clinically evaluated and that evaluation was documented. It further stated that the evaluation of the outcome of a medical exposure was communicated to the referrer or other relevant staff, in a timely manner. This was to facilitate appropriate clinical management of the patient.

The SAF stated that radiology provided a formal report in RadIS2 for examinations performed by the service. Regular checks were made to ensure all

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[17] 'Feed and wrap' is a technique used with young babies instead of sedation or general anaesthesia. Generally babies tend to fall asleep after a feed, babies are then scanned while asleep.

examinations had a report. Performance monitoring took place to measure the report turnaround times in accordance with the guidance from the medical imaging sub-committee (MISC). A monthly check was also carried out to monitor the backlog against the MISC guidance. This monitoring was reported to the radiology senior team and the secondary care clinical effectiveness group.

We spoke with senior managers about how the employer satisfied themselves that all operators making clinical evaluation were entitled, competent and trained to do so. We were told that training and competency were checked prior to the entitlement to clinically evaluate the exposure. A letter would be issued to each operator to show this entitlement and scope of practice.

Equipment: general duties of the employer

The employer had an up-to-date inventory (list) of the equipment used within the radiology department. The inventory contained the information required under (IR(ME)2017).

Safe care

Almost all the staff who expressed an opinion, said their organisation had the right information to monitor the quality of care across all clinical interventions and took swift action when there were shortcomings, at least on some occasions. The vast majority of staff said that they were content with the efforts of their organisation to keep them and patients safe, again at least 'sometimes'. From the staff who expressed an opinion, the survey also showed that:

- 90 percent agreed that care of patients and service users was the organisation's top priority

- 96 percent agreed that the organisation acted on concerns raised by patients and service users

- 82 percent agreed they would recommend their organisation as a place to work

- 81 percent agreed they would be happy with the standard of care provided by their organisation for them or for their friends or family.

Managing risk and promoting health and safety

There was signage throughout the department, on the floor and the walls, to direct patients from the main waiting area to the separate sub waiting areas for the relevant examinations. Whilst there were some trolleys and wheelchairs lined up in the corridors, there was still sufficient space in these areas. We saw patients and beds being transported past these areas without any issues.

Arrangements were in place to promote the safety of staff, patients and visitors. For example, appropriate signage and restricted access arrangements were in place to deter and prevent unauthorised persons entering areas where radiology equipment was being used.

The majority of staff who completed the questionnaire said that if they were concerned about unsafe clinical practice, they would know how to report it. The majority also said they would feel secure raising concerns about unsafe clinical practice. Whilst only 51 percent felt confident their organisation would address their concerns once reported, 33 percent answered that they did not know.

Infection prevention and control

The department appeared clean and in a good state of repair. There were hand washing facilities noted in the patient toilets and staff areas within the department. Additionally, hand sanitiser gel was available throughout the department. Face masks and hand sanitising gel were available at the reception desk. 96 percent of patients who answered the questionnaire said that the setting was 'very clean' or 'fairly clean'.

The stock of personal protective equipment (PPE) was observed in staff areas adjacent to examination rooms. Staff we spoke with, also confirmed that should further PPE be required it could be accessed within the department. Staff stated that they were confident and competent at using PPE and there was sufficient supplies of this equipment. Staff had also been fit tested to use the FFP3[18] mask.

There were signs displayed at the entrance to the department stating that patients only were permitted beyond that point, to keep to the left within the department and to report to reception and to sanitise their hands. Signage was displayed within the department to remind individuals to keep left and to ensure social distancing.

We observed patients arriving with relatives or partners, but only the patients were allowed to go from the reception to the sub-waiting areas and treatment rooms. Staff confirmed that only in certain circumstances were patients allowed to be accompanied, for example children with a parent or carers of patients.

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[18] FFP3 masks provide the highest level of respiratory protection that a disposable mask can offer. A well-fitting FFP3 mask can protect users against fine toxic particulates including asbestos, bacteria, viruses and radioactive particles.

Information provided by staff indicated that there were arrangements in place for effective infection prevention and decontamination within the department. We were informed that these arrangements had been strengthened as a result of COVID-19.

We asked patients a question about COVID-19 compliant procedures being evident during patient visits. 93 percent said these were 'very evident' during their time at the setting. We also asked staff a series of questions about COVID-19 compliance. All staff agreed their organisation had implemented the necessary environmental changes and all agreed their organisation had implemented the necessary practice changes. 92 percent said that there had been a sufficient supply of PPE and 93 percent of staff said that infection prevention and control procedures were 'always' or 'usually' followed. However, all staff agreed there were decontamination arrangements for equipment and relevant areas. Staff comments included:

> *"PPE was an issue initially"*

> *"Short on certain PPE and masks meaning some staff were unable to work in certain areas. They were very slow to address this"*

> *"There have been shortages nationally and we were short of PPE then, but since I have not noticed a shortage."*

Staff we spoke with were able to described the cleaning methods used after all patients, whether COVID-19 was suspected or not. We were told that there had been various videos available to staff in relation to donning and doffing[19] PPE, as well as fit testing for the FFP3 mask. We were also told that staff had received training in the use of a portacount[20] mask as well as being trained on the masks used in the intensive therapy unit (ITU).

Safeguarding children and adults at risk

Discussions with staff within the department demonstrated that there was an awareness of current safeguarding procedures in place. We were also informed

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[19] Donning – putting on personal protective equipment (PPE); Doffing – taking off personal protective equipment (PPE)

[20] The Portacount is an ambient particle counting device which is used to conduct fit testing by providing a quantitative assessment of faceseal leakage.

that staff had completed online training to help them keep up to date with relevant safeguarding issues. We were informed that safeguarding guidance and support was also available on the health board intranet page.There was over 88 percent staff compliance, based on information supplied, with this mandatory training.

Effective care

Quality improvement, research and innovation

Clinical audit

We were provided with a copy of the clinical audits for the year. The SAF stated that each quarter a joint audit meeting was held sharing information across the whole service. These meetings were recorded so that staff unable to attend, could view the meeting notes at another time. The local radiology quality, safety and patient experience groups were informed of the results and as appropriate the results were reported to the senior team meeting.

We were told of the joint clinical audit with involvement from the clinical team, radiographers and MPEs looking at the imaging of facial bones referrals from the emergency department. The audit findings resulted in a change in practice for mid face imaging.

The department performed annual audits on IR(ME)R compliance in areas including pregnancy status checks, recording doses, patient identification, and justification of exposure. The results of the annual audits were presented to staff on site and also highlighted in staff huddles to provide learning points.

Expert advice

The SAF completed showed that the MPEs and Radiation Protection Advisors[21] played a full role in the department. They were involved in high dose interventional and high dose CT services. Also, they were members of a number of committees and groups that were part of the governance of the department. These included membership of the health board area Radiation Protection

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[21] RPA are competent to advise employers on the safe and compliant use of Ionising Radiations. The post is a legally recognised position and is a requirement of IR(ME)R 2017.

Committee (RPC)[22] and the health board overarching RPC. They were also core-standing members and actively involved in the various RIOTs. In addition, they contributed on an all Wales basis as members of the All Wales Quality Forum[23] and the All Wales Radiation Protection Specialist Standing Group (RPSSAG)[24].

We were told that the MPEs and quality assurance (QA) radiographers were in the process of drafting a health board policy for QA, which they hoped would become an all Wales policy. The quality assurance programme was established for each piece of equipment, developed with advice from the manufacturer and the MPE. The QA programme specified the frequency and method of testing as well as the remedial and suspension levels for tests performed by radiographers. They also acted on professional guidance and advised on the implications for regulation compliance across the health board, both locally to departments and via the RPC. The links between the MPEs and the department were described by staff as excellent.

We were also provided with the radiation protection audit report for CT for the health board (including Wrexham Maelor). We were told that where areas had been highlighted for improvement or training needed in certain groups, the department had taken the opportunity to look at these areas and provided additional training.

Medical research

The SAF provided showed that there was an employer's procedure in place with regard to research involving ionising and non-ionising radiation. There was also a policy in place relating to research involving ionising and non-ionising radiation. Additionally, the department employed research radiographers and a QA radiographer.

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[22] The RPC has members from Radiology, Radiotherapy, RPA/MPE and other radiation users. These members provide advice and guidance to the employer in relation to any guidance that has been issued from regulators or professional bodies. It is chaired by the Executive Director of Therapies and Health Science who holds the delegated responsibility for the regulations

[23] A sub-committee of the National Imaging Programme Board that works to set standards across the whole of Wales. During

[24] The Radiation Protection Specialist Standing Advisory Group (RPSSAG) is working with other Welsh Scientific Advisory Committee groups to develop 'once for Wales' guidance related to 'carers and comforters' and 'risk benefits information for patients'

The SAF indicated that the research radiographer received all requests for research trials. Referrals are reviewed, and for nuclear medicine all licencing requirements are checked, prior to approval being given. These checks would be done in accordance with the procedure and included discussions with the practitioners and MPEs.

Once a trial is agreed, the research radiographer created a set of documentation for that particular trial that included the imaging protocol, dose constraints and number of expected patients to be recruited. The research nurse informs the research radiographer when patients were recruited and the patient's RadIS2 record would be amended to reflect the trial they were on. For trials where the radiology department held the principal investigator role, the research radiographers would recruit to the trial.

Information governance and communications technology

Information management systems within the department were described and demonstrated by staff. The systems in place allowed for relevant patient details and information about diagnostic and interventional procedures performed, to be recorded and easily accessed by staff.

Record keeping

We reviewed a sample of patient referral records. The majority of records reviewed had been completed with appropriate details by those staff involved in the exposure. The forms were clear and completed to a good standard with relevant clinical information seen to justify the referral. All forms had three points of identification[25] and the referral had been signed and the name of the signer was clear in all cases. The dose was recorded along with the initials of the operator and practitioner and the practitioner in CT also wrote the specific protocol to be used.

We also noted that there was a regular annual audit on the Last Menstrual Period (LMP)[26]. The audit was conducted to ensure that all radiographers were correctly checking the pregnancy status of all patients of child bearing age (12-55). The

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[25] Name, date of birth and address

[26] LMP refers to the first day of your last menstrual period. Health care providers measure pregnancies in weeks starting from the first day of the LMP.

audit in 2021 showed that 32 percent of patients selected in the sample had not been correctly identified or documented.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards

We found there was a robust management structure with clear lines of reporting in place. There were effective governance arrangements in place to support ongoing regulatory compliance.

Staff demonstrated they had the correct knowledge and skills to undertake their respective roles within the department.

Senior staff confirmed that there were staffing issues. However this was being actively managed by the health board to minimise the impact on the delivery of services.

Some issues were identified that needed to be addressed by the employer.

Over the course of our inspection, senior management staff made themselves available and facilitated the inspection process. They were receptive to our feedback and demonstrated a willingness to make improvements as a result of the issues highlighted.

As previously detailed, as part of our inspection a staff survey was made available to provide all staff working within the department with the opportunity to provide their views. Additionally, discussions were held with senior managers of the service, as well as a selection of staff working within the department. The three members of the department staff we spoke with, spoke clearly and well.

Governance, leadership and accountability

We spoke with three members of staff and three senior managers about items relating to health and care standards.

Senior management we spoke with stated that the department was a pilot site for Wales in the Quality Standards in Imaging[27]. The department was working towards accreditation, there were four tiers to complete before the site could apply for accreditation. The department were currently at tier three and they hoped to be fully accredited within the next 18-24 months.

We were told that the radiology services manager met the heads of service every week. There were regular modality lead meetings held with each area to provide updates on status and challenges. Each site lead had their own arrangements for sharing information within each site. A COVID-19 meeting was held every fortnight for the heads of modalities to share the latest guidance and to make staff aware of the issues.

At the department there were heads of department meetings once a week which included the principle leads from each area. These meetings allowed staff to provide feedback to the head of the department as well as providing updates. Senior management confirmed that radiology briefings were circulated to all staff via emails at least once a week, but usually around two or three times a week. Face to face meetings had not restarted due to COVID-19 and the department were relying on sending out messages by email.

The management structure in place, had clear lines of reporting, which was described by senior staff and demonstrated through an organisational chart. We found that governance arrangements were in place to support the effective operation of the department.

We asked some questions relating to senior managers as part of the staff questionnaire. The vast majority of staff who responded said they knew who senior managers were and said that communication between senior management and staff was at least 'sometimes' effective. The majority of staff said senior managers at least 'sometimes' tried to involve staff in important decisions.

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[27] The quality standard for imaging (QSI) has been developed by The Royal College of Radiologists and the College of Radiographers to set out the criteria that defines a quality imaging service. UKAS accreditation of imaging services is a patient-focused assessment that is designed to give stakeholders, service users, patients and their carers, confidence in their diagnosis and all aspects of their care. The QSI provides a framework for the NHS and private sector to provide consistently high quality services delivered by competent staff working in safe environments.

Duties of the employer

Entitlement

The process for the entitlement of duty holders for medical exposures was evidenced in the employer's procedure and in an appendix to the Ionising Radiations Safety Policy. This described how staff were entitled to be referrers, practitioners or operators (including MPEs).

The SAF provided stated the process by which each operator or group of operators were made aware of their entitlement and scope of practice. Radiology operators had a signed letter of entitlement that was issued at the start of employment and then reissued if there were any amendments to their scope of practice for entitlement or regulatory changes. Entitlement was also confirmed annually via the appraisal process.

Practitioners are identified through inclusion on the IR(ME)R entitlement matrix and we saw evidence of this. The SAF stated that practitioners have a session on IR(ME)R compliance on their induction programme. Practitioners receive a letter of entitlement for their scope of practice.

We were told that each non-medical referrer is written to, annually, to confirm their competency. The radiology service issue an annual letter of entitlement to GP practices and all consultants (for sharing with their team) which includes a reminder of good referral practice. As part of recruitment processes all new staff will have their registration and qualifications checked. Radiology would perform a check every 2 years of the GMC professional registers, to ensure medical referrers are still registered. When non-medical referrers make a referral outside their scope of practice, it is turned down by the radiographer and their line manager is informed. Additionally, the SAF went on to state that annually or when there are changes to the regulations, the department would write to secondary care consultants and all primary care practices to remind them of their entitlement to refer and of the referral guidelines available.

Staff we spoke with were aware of their duties and scope of entitlement under IR(ME)R. Entitlement was linked to successful completion of the relevant training and competency checks for specific equipment and examinations. These entitlements were recorded on a training matrix in the department. Overall, the staff entitlement records we saw as part of our inspection were complete and up to date.

Written procedures and protocols

The Chief Executive of the health board was designated as the IR(ME)R employer. This arrangement was detailed within the Ionising Radiation Protection Policy. The Chief Executive could delegate tasks, but not responsibility, for

ionising radiation safety appropriately through the organisational arrangements in order to effectively manage and control the risks from ionising radiation. The Chief Executive appointed the Executive Director of Therapies and Health Science to be responsible for the co-ordination of radiation-related health board activities.

Staff we spoke with, as part of our inspection, confirmed that they had access to current versions of the policies and procedures in place. Also, senior staff confirmed that changes would be communicated to staff in a number of ways depending on the change. These included emails, during daily huddles, at radiology site briefings, the radiology monthly newsletter and the procedure would be updated on the radiology SharePoint site. Staff we spoke with confirmed this process of communication of information.

We saw that written procedures and protocols had been developed and implemented in accordance with IR(ME)R 2017. There was also an employer's procedure on the quality assurance of IR(ME)R written procedures, protocols and equipment. The purpose of this procedure was to ensure that all procedures and protocols related to IR(ME)R were subject to a quality assurance programme. Similarly, that all equipment covered by IR(ME)R was subject to a quality assurance programme.

Staff we spoke with, as part of our inspection, confirmed that they had access to current versions of the policies and procedures in place. Also, senior staff confirmed that when any changes to documents occur, notifications were circulated to department staff, who were subsequently asked to confirm that they had read and understood the relevant changes. This was also confirmed as part of the performance appraisal and development review (PADR).

We were told that there was a peer review system for reporting radiographers. The percentage accuracy was reported to the radiology quality, safety and effectiveness group. All non-medical referrers were required to perform audits, which radiology would request from time to time for assurance purposes. This was not reviewed during the inspection.

The department were working towards a peer review system for radiologist and Everlight. Senior staff said that Everlight had an internal process of five percent peer review. They were not peer reviewed by the health board currently, due to availability of staff.

The employer had a set of employer's procedures for radiology that were required under Schedule 2 of IR(ME)R 2017. In addition, there were protocols documented for diagnostic examinations such as a general X-ray technique protocol and the CT technique protocols. However, it was not clear who had signed the protocols, whilst there was a signature there was not a printed name

to easily identify the signature. The employer needs to ensure that the protocols have a name printed on them.

Significant accidental or unintended exposures

A third of staff said they had seen patient safety errors, near misses, or incidents in the last month. The majority of respondents agreed the last time they saw an error, near miss or incident, it was reported.

All respondents agreed staff who are involved in the investigation and reporting of an error, near miss or incident were treated fairly and that the organisation encouraged them to report errors, near misses or incidents. Almost all agreed their organisation treated reports of errors, near misses or incidents confidentially and that their organisation did not blame or punish people who were involved in these. Again, almost all respondents agreed that, when errors, near misses or incidents were reported, their organisation took action to ensure that they do not happen again. One member of staff commented:

> *"A DATIX was completed in relation to the incident, plus my immediate manager and relevant colleagues were notified. Following the incident, the relevant department supplies regular information in order to help avoid future errors."*

Almost all staff who expressed an opinion agreed they were informed and given feedback about changes made in response to errors, near misses and incidents that happen in the organisation. Although, only 60 percent said there were 'usually' enough staff working in the department to do their job properly, the remaining 40 percent said they 'sometimes' were.

The procedure for reporting and investigating accidental or unintended exposures and other incidents was described by staff we spoke with. This included the member of staff reporting the incident on Datix, the incident reporting tool used by the department and the process of investigation by a senior member of staff.

The employer had a written employer's procedure for reporting and investigating accidental or unintended exposures within the department. The employer's procedure set out the process staff should follow if they suspected that a significant accidental or unintended exposure (SAUE) had occurred. The procedure guided staff of the process to follow and subsequently resulting in HIW being informed of such incidents in a timely manner, where necessary. However, it was not clear from the employer's procedure who would establish when an incident was deemed clinically significant.

Staff interviewed were aware of the procedure for reporting accidental or unintended exposures. Senior management stated that the procedure for

reporting and investigating would also involve a dose and risk estimation provided by the MPE for the report. Staff stated that they would be made aware of the lessons learned to avoid a repetition of any event.

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Improvement needed

The employer must ensure that:

- The employer's procedure relating to dealing with accidental or unintended exposures gives clear guidance on who would establish when an incident is deemed clinically significant

- The protocols have the authors name printed on them, in addition to a signature.

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Staff and resources

Workforce

We were concerned to find that six members of staff, who completed our survey, answered the question that they had faced discrimination at work within the last 12 months. The health board must ensure that processes are in place to allow any member of staff to report any issues of concern internally, as well as to ensure that any concerns raised are appropriately investigated and responded to.

92 percent of staff agreed with the comment that staff had fair and equal access to workplace opportunities regardless of the protected characteristics[28], the remaining eight percent answered 'prefer not to say'. Similarly, 90 percent agreed their workplace was supportive of equality and diversity, the remainder answered 'prefer not to say'. Staff we spoke with said there was equal access to workplace opportunities for all staff and that they would go to their line manager to report discrimination.

Senior staff we spoke with said that the interview process for any vacancies was open and transparent. Additionally, any requests for study leave were discussed at a weekly meeting to ensure fairness across all sites in the health board. They

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[28] Regardless of Age, Disability, Gender reassignment, Marriage and civil partnership, Pregnancy and maternity, Race, Religion or belief, Sex and Sexual orientation

also said there was an anonymous health board reporting system that could be used to report any discrimination noted.

Wellbeing

We asked a series of questions relating to staff wellbeing. Their responses are given below:

- 88 percent agreed their job was not detrimental to their health

- 93 percent agreed their immediate manager takes a positive interest in their health and well-being

- 86 percent said their organisation takes positive action on health and well-being

- 88 percent agreed their current working pattern and off duty allows for a good work life balance.

Members of staff comments included the following:

"…they have been very flexible with hours to suit my family life"

"Feel as though I work a lot, and a lot out of hours, so not necessarily nailing the work life balance. Although I haven't talked to management about this, so not their fault"

Staff we spoke with, were aware of how to access occupational health and wellbeing at the health board. Senior staff described the wellbeing initiatives that were available to support staff due to COVID-19. These included drop in counselling sessions, cycling to work and measures if struggling with masks, as well as signposting staff to wellbeing and occupational health. Whilst 89 percent of staff agreed they were aware of the Occupational Health support available we received two negative comments in the staff survey, these were:

"Occupational health department is very poor and takes weeks to speak to staff or access an appointment"

"Occupational health in this trust is not fit for purpose. Approximately 4 days to respond to needlestick injuries"

However, 95 percent of staff agreed that they are offered full support in the event of challenging situations.

Improvement needed

The health board must ensure that processes are in place:

- To allow any member of staff to report any issues of concern internally, as well as to ensure that any concerns raised are appropriately investigated and responded to

- To ensure that staff are treated fairly and equally and that any instances of discrimination will not be tolerated and appropriate action taken

The health board must ensure that arrangements are put in place to reduce the perceived issues with occupational health.

Staffing

Senior staff that we spoke with said that staffing levels were not appropriate and that the radiologist numbers were the lowest in Europe. They said that they had received some investment this year and were now working on a sustainable plan. Additionally, the department were about to advertise for 23 more radiology staff across the health board. There were a number of vacancies in ultrasound, we were told that there were not available applicants to fill these vacancies. The department were also advertising for 3 consultant posts. Due to the number of vacancies in the department, the SAF stated that there were a number of radiographers who take part in advanced practice or extended roles. They were required to follow a formal training programme agreed by the radiology service. Where there was a recognised post-graduate training programme the member of staff would be required to complete this training.

Where there was no identified formal qualification, the radiology service would develop a bespoke training package which would include, theory and practical elements and cover all governance aspects.

All staff completing advanced or extended practice were required to complete training and demonstrate competence. This was in line with the governance documentation for the practice before being formally entitled in writing and adding to the entitlement matrix. This also gave staff additional training and opportunities to advance within the department.

We were told that there would be an increase in students in the department in the coming year. The department were speaking to the university on a plan to manage and mentor the students in practice. This was to ensure there would be a workable spread of students to allow staff to support them on top of their own roles. In addition they would be making much more use of our community sites to help with student placements. For example there was a student based at Mold

Community Hospital. The university has now also implemented virtual reality training for students.

Staff we spoke with said that they felt that the number and skill mix of staff in the department was sometimes understaffed and that they believed that the department was struggling with staffing levels. They also commented on the challenge of completing their own workload and supervising the students in the department.

The responses were also similar in the staff surveys with 60 percent who expressed an opinion said there 'always' or 'usually' enough staff working in the department to do their job properly. The remaining 40 percent said there were 'sometimes' enough staff working in the department.

The majority of staff said they were at least 'usually' able to meet all the conflicting demands on their time at work and had adequate materials, supplies and equipment to do their work. Almost all staff were at least 'sometimes' able to make suggestions to improve the work of their team / department and were involved in deciding on changes introduced that affected their work or area. Similar numbers of staff also said that their organisation at least 'sometimes' encouraged teamwork and were supportive.

Staff comments included:

> *"Too much pressure on frontline staff who are working with patients and short staffed. Made to feel like whinging and not enough time to sort things out. When requiring support no management are around to talk to the patients."*

> *"I have been employed by BCUHB since November 2019 and have found it a welcoming and friendly place to work. The Mammography, and wider Radiology, staff are always there for guidance and support. From my limited experience working here, my impression is that the Radiology department are caring, hard-working health professionals."*

> *"I have needed support and advice a lot from my managers over the past year and they have been extremely supportive and helpful. Experience of other hospitals and health boards has shown me that in Betsi and in Radiology specifically the support here is extremely important to me and very much appreciated."*

> *"Managers have been very helpful especially over the past year or so where I have needed support much more than usual."*

72 percent, said front-line professionals who dealt directly with patients, were 'always' or 'usually' sufficiently empowered to speak up and take action if they identified issues in line with the requirements of their own professional conduct and competence. 23 percent said they 'sometimes' were empowered

63 percent of staff who expressed an opinion said there was 'always' or 'usually' a culture of openness and learning within the organisation that supported staff to identify and solve problems, 32 percent said there 'sometimes' was. One member of staff commented:

> "The department where I work does not encourage staff to voice concerns about the management of the department. Staff are disciplined for speaking up, therefore creating a culture of 'just put up with it'… Morale is very low. No encouragement from management when staff are doing a good job, only criticism when things go wrong"

We also asked a series of questions about the immediate and senior manager of staff, of those who expressed an opinion relating to their immediate manager we noted the following:

- 86 percent said their immediate manager encouraged those who work for them to work as a team

- 76 percent said their immediate manager could be counted on to help with a difficult task at work

- Whilst 64 percent said their immediate manager gave clear feedback on their work, 23 percent also said they 'sometimes' did. They also said that 42 percent of senior managers acted on staff feedback and 42 percent said they 'sometimes' did

- Again whilst 67 percent said their immediate manager asked for their opinion before making decisions that affect work and 20 percent said they 'sometimes' did

- 84 percent said their immediate manager was supportive in a personal crisis.

Training

A review of the mandatory training records for staff showed there was clear evidence that the majority of staff had completed the relevant training. The percentage completion was in between 83 percent for manual handling and 98 percent for violence and aggression training.

Almost all staff who expressed an opinion, said they had completed their mandatory training. Additionally, we asked staff about the training they had received in relation to IR(ME)R. Approximately 90 percent said they had received training in IR(ME)R relevant to their functions as practitioner or operator. A similar percentage also said they had up to date training in accordance with IR(ME)R relevant to their specific area of practice and other training relevant to their area of work. We received comments on training staff would find useful, some of which are shown below:

> *"The mandatory training is of course essential but I would like more training relevant to my job such as image interpretation, improving techniques, training to help with supervising students"*

> *"Suspected Inflicted Injury (SII) E-learning"*

> *"Leadership/Management"*

> *"Disability/Carer awareness"*

In response to a series of questions relating to training, the percentages of staff who expressed the opinion of 'always' or 'usually' included:

- 87 percent said training helped them do their job more effectively

- 91 percent said training helped them stay up-to-date with professional requirements

- 81 percent said training helped them deliver a better patient experience.

Appraisals

The information supplied showed that 66 percent of the PADRs were up to date. This figure was similar to the 69 percent of staff who expressed an opinion, in the questionnaire, that they had an annual review or appraisal within the last 12 months.

Senior staff told us that this is one of the weekly agenda items on the heads of department meetings. Staff had been encouraged to ensure that their appraisal were carried out with their supervisors and all outstanding appraisals had now been booked in management diaries. Whilst the appraisals should include identifying training, learning and development needs, only 55 percent said that these were covered in these meetings. Additionally, 73 percent of staff said their manager supported them to receive training and development.

> **Improvement needed**
>
> The health board must ensure that:
>
> - Processes are put in place to ensure that appraisals are completed annually
>
> - The appraisals are completed in full, including identifying training, learning and development.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection

- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking

- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Where we identify any serious regulatory breaches and concerns about the safety and wellbeing of patients using the service, the registered provider of the service will be notified via a non-compliance notice. The issuing of a non-compliance notice is a serious matter and is the first step in a process which may lead to civil or criminal proceedings.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales

- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed

- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation

- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect services that use ionising radiation

HIW are responsible for monitoring compliance against the Ionising Radiation (Medical Exposure) Regulations 2017 and its subsequent amendment (2018).

The regulations are designed to ensure that:

- Patients are protected from unintended, excessive or incorrect exposure to medical radiation and that, in each case, the risk from exposure is assessed against the clinical benefit

- Patients receive no more exposure than necessary to achieve the desired benefit within the limits of current technology

- Volunteers in medical research programmes are protected

We look at how services:

- Comply with the Ionising Radiation (Medical Exposure) Regulations

- Meet the Health and Care Standards 2015

- Meet any other relevant professional standards and guidance where applicable

Our inspections of healthcare services using ionising radiation are usually announced. Services receive up to twelve weeks notice of an inspection.

The inspections are conducted by at least one HIW inspector and are supported by a Senior Clinical Officer from Public Health England (PHE), acting in an advisory capacity.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

These inspections capture a snapshot of the standards of care relating to ionising radiation.

Further detail about how HIW inspects the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.			

Appendix B – Immediate improvement p

Hospital: **Wrexham Maelor Hospital**

Ward/department: **Diagnostic Imaging Department**

Date of inspection: **19 and 20 October 2020**

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
No immediate assurance issues				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role:

Date:

Appendix C – Improvement plan

Hospital: Wrexham Maelor Hospital

Ward/department: Diagnostic Imaging Department

Date of inspection: 19 and 20 October 2020

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
Quality of the patient experience				
The employer must ensure that there is a documented process for informing patients of the benefits and risks of the radiation exposure when undergoing all radiological examination including during theatre procedures. This must include who will deliver the information and how this is recorded.	IR(ME)R 2017 Schedule 2 1(i)	RAD 072 Communicating of the benefits and risks of ionising radiation prior to an examination as required by IR(ME)R to be updated to make it explicit in relation to patients undergoing theatre procedures that this needs to be included in the consent process. The annual notification of entitlement to medical referrers will include a section on risk benefit discussions and information on dose and it's risk	Head of Quality and Governance Radiology Professional Services Manager Radiography	5th February 2022 31st January 2022

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
		Remind clinical staff when they are consenting for a procedure that uses X-ray guidance that this should be included in the consent discussion this will be done as part of the radiology annual notification and compliance monitored via BCU audit of consent processes	Medical director or Director of Therapies & Healthcare Sciences	Continuous
The health board is required to ensure that action is taken to promote the availability of Welsh speaking staff or support within the department to help deliver the 'Active Offer'.	3.2 Communicating effectively	All staff reminded of the availability of language line particularly for out of hours when none welsh speaking staff are on duty Welsh Language posters displayed in the department for patients to be informed that they can ask for a welsh speaker	Head of Quality & Governance	Completed November 21 31st January 2022

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
The health board must ensure that: • There is a system in place to ensure feedback is requested from patients, and staff, on a regular basis • Results of the feedback are made know to patients and staff • Staff understand how patient feedback is used to make improvements.	6.3 Listening and Learning from feedback	CIVICA (Patient experience platform) has been rolled out across the health board. The posters for the QR codes will be in place across the radiology departments from January 2022. Feedback from this system will be received on a regular basis and shared via quality meetings Staff can feedback via a number of routes either directly with in radiology or via the confidential health board systems Feedback to staff is via the department briefing and the Newsletter, audit days and Quality and experience meetings. Improvements made will be fed back to patients via posters in the departments and via reports to the Patient & Carer experience committee)	Head of Quality & Governance	31st January 2022 Continuous Continuous
Delivery of safe and effective care				

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
The employer must ensure that the: • Pregnancy checks are carried out for every individual of childbearing potential where relevant and the record of this check is documented • Age range of patients who should be asked about pregnancy is included in the flowchart as described in the relevant employer's procedure • Non-medical imaging employer's procedure is update to in line with current examinations being provided • Record of pregnancy checks carried out on carers and comforters is recorded in the relevant book in the examination rooms.	IR(ME)R 2017 Regulation 6 (8) Schedule 2 1(c) IR(ME)R 2017 Schedule 2 1(m) IR(ME)R 2017 Regulation 12 (5) Schedule 2 1(c) (n)	Radiology improvement notice circulated immediately following the inspection and staff reminded via briefings and huddles. Monthly snap shot assurance audits introduced Flowchart amended to include age range Procedure up dated to reflect current guidance Holding document amended to include a column on pregnancy check being carried out for comforters and carers.	Head of Quality & Governance Radiology Head of Quality & Governance Radiology Head of Quality & Governance Radiology MPE/Professional Service Manager Radiography Head of Quality & Governance	Completed 4th Nov 2021 Continuous Completed Dec 2021 5th Feb 2022 5th Feb 2022

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
The employer must ensure that all induction and training records are completed in full, with signatures and dates to show the training has been completed.	IR(ME)R 2017 Regulation 6 (3) (b) Regulation 17 Schedule 3 1	Radiology Service Managers and Clinical leads reminded of the need to ensure that all induction and training records are signed off and dated once completed prior to entitlements being issued. Assurance of compliance will be done as part of the IR(ME)R annual audit process	Professional Service Manger Radiography	Continuous
The employer must ensure that the authorisation guidelines have an identifiable practitioner named.	IR(ME)R 2017 Regulation 6(1) Regulation 11 (1) (c) Regulation 11(5)	Delegated authorisation procedures updated to clearly indicate who the IR(ME)R practitioner is	Professional Service Manager Radiography	Completed November 2021
Quality of management and leadership				
The employer must ensure that: • The employer's procedure relating to dealing with accidental or unintended exposures gives clear guidance on who would establish when an incident is deemed clinically significant	Governance, Leadership and Accountability IR(ME)R 2017 Regulation 8 (1) Schedule 2 (1) (l)	Procedure to be updated to indicate who will establish when an incident is deemed clinically significant.	Head of Quality & Governance Radiology	5th February 2022

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
• The protocols have the authors name printed on them, in addition to a signature.	IR(ME)R 2017 Regulation 6(4)	Protocol document amended to include date	Radiology Service Manager East	Completed 6th Jan 2022
The health board must ensure that processes are in place: • To allow any member of staff to report any issues of concern internally, as well as to ensure that any concerns raised are appropriately investigated and responded to • To ensure that staff are treated fairly and equally and that any instances of discrimination will not be tolerated and appropriate action taken	7.1 Workforce	All radiology staff complete Equality training as part of mandatory training compliance BCU have the following policies in place to ensure staff are treated fairly and any discrimination is not tolerated: • WP6 (Code of Conduct) • WP8 (Equality and Human Rights Policy) • WP42 (Dealing with Hate incidents Policy) BCU has rolled out the Speak out Safely programme. Promote and raise awareness of the above policies and Speak out Safely portal to radiology staff via:	Professional Service Manager Radiography/Head of Quality & Governance Radiology	February 2022

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
The health board must ensure that arrangements are put in place to reduce the perceived issues with occupational health.		Posters Awareness sessions Section in the radiology newsletter There is an advice line available for needle stick injuries 5 days per week with a 45 minute KPI for providing advice. Out of hours the Emergency Department. Occupational health are recruiting additional staff to support service delivery. There is an advisory service available for staff to self-refer 5 days a week.	Head of Occupational Health	April 2022
The health board must ensure that: • Processes are put in place to ensure that appraisals are completed annually	7.1 Workforce	Radiology Quality & Safety group monitor compliance with appraisals (PADR) on a monthly basis All appraisers to ensure a date is in the diary for the next appraisal (PADR)	Professional Service Manger Radiography	30th March 2022

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
• The appraisals are completed in full, including identifying training, learning and development.		Training plans are required as part of the appraisal (PADR) process. All Appraisers reminded of the need to ensure training, learning and development needs are identified		

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): **Helen Hughes**

Job role: **Professional Service Manager Radiography**

Date: **6th January 2022**

NHS Mental Health Service Inspection (Unannounced)

Ysbyty Gwynedd

Hergest Unit

Betsi Cadwaladr University

Health Board

Inspection date: 6 – 8 September 2021 &

20 – 22 September 2021

Publication date: 23 December 2021

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Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities

Through our work we aim to:

Provide assurance:	Provide an independent view on the quality of care
Promote improvement:	Encourage improvement through reporting and sharing of good practice
Influence policy and standards:	Use what we find to influence policy, standards and practice

1. What we did

Healthcare Inspectorate Wales (HIW) completed two unannounced mental health inspections of Ysbyty Gwynedd, Hergest Unit within Betsi Cadwaladr University Health Board. The first starting the evening of 6 September 2021, the second starting the evening of 20 September. The following sites and wards were visited during these inspections:

- Aneurin - Female acute mental health admission ward

- Cynan - Male acute mental health admission ward

- Taliesin - Psychiatric Intensive Care Unit (PICU)

Our team, for the inspection comprised of two HIW inspectors and two clinical peer reviewers. A HIW inspection manager led the inspection.

The first unannounced visit took place on the evening of Monday 6 September 2021. Shortly after arriving at the hospital, HIW were advised of a patient and two staff members who had tested positive for COVID - 19. As a result, the remaining two days of this inspection took place remotely and focussed on the following concerns:

- Management of Coronavirus (COVID-19)

- Staffing levels

- Staff welfare.

HIW completed a second unannounced inspection on the evening of the 20 September and the following days of 21 and 22 September 2021. This inspection focussed on what improvements had been made since our inspection on the 6 September 2021. In addition, we also inspected the following areas:

- Infection Prevention Control

- Patient Care Plans

- Environment of care

- Governance and staffing.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct NHS mental health service inspections can be found in Section 5 and on our website.

2. Summary of our inspection

During our inspection commencing 6 September, we identified a number of areas of concern particularly around Infection Prevention and Control, and Governance and Leadership. Due to concerns about patient safety, we issued an immediate assurance letter, where we write to the service immediately after our inspection with our findings requiring urgent remedial action. We then returned to undertake a further unannounced inspection on 20-22 September to ensure the Hergest Unit was providing safe and effective care.

Overall, we found evidence that the Health Board had started to implement systems and processes to address areas identified in the immediate assurance issued. However, further improvements were identified in the inspection on the 20-22 September 2021.

We found a dedicated staff team that were committed to providing a high standard of care to patients. We observed staff interacting with patients respectfully throughout the inspection.

A number of environmental issues, a lack of infection prevention and control measures relating to COVID-19 procedures, and staffing issues were escalated during both inspections.

Improvements are required in completion of patient care plans and in maintaining accurate staff rota records.

Improvements in communication and engagement between senior managers and ward staff is required to develop a trusting relationship.

This is what we found the service did well:

- We observed that staff interacted and engaged with patients respectfully

- Good team working and motivated staff

- Established governance arrangements.

This is what we recommend the service could improve:

- The maintenance of the hospital facilities

- The capacity of its older adult inpatient mental health service

- Organisation and completion of care plans

- Improvements in welfare and morale of the hospital workforce

- A more stable and consistent senior management team

- Management of staff rota records.

Following the inspection on the 6 September 2021, HIW had some immediate concerns, which were dealt with under our immediate assurance process. This meant that we wrote to the Health Board immediately after the inspection, outlining that urgent remedial actions were required.

Details of the immediate improvements that were required are summarised below and the actions the provider has/is taking to address them are provided in Appendix B:

- We were concerned that some staff were working excessive hours and were regularly working beyond the end of their shift

- Staff informed HIW that they were not always having meal breaks during 12-hour shifts

- Staff were being used from Psychiatric Liaison Teams to fill rota gaps on the wards to cover sickness and staff long-term leave. As a result, this impacted upon the capacity of the Psychiatric Liaison Team to undertake their role

- Staff rotas we reviewed highlighted a number of unfilled shifts

- There is no evidence of a ward acuity assessment to identify if current staffing levels were suitable for the current patient demands on the unit.

- HIW were not assured that all staff were aware of COVID-19 cases on the unit or that correct reporting mechanisms were in place

- As visitors on the unit HIW inspectors were not advised to adhere to COVID-19 protocols, such as hand hygiene compliance

- Staff were not always following infection control protocols, for example, Security Guards were observed coming onto the unit from another area of the hospital. They were not wearing their masks correctly and went straight onto a ward without complying with hand hygiene protocols

- Staff were being utilised from other areas of the hospital and across the Health Board to assist with staffing issues on Hergest unit. It was unclear what procedures were in place to prevent any potential transmission of infection.

These are serious patient safety issues and we issued an immediate assurance letter to the health board following the inspection. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

No new areas requiring immediate assurance were identified during the inspection on 20 September 2021.

3. What we found

Background of the service

The Hergest Unit provides NHS mental health services at Ysbyty Gwynedd, Penrhosgarnedd, Bangor, LL57 2PW, within Betsi Cadwaladr University Health Board.

The service has three wards:

- Aneurin, a 17 bed female acute mental health admission ward

- Cynan, a 17 bed male acute mental health admission ward

- Taliesin, a 6 bed mixed gender Psychiatric Intensive Care Unit (PICU).

- A dedicated Section 136 Suite[1].

At the time of our inspection, bed capacity had been reduced to help support social distancing measures required due to COVID -19. Aneurin and Cynan Wards bed capacity was 14 and Taliesin remained at 6.

The service employs a staff team, which includes a team of registered mental health nurses and healthcare support workers. The multi-disciplinary team consists of consultant psychiatrists and occupational therapists.

Dedicated teams of administration staff, maintenance, catering and domestic staff support the day-to-day operation of the hospital.

The hospital is overseen by the health board's clinical and administrative structures.

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[1] Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety. A Section 136 Suite is a designated place of safety.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

We observed staff interacting and engaging with patients appropriately, and treating patients with dignity and respect.

Patients we spoke to told us they were receiving good care at the hospital.

The health board needs to review the inpatient service provision for older adult mental health care, to ensure it has sufficient capacity and appropriate care to meet the needs of older adult mental health patients.

Staying healthy

There was a wide range of relevant information leaflets for patients, families and other visitors available in the reception areas of the unit and on the individual wards. These areas contained information on mental health issues, guidance around mental health legislation and physical well-being such as healthy eating. There was also information on organisations that can support patients, their families and carers.

Hergest Unit had a team of occupational therapists that provided a wide range of activities for patients within the unit. Each ward had their own designated garden area, which provided outdoor space for patients.

The unit had a therapies area, which included an activities area with a pool table and cardio exercise equipment, an arts therapy room, and a crafts room. However, at the time of the inspection we were informed that the gym equipment was not being used by patients due to restrictions relating to the COVID-19 pandemic.

Dignified care

We noted that all employees; ward staff, senior management and administration staff, interacted and engaged with patients appropriately and treated patients with dignity and respect.

The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients. We observed most staff taking time to speak with patients and address any needs or concerns the patients raised, this demonstrated that staff had responsive and caring attitudes towards the patients.

We noted locked doors and an intercom system on the entrance to the wards to prevent any unauthorised access. Taliesin was a Psychiatric Intensive Care Unit (PICU)[2] that had six individual bedrooms. Aneurin and Cynan were both designated as 17 bed acute admission wards; both were a mix of individual bedrooms and dormitory areas. At the time of the inspection, both wards were operating at 14 beds due to COVID–19 restrictions. Most patients had access to their own bedroom. However, there was one shared cubicle area on Cynan and Aneurin Ward. The three bedded cubicles had curtains between them, which only afford the basic level of privacy for patients and do not reflect modern mental health care provision.

There were bathrooms available on each ward that patients could utilise if they wished to have a bath. There were appropriate aids available to provide additional support for patients if required. On the first night of the inspection, we were told that the bath on Cynan Ward had not been working correctly. This matter was immediately brought to the attention of the health board and resolved during the inspection. There was also a blocked toilet on Aneurin Ward, which was also brought to the attention of the health board during the inspection.

Some of the bathroom areas on Aneurin and Cynan Ward were being used for storage, a number of boxes were positioned in corner areas of the bathroom. The health board must ensure that all items are stored in appropriate areas. In addition, three unused hospital beds were being stored in the reception area of

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[2] PICUs are designed to look after patients who cannot be managed on open (unlocked) psychiatric wards due to the level of risk the patient poses to themselves or others.

Cynan Ward. This was brought to the attention of the health board and the beds were immediately removed.

There was a patient status at a glance board[3] in the nurse's office displaying confidential information regarding each patient being cared for on the ward. The boards are designed in such a way that confidential information could be covered when the boards were not in use. This meant that the staff team were making every effort to protect patient confidentiality.

Hospital policies and the staff practices we observed, contributed to maintaining patient dignity and enhancing individualised care at the hospital.

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Improvement needed

The health board must ensure that

- The blocked toilet on Aneurin Ward, and the bath on Cynon ward are fixed

- Bathroom areas are not used for storage.

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Patient information

We saw advocacy posters that provided contact details about how to access the service. Due to Welsh Government restrictions associated with COVID-19 legislation, Advocacy services were no longer visiting patients, however patients were able to contact a representative of the statutory advocacy service by telephone to speak to a representative.

Across all wards, we saw information relating to patient feedback and posters were displaying QR codes for patients to scan in order to provide feedback directly to the health board. Wi-Fi was available to facilitate this. In addition, there

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[3] A board that provides staff with a quick reference to essential information about the individual patients being cared for on the ward.

was the opportunity for patients, relatives and carers to provide feedback on the care provided via the NHS Putting Things Right[4] process.

Communicating effectively

Patients we spoke with stated that they felt safe and able to speak with a staff member should they need to. Patients told us they were happy at the hospital and that staff were kind and helpful. There was clear mutual respect and strong relational security between staff and patients.

Through our observations of staff and patient interactions, it was evident that staff ensured that they communicated appropriately and effectively with patients. Staff took time to have discussions using words and language suitable to the individual patient. Where patients remained unclear, or what they were trying to communicate was misunderstood, staff would patiently attempt to explain what they had said.

For individual meetings, patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. With patients' agreement, wherever possible, their families and carers were also included in some meetings.

Timely care

Each morning there was an Acute Care Meeting involving all ward managers, multi-disciplinary team members, and representatives from the community services. Each patient being cared for at the hospital was discussed in turn.

Hergest Unit has a designated Section 136 suite where the police could bring people for a Mental Health Act assessment. This unit was closed on the 6 September, and patients were being re-directed to an alternative Section 136 suite in the health board. We were advised that the Section 136 facility had been on divert to Ablett and Heddfan units from 25 August 2021 – 7 September 2021. This had been agreed following discussion with North Wales Police.

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[4] Putting Things Right is the integrated processes for the raising, investigation of and learning from concerns regarding treatment within the NHS

The reason for the divert was staffing challenges arising from the COVID-19 positive patient requiring 2:1 nursing in an isolated ward next to Aneurin Ward. We were told that this is the contingency plan for all the Section136 facilities and it is not usual practice for Hergest to divert due to staff shortages. The health board must ensure that there are always sufficient staffing numbers on duty to deal with any Section 136 admissions. Transporting a person further to a different Section 136 Suite within the health board is detrimental to the person's well-being.

The Section 136 suite was available for use on the unannounced inspection that took place on the 20 September and there were sufficient staff available to deal with a Section 136 admission.

The Section 136 Suite was adequately equipped to provide comfort and safety for a person awaiting and undergoing an assessment. There was a toilet available within the Section 136 Suite, however, there was no door or screen within the toilet entrance to afford privacy to a person using the facility. This had been highlighted as an area that needed improvement during our last inspection in 2018 but remains a significant dignity issue. The health board must ensure that this work is carried out.

The suite complied with the National Institute for Health and Clinical Excellence (NICE) standards, and the hospital ward and police had an agreed protocol on the use of the suite.

We were told meetings took place between the police and ward staff to evaluate admissions and frequency of use of the suite. It was positive to hear that any lessons learnt and organisational feedback would be discussed during these meetings. Close partnership working with the police and effective use of the Section 136 suite is essential to ensure that people presenting with mental health issues are getting the right care at the right setting.

Due to capacity demands across the health board older person's mental health service, there were occasions when older persons mental health beds were unavailable and therefore a person would be admitted to the adult acute admission wards where there was a bed available. Staff told us that there were also occasions when older persons with a diagnosis of dementia were admitted to the adult acute admission wards. The environment of care on acute mental health wards are not the most appropriate environment to meet the specific needs of those patients, lacking visual and orientation aids that are commonplace on dementia wards. Staff on acute mental health wards may also lack the skillset and be unfamiliar with providing care to patients with a diagnosis of dementia, in meeting their needs and managing their behaviours.

Staff spoken to raised concerns regarding the suitability of the environment of care and the complex challenges that present with older patient care. They described situations where some patients would require enhanced observations and different levels of physical care which staff may be unfamiliar with providing.

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Improvement needed

The health board must ensure that:

- Section 136 suite remains open and there are sufficient staff available to cover admissions

- There is appropriate privacy measure for the toilet located in the Section 136 Suite

- A pathway is developed in the health board for older adult care.

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Individual care

People's rights

Patients could also utilise the Independent Mental Health Advocacy (IMHA) service where a representative could be contacted via telephone or when they attended the hospital. We were told that advocacy were not currently attending the wards, however were available by telephone for patients to make contact.

During the course of reviewing patient records, we noted that there were no capacity assessments being recorded. Therefore, there was no record to determine if the patient had capacity to make informed decision around:

- Administration of medication within the ward environment

- Understanding the inherent restrictions of being admitted onto a locked ward.

Established hospital policies and systems ensured that patients' equality, diversity and rights are maintained. Information was displayed on the wards to

inform patients, who were not restricted by the Act[5], about their rights to leave the ward.

Due to Welsh Government restrictions associated with COVID-19 legislation, visitors were not allowed on to the unit. However, some patients could meet with family and friends within the hospital grounds. Other patients could maintain contact with family and friends by telephone and video calls.

There was a designated area for children and families visiting which was off ward. This meant that patients could meet with younger family members away from the ward environment.

Improvement needed

The health board must ensure that capacity assessments are completed and recorded in patient records.

Listening and learning from feedback

There was the opportunity for patients, relatives and carers to provide feedback on the care provided via the NHS Putting Things Right process. Senior ward staff confirmed that wherever possible they would try to resolve complaints immediately.

There was no evidence of regular patient meetings taking place, where patients would have the opportunity to discuss any improvements or patient initiatives.

It was positive to note that there was a large display of thank you cards on display in the nurse's office.

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[5] Commonly referred to as "informal patients", where the patient has capacity to agree to remain in hospital to receive care for their mental health.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

Whilst overall the physical environment at Hergest Unit was maintained to a good standard, we identified a number of areas that require action.

We also identified areas for improvement concerning staff practice, in particular around completion of care plans to evidence in detail the care being provided.

Safe care

Our concerns regarding management of COVID-19 and staffing issues from the inspection on 6 September 2021 were dealt with under our immediate assurance process. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

No immediate assurances were identified when we return to Hergest on the 20-22 September 2021.

Managing risk and promoting health and safety

There were established processes in place to manage and review risks, and to maintain health and safety at the hospital. This assisted staff to provide safe and clinically effective care.

The Hergest Unit is located within the grounds of Ysbyty Gwynedd with its own entrance and staffed reception during the day. During the evening and night, the entrance to Hergest Unit is secured to prevent unauthorised entry, during these times the wards can be contacted via the intercom located at the entrance. However, when the inspection team arrived unannounced on the first evening on 6 September 2021 we were let through the locked doors on to the ward without being asked for identification. Staff must act with vigilance and ensure that the identity of visitors is confirmed prior to allowing their access on to the ward. It was positive to note that on the second unannounced visit, identification was requested.

The inspection team considered the hospital environment during a tour of the hospital on the night of 20 September 2021 and the remaining days of the inspection. We identified a number of decorative and environmental issues that required attention, these included:

- Sticky tape residue marks where items had been stuck to doors and windows. This unfortunately left the wards, in parts, looking scruffy and a unkempt

- Plaster flaking on walls both sides of garden entrance door to Cynan Ward

- Plaster flaking and dampness near the external entrance door to 136 suite

- Cluttered and disorganised storage cupboards

- Hot water tap not working in kitchen on Aneurin Ward

- Patient bathrooms being used as additional storage areas.

These issues were brought to the attention of the health board and the estates team were notified. The health board must ensure that the environmental and decorative issues are resolved.

We told that some of the wards on Hergest had high-low profiling beds to assist in maintaining the safety of patients with reduced stability and mobility. We were told that risk assessments were in place for individuals who use these beds; however, it was unclear if risk assessments had been completed for other individuals on the wards that could gain access to these beds. Staff had access to personal alarms to call for assistance if required, there were also nurse call points around the hospital so that patients could summon assistance if required.

There were established systems in place for assessing and monitoring patients' level of agitation, and staff were trained in recognised Restrictive Physical Intervention (RPI) techniques for managing patient behaviours. Senior staff confirmed that the physical restraint of patients was used, but this was rare and only used as a last resort.

There was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the health board's incident reporting system (DATIX) that included the names of patients and staff involved, a description, location, time and length of the incident. Any use of restraint was documented.

There was a hierarchy of incident sign-off with regular incident reports produced and reviewed so that occurrence of incidents could be monitored and analysed.

We attended a Putting Things Right meeting. Incidents, safeguarding, staffing and Infection Prevention Control were among the items discussed. It was reassuring to see and hear senior management discussing issues during this meeting, however, no members of the ward staff were available at this meeting. It would be beneficial if ward staff were provided with an opportunity to represent the themselves at these meetings. This would ensure that ward staff have an opportunity to contribute to discussions and improvements made with the senior management team.

There were up-to-date ligature point risk assessments in place for the wards. These identified potential ligature points and what action had been taken to remove or manage these. We reviewed records and confirmed there was evidence of audits.

Improvement needed

The health board must ensure that:

- Staff confirm the identity of visitors prior to allowing access on to the ward

- Sticky residue is removed from windows

- Re-plastering is completed on Cynan Ward and Section 136 suite

- Storage cupboards on all wards are organised

- Patient bathrooms are not used as additional storage areas

- Hot water tap on Aneurin Ward is fixed

- There are regular environmental audits to identify any unreported damaged areas

- Representation from ward staff at meetings.

Infection prevention and control

We found that the arrangements for the prevention and control of infection within Hergest Unit did not protect potential transmission of COVID-19 to other patients and visitors. During the unannounced visit on 6 September, the inspection team

questioned if there were any COVID -19 cases on the ward. We were told that one positive patient was being nursed in isolation. However, the inspection team were later advised by another member of staff that two members of staff had tested positive across the unit. We were not assured that all staff were aware of the cases on the unit or that the correct reporting mechanisms were in place.

In addition, as visitors on the unit, we were not advised to adhere to COVID-19 protocols, such as hand hygiene compliance. We also observed security guards coming onto the unit from another area of the hospital. They were not wearing masks correctly and went straight onto one of the wards without complying with hand hygiene protocols. We also identified that staff were being utilised from other areas of the hospital and across the health board to assist with staffing issues at Hergest. It was unclear what procedures were in place to prevent any potential transmission of infection from other areas of the hospital.

Our concerns regarding management of COVID-19 and staffing issues from the inspection on 6 September 2021 were dealt with under our immediate assurance process.

Following the unannounced inspection on the 6 September 2021, HIW were provided with evidence to confirm that the health board conducted necessary risk assessments and updated relevant policies and procedures to meet the additional demands of the COVID-19 pandemic. We also examined COVID-19 documents, which supported staff to ensure they remained compliant with policies and procedures.

When we returned unannounced on 20 September 2021, we noted improvements. Staff were checking that we had complied with COVID-19 protocols such as hand hygiene and wearing and changing of face masks. Staff were also aware of the COVID-19 status of the unit.

On the 20 September 2021, two patients were being nursed in the isolation suite. We were unable to inspect this area but through glassed doors, we were able to observe staff donning PPE in an area outside the isolation suite The PPE was being stored on a table outside the isolation suite. The acute manager told us of further improvement plans she was implementing in the isolation area. This included separating a room into designated donning and doffing areas and estates were fitting a cupboard in this area to store supplies of PPE. The health board must provide an update on the further improvements the health board are making to the isolation suite.

Staff we spoke to were aware of infection control obligations. We were told by staff and saw evidence of staff policies relating to self- isolation, and COVID-19

workforce risk assessments. We were also told that any staff who tested positive were discussed at safety huddles, and Datix incidents would be completed. In addition, a 72-hour review would be undertaken to ensure that appropriate safeguards were in place to protect staff and patients. Regular communication via emails ensured everyone has up to date advice and guidance on COVID-19.

Weekly cleaning audits and daily hand hygiene audits were carried out on the unit. The acute care manager also completes a daily walkabout with the senior leadership team on a weekly basis. Any breaches or issues are addressed directly with staff and with ward/team managers. In addition, external audits are undertaken by external health board staff to ensure compliance. The nursing team were very complimentary of the domestic staff and we were told that they all worked well together as a team.

Cleaning equipment was stored and organised appropriately. There were suitable arrangements in place for the disposal of clinical waste. Bins were available to dispose of medical sharp items and these were not overfilled.

Improvement needed

The health board must ensure that:

- All staff check visitors compliance with COVID-19 procedures

- Isolation suite has suitable storage for PPE

- HIW are provided with details of improvements made to the isolation suite.

Nutrition and hydration

Patients were provided with meals at the hospital making their choice from the hospital menu, and had access to drinks and fresh fruit on the wards. The patients we spoke with were positive about the food provided.

We were told that specific dietary requirements were accommodated and if patients missed mealtimes, they would be provided with sandwiches. Staff said patients make their food choices in advance and stated if a patient changes their mind, they can usually be accommodated with another option.

The dining room was clean and tidy and provided a suitable environment for patients to eat their meals. We were also told that patients could also eat meals in their rooms to help with social distancing measures.

Medicines management

Overall, we noted that medication was securely stored. Staff locked the clinic room and medication cupboards to prevent unauthorised access. The automated medication dispensing cabinet was not working correctly on Aneurin ward, however staff were still able to dispense medication. This issue had been reported and was resolved whilst the inspection was ongoing.

Staff locked medication fridges when not being accessed. There was evidence of regular temperature checks of the medication fridge to monitor that medication was stored at the manufacturer's advised temperature. However, we saw that on both Aneurin and Taliesin wards, the fridge temperatures recorded were outside the required range but staff had not escalated this. This was immediately raised by HIW and both fridges were fixed. The health board must ensure that fridge temperatures are in the required range to ensure that medication is stored at the correct temperature.

Staff told us that since the installation of the automated mediation dispenser unit, the temperature of the clinic in the summer months could be high. We noted that no ambient room temperature checks of the clinical room were routinely monitored or recorded on Aneurin Ward. It is important that temperature checks of the clinical room are taken and recorded to ensure that medication is not affected by temperatures outside of the manufactures' stated temperature range.

There were regular stock checks of medication, including Controlled Drugs and Drugs Liable to Misuse, to ensure that the correct amounts were present. A number of liquid medicines on Taliesin Ward were reviewed, these were appropriately stored, however they were not labelled with a date of opening. It is important that dates of opening are recorded on liquid medication as this may affect the shelf life and quality of the medication.

There was a regular pharmacy input, and audits were undertaken, which assisted the management, prescribing and administration of medication. We observed a number of medication rounds, and saw that staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately.

The majority of Medication Administration Records (MAR Charts)[6] reviewed were fully completed by staff. This included completing all patient details on the front and subsequent pages and their Mental Health Act legal status. However, on one patient chart the allergy section stated 'as per GP record'. This would require the nurse to look at the GP records, when all allergies should be recorded on the drugs chart to prevent any drug induced allergic reactions. It is important that any allergies and information are documented on patient charts.

A Medication Management Policy was not available in the clinic and staff were unable to demonstrate where the policy was kept. The heath board must make sure that all staff understand the policy, are familiar with the content and that a copy of the policy is available in the clinical area.

Staff had access to all relevant medicine management policies at the hospital along with the current British National Formulary (BNF)[7].

There were regular checks of resuscitation equipment. Staff had documented when these had occurred to ensure that the correct equipment was present and in date.

Improvement needed

The health board must ensure that:

- Staff record fridge and clinical room temperatures

- Any fridge or clinic room temperatures outside the required range are addressed

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[6] A Medication Administration Record is the report that serves as a legal record of the drugs administered to a patient by a health care professional. The Medication Administration Record is a part of a patient's permanent record on their medical chart.

*7 British National Formulary is a pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about individual medicines.

- Management investigate the raised temperature in clinical room

- Dates of opening liquid medications are recorded

- Allergies are clearly specified on drug charts

- Staff are aware of the location and content of the medication management policy.

Safeguarding children and adults at risk

There were established health board policies and processes in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

Ward staff had access to the health board's safeguarding procedures via its intranet. Senior ward staff confirmed they were confident that staff were aware of the correct procedure to follow should they have a safeguarding concern. During discussions with staff, they were able to demonstrate knowledge of the process of making a safeguarding referral. As highlighted above all safeguarding referrals are discussed during the putting things right meeting where the health boards safeguarding lead would be present.

Medical devices, equipment and diagnostic systems

There were regular audits of resuscitation equipment undertaken on each of the wards when required, which documented that all resuscitation equipment was present and in date.

There were a number of ligature cutters located on each of the wards, for use in the event of an emergency. During the inspection, all staff we spoke with were aware of the location of ligature cutters.

Effective care

Safe and clinically effective care

Overall, we found that systems and governance arrangements were in place, which helped ensure that staff provided safe and clinically effective care for patients. However, as detailed within the report the health board needs to address the deficiencies identified during the inspection and these are detailed, along with the health board's actions, in Appendices A, B and C.

Record keeping

Patient records were mainly paper files that were stored and maintained within the locked nursing office, with some electronic documentation, which was password protected. We observed staff storing the records appropriately during our inspection.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision

We reviewed the Care and Treatment Plans of four patient records provided to us after the unannounced inspection on 6 September 2021, and five patient records were viewed during the unannounced return on the 20 September 2021.

We highlighted a number of errors in the care plans reviewed from both inspections.

The unmet needs of patients were not identified. It is important that any unmet needs are documented, so that these can be regularly reviewed by the multidisciplinary team. It is important to consider options for meeting all needs, as this may result in identifying an alternative placement.

We also noted a number of missing observation recordings in observation recording forms. Signatures of observing staff were missing and forms contained gaps with no entries. During one set of patient notes the fluid balance (input/output) charts, had some discrepancies where the charts had been poorly completed or were incomplete. The charts inspected did not provide sufficient information to document the patients' consumption over a period of time and it was difficult to establish if this patient had access to appropriate amount of fluids. In addition, the care plans did not adequately cover the following areas:

- No date of review was recorded on some care plans

- No evidence of physical assessments taking place

- No entries to show if patient had capacity to agree to treatment plan

- COVID–19 care plans were signed but not fully completed.

- Care co-ordinators were unnamed and just recorded as nursing staff.

The health board must ensure it addresses all the deficiencies with care plans to ensure that accurate and historical data is captured and recorded.

Improvement needed

The health board must ensure that:

- Unmet needs are evidenced and documented within patient care plans.

- Observation record sheets are accurately completed

- Food and fluid charts are completed in full and accurately recorded

- Review dates are recorded in care plans

- There is evidence of physical assessments taking place

- That capacity assessments are completed

- COVID–19 care plans are fully completed

- Care co-ordinators are identified and named.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

Throughout the inspections and at the feedback sessions, staff and management at Hergest Unit were receptive to our views, findings and recommendations.

Throughout the inspections, staff demonstrated their commitment to provide care for patients within the hospital. However, we are concerned that some staff may be working excessive hours and not taking their required breaks. Fatigue may affect staff well-being and impact upon professional judgements.

Improvements are required in relation to maintaining accurate staff rota records.

We also noted that findings from other inspections within the health board were replicated at Hergest. This identifies a lack of joint learning by the health board on the outcomes of inspections.

Governance, leadership and accountability

The significance of the areas of improvement identified in the below Workforce section, along with Infection Prevention and Control, and Care Planning sections of this report, highlights the need for improvement in audit and governance regarding these areas to support patient safety.

Throughout interviews with staff, it was clear that working relationships built on trust had not yet been fully developed between the ward staff and health board senior management teams. This was partly due to a number of significant changes to the management and multi-disciplinary team. In addition, staff we spoke to raised concerns around the quality of communication from senior leaders around recent staff movements on Hergest Unit. The health board must

ensure it has a communication strategy in place to brief staff when any changes are made.

During interviews with staff, we were told that changes in the senior management teams made it difficult to build up working relationships that allowed them to raise confidential issues or concerns. There was a clear lack of trust in senior management from the ward staff who described working in a culture of blame; this feeling amongst staff was having a significant impact on staff morale and well-being.

Some staff described being 'petrified' of making mistakes and were fearful that they would be redeployed or suspended from duties. However all staff spoke positively about their immediate line managers and described working in resilient and supportive teams.

We spoke to ward staff and were told that they escalated some environmental and patient care issues to management. They also told us they were not confident these issues would be dealt with. However, senior staff informed us that they were unaware of these issues. It is unclear if this difference is due to a lack of structured escalation procedures, or a lack of confidence from ward staff in the senior team. The health board must provide a system for escalation of issues for staff to follow, including regular updates of actions taken by management. This system should be clearly communicated to all staff.

The health board have appointed a Clinical Operations Manager, along with a Head of Nursing and Clinical Acute Care Manager. Discussions held with these individuals and the Interim Director of Mental Health highlighted that they were aware of issues on Hergest Unit that require improvement. They indicated they had a commitment to addressing these to raise the standard of the environment and treatment and support to patients and staff.

Senior staff advised us of initiatives they were developing to try to support staff well-being. In order to bridge the gap between senior management and ward staff, senior managers were ensuring that they were a visible presence on the ward and were making efforts to build up confidence and trust between ward staff and senior management. However it was evident through interviews with staff that they did not feel valued or supported by senior management. The health board must ensure that its senior leaders encourage professional integrity, inclusive and supportive relationships so that staff feel valued, respected and confident to report concerns. In order to achieve this the health board needs to provide a stable and consistent senior management team for staff on Hergest Unit.

At the time of the inspection there was no permanent consultant psychiatrists nor psychologists in post, the health board had arranged cover for these positions. However, this had been sporadic and had not provided consistency of care. Ward staff we spoke to told us that they did not feel involved in decisions around patient care and treatment that were being made by the consultant psychiatrists.

As a result there was a lack of collaboration between the disciplines, and whilst there was also occupational therapy input, there was no evidence of cohesive multi-disciplinary team working. The lack of an established multi-disciplinary team impacts negatively on patient care and safety. Patients were not getting timely access to the range of care and support they need. The lack of MDT collaboration also prevents ward staff, including newly qualified nurses, developing clinical judgement skills.

It is vitally important that the health board ensure that the staff at the hospital work together and become a more cohesive team who communicate, consult, and make decisions together to optimise patient care.

A key finding from our our last Mental Health Inspection of Wrexham Maelor Heddfan Unit in July 2020 was a lack of communication and consultation between senior management and ward staff. This highlights a lack of shared learning from other inspections within the health board.

Improvement needed

The health board must ensure that:

- Senior management and ward staff work together to build up confidence and trust

- Senior management improve communication with staff

- MDT work collaboratively with ward staff

- Consistent and stable senior management team is maintained.

Staff and resources

Workforce

During the unannounced inspection on the 6 September 2021, we were given conflicting information on the staffing numbers and the observation needs of the patient group. The health board subsequently provided us with accurate data on the staff who were working on the night of the inspection and the observational levels required. This data reflected that there were sufficient staffing levels to meet the needs of the patient group. However, this was only because staff were not taking their breaks and some staff were working extra hours after their rostered shift to support their team members. Details on the health boards' response are included in Appendix B.

Further examination of previous rotas indicated unfilled gaps. The health board told us that these gaps had been filled with staff, however, this was not reflected on the rotas we examined. The health board must ensure that staff rota records are robustly managed and that any changes or amendments to staffing are accurately recorded, and historical data on resources is captured.

Staff told us that they would often work beyond their rota'd shifts to support colleagues due to staffing shortages. Staff indicated that there were occasions where they felt staffing levels were too low, in particular at night-time and on weekends. In addition, we were told that staff were working through their breaks as they felt it was unsafe to take a break and they were fearful of leaving colleagues short staffed on the unit. This type of working environment will lead to fatigue and affect staff well-being, compromise their professional judgements and impact on patient safety.

Senior management confirmed that they were encouraging staff to have breaks by discussing breaks during morning meetings and arranging coverage on the wards for staff to have breaks. In addition, senior management had developed a weekly accountability meeting where they look at hours staff worked to try and alleviate staff working excessive shifts and becoming fatigued. However, staff told us that even though management were telling them to have breaks they did not always feel that the unit would still be safe if they went on break. This was due to the acuity of patients and staffing levels. The health board must ensure there are sufficient staff to meet the demands of the patients.

During conversations with senior management, it was unclear when the most recent review of safe staffing numbers had taken place on Hergest Unit. This should be based on the current acuity levels and changing demands on the unit. Safe staffing is a fundamental part of good quality care and it is important that the health board undertake a review of its staffing establishment on Hergest Unit, including the S136 suite.

Senior staff confirmed that there were a number of registered nurse vacancies and recruitment had been ongoing for these posts. There were also a number of staff who had been temporarily redeployed or absent due to sickness. Therefore, additional resources were required to fulfil staff rotas. Where possible the ward utilised its own staff and regular registered nurses from the health board's bank staff.

There was a lack of staff break facilities on the unit, and those available were small and cluttered. In addition, due to limited storage space across the unit, staff rooms for the unit included items that should be stored elsewhere. This meant that there were limited suitable places where staff could take their breaks.

Staff told us that team meetings were not taking place. This was something the acute care manager told us she was looking to improve upon. The health board must ensure that regular team meetings can take place, this should be planned in order to make this a more meaningful, supportive and valuable process for staff.

The training statistics reviewed identified low compliance with some modules on Aneurin Ward. For example, the compliance rates for fire safety was 44%, Information Governance was 51% and Moving and Handling was 48%. In addition, compliance with staff appraisals was only at 68%. We have recognised that the figures on Aneurin Ward may be due to staff absences and that face-to-face training has been difficult due to the pandemic, however, improvements are still required in these areas.

It was positive that, throughout the inspection, staff engaged openly and were receptive to our views, findings and recommendations.

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Improvement needed

The health board must ensure that:

- Staff do not work excessive hours

- Staff have breaks and feel confident leaving the ward for breaks

- There are appropriate areas where staff can take their breaks

- Staff rota records are robustly managed and that any changes or amendments to staffing are accurately recorded.

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- That there are adequate staffing levels to maintain a safe environment at all times including additional staff to cover observation times

- Mandatory training figures are improved

- Regular team meetings take place for staff.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection

- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking

- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales

- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed

- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation

- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect NHS mental health services

Our inspections of NHS mental health services are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of NHS mental health services will look at how services:

- Comply with the Mental Health Act 1983, Mental Capacity Act 2005, Mental Health (Wales) Measure 2010 and implementation of Deprivation of Liberty Safeguards

- Meet the Health and Care Standards 2015

We also consider other professional standards and guidance as applicable. These inspections capture a snapshot of the standards of care within NHS mental health services.

Further detail about how HIW inspects mental health and the NHS can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
We found the bath was not working on Cynan Ward	Patients were unable to use the bath	We raised this concern with the health board during the inspection and requested this was immediately resolved.	The health board immediately resolved this issue during the inspection
We found that the toilet was blocked on Aneurin Ward	Patients were unable to use the toilet	We raised this concern with the health board during the inspection and requested this was immediately resolved.	The health board immediately resolved this issue during the inspection.
We found that the temperature on the fridges in both clinical rooms were not within the required temperature ranges	Medication may not have been stored correctly	We raised this concern with the health board during the inspection and requested this was immediately resolved	Both fridges were fixed and medication was being stored safely on the ward

Appendix B – Immediate Improvement plan

Service: Ysbyty Gwynedd

Area: Hergest Mental Health Unit

Date of Inspection: 6 – 8 September 2021

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of patient experience				
No immediate concerns identified at this time.				
Delivery of safe and effective care				
HIW were not assured there was sufficient staffing to provide appropriate clinical care to support and maintain the safety of the ward. The health board must ensure the wards have a sustainable staffing model with the required levels of expertise to meet the clinical needs of all patients.		A Divisional Inpatient Establishment review has recommenced, which was stood down in 2020 due to Covid-19 pandemic priorities. This will enable an understanding of staffing requirements across the Division and a model to be agreed to ensure safe delivery of care in all Divisional inpatient settings.		**24/09/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Action:	**Head of Operations (HON)/Head of Nursing (HOP)**	
		1. Local Senior Leadership (SLT) to review and submit their inpatient staffing establishment template to inform the overall Divisional inpatient establishment review.	**Director of Operations (DOP)/ Director of Nursing (DON)**	**20/09/21**
		2. Reaffirm the staffing escalation process across the unit and the Division as a whole.	**HOP/HON** **DOP/DON**	**15/10/21**
		3. Information sessions to be held with all Hergest unit/ward leads to ensure a strengthened understanding of the Hergest Standard Operational Procedure (SOP), to enable consistent implementation.	**DOP/DON**	**31/12/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		4. Continue to progress with the "Stronger Together" Discovery phase across the Division, to give staff the opportunity to work together to shape how the organisation works. This will include attendance at workshops.	**Divisional Head of Workforce (DHOW)**	**30/10/21**
		5. Progress with a Divisional communication campaign aligned to the "Speak out safely" initiative, so staff are aware and are supported in raising any concerns across BCUHB. This will enable staff to use a confidential and anonymous platform to raise any concerns.	**DHOW** **DOP/DON**	**31/11/21** **15/09/22**
We talked to staff throughout the inspection and examined staff rotas. We identified significant staffing issues on the unit, these were:		6. Raising awareness with the Respect and Resolution policy as part of developing health working relationships in the workplace.		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Staff were working excessive hours and were regularly working beyond the end of their shift.		7. Progress with the Maturity Matrix approach to track improvement across the Division.	HOP/HON	30/09/21
		Current position When the ward rosters are initially completed and signed off, staff are not rostered to work excessive hours. For any additional hours worked this is in addition to contracted hours which staff have agreed to undertake through either bank or overtime.	DHOW	15/10/21
Staff informed us they were not always having meal breaks during 12 hour shifts. They had notified management of this but the situation had not changed.		**Action:** 8. Local arrangements to be implemented to ensure a robust system is in place to closely monitor, review and address timely any issues in relation to staff working		17/09/21

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		excessive hours and with regularity working beyond their shift, to ensure staff wellbeing in work.	**Acute Care Site Manager (ACSM)**	
			DON/DOP	**15/10/21**
		9. A Divisional standard template to be developed to inform decision making regarding authorisation of additional shifts for staff.		
Staff were being used from Psychiatric Liaison Teams to fill rota gaps on the wards to cover sickness and staff long term leave. As a result this had impacted upon the capacity of		**Current position - Meal Breaks** The interim SLT have recently been made aware regarding this issue and have commenced renewed focus to ensure that staff are taking their breaks appropriately. **Action:**	**ACSM**	**18/10/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
the Psychiatric Liaison Team to undertake their role.		10. Strengthen the escalation and action in the daily Acute Care Meeting (ACM) for any issues regarding staff breaks.		
		11. Through an agreed cycle of business and through a range of communication means i.e. Memo, Staff Briefing, visit to units, staff forums, including the Joint Partnership Forum with staff side partners and Wellbeing Hubs, highlight the importance of staff wellbeing in work and to limit working excessive hours, the importance of staff taking their breaks and reaffirm the appropriate escalation processes.	**HOP/HON** **ACSM**	
		12. To ensure the importance of working reasonable hours and meal breaks are included in the Staff Induction Pack within		**15/10/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		the staff Wellbeing Section and also include as part of the checklist for staff supervisions.	**HOP/HON**	**17/09/21**
Staff rotas we reviewed highlighted a number of unfilled shifts, for example the shifts for the 6th of September showed that there were 5 unfilled HCA night shifts on Aneurin Ward and 2 HCA night shifts on Taliesin Ward. Similar gaps were highlighted from rotas provided to us for week commencing 6th-11th September 2021 with no staff allocated to some shifts.		**Current position regarding utilisation of Psychiatric Liaison staff** In order to provide safe staffing on inpatient environments, there has, on occasion, been the need to use Psychiatric Liaison staff overnight for duty nurse purposes. However, this is considered in relation to the number of liaison nurses on duty to ensure there is a psychiatric liaison service available to the District General Hospital (DGH). In addition, to ensure continuity of service, the doctor on duty will hold the Psychiatric Liaison bleep to be able to support any assessments required.	**DON/DOP** **HOP**	**Completed** **23/09/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Action:		
		13. Review of the current SOP and the Business Continuity Plan to ensure clarity of the mitigation plans to support continuity of services.		**30/10/21**
		14. The Interim Hergest SLT to ensure discussions are routinely taking place regarding safe staffing levels in daily ACM and Safety Huddles, and that appropriate mitigation and/or escalation is in place where required.		
		15. To continue to ensure a member of the SLT, or the duty nurse at the weekends, routinely attend the ACM and Safety Huddles and escalate any issues to the Divisional Huddle or Bronze on-call at weekends.	**HOP/HON**	

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		16. Reaffirm the requirement aligned to the MH&LD Staffing Escalation Policy across the Division.		
		17. To monitor and review key performance indicators aligned to Psychiatric Liaison to address any issues where required.	ACSM	
It was not evident that up to date ward acuity assessments had been completed to identify the required staffing levels. It is unclear if the current staffing levels were suitable for the current acuity and patient demands on the unit.		**Current Positon regarding unfilled shifts** Unfilled shifts were covered via redeployment of staff from other areas. These were additional staff to the rostered numbers on the E-Roster system e.g. the Duty Nurse was based on the ward. Likewise, other staff were deployed from other areas to enable safe staffing, again these staff would not show on the Hergest E-Roster as they were on the E-Roster for other areas.		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Staff were unclear what the escalation arrangements were and how to contact an on-call doctor.		The current agreed staffing establishment for the three wards in Hergest unit is:- Aneurin 5/5/3 - 17 established beds (also one escalation bed). Cynan 5/5/3 - 17 established beds (also one escalation bed). Taliesin 5/5/4 - 6 beds. Having reviewed the staffing positon, none of wards on the evening of 06/09/2021, at the time of the inspection, were below the staffing template. Further to this, the staffing template is based on 18 patients for both Aneurin and Cynan, and the bed occupancy at the time of the inspection was 14. Also to note, both Cynan and	**Ward Manager**	**25/09/21** **17/09/2021**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Taliesin on 06/09/2021 were over establishment for HCSW's * **Action:** 18. Through communication and engagement with key unit managers, ensure that there is – a. Clear understanding of the E-Roster processes. b. Timely E-Roster sign-off to enable all additional shift requirements identified to be processed to bank office. c. Putting in place scrutiny on E-Roster controls reporting through to HON and HOP. 19. Reaffirm the requirement for Ward manager to escalate any unallocated shifts within the agreed timeframe to daily ACM huddle for discussion and agreement of any	**DOP** **HOP/HON** **HOP** **DHOW**	**25/09/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		action/mitigation to be put in place. **Current position aligned to ward acuity assessments** The ACM discuss and agree staffing levels required based on patient acuity. Ward managers/ representative for the ward provide an overview of their ward staffing requirements to ACM, which feeds into the daily Safety Huddles. **Action**: 20. To ensure the bed flow twice weekly meeting includes ward acuity assessments to plan safe staffing levels for the forthcoming days. **<u>Current position aligned to escalation arrangements</u>** Current on-call arrangements include a unit bleep holder, bronze		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		on-call, silver on-call and medical on-call. A rota is circulated on a monthly basis for all these positions, and more frequently if changes or gaps occur. The silver on-call was established at the beginning of the Covid pandemic to provide additional advice and support to the bronze on-call due to the increase in activity across the Division.		
		Bronze and silver on-call communicate on a regular basis as required, and bronze on-call attend local area Safety Huddles and site meetings during their on-call period.		**25/09/21**
		There is a Consultant on-call rota and junior doctor on-call rota, with contact details. The rotas are communicated, there is a pan-Division distribution list and this is		**25/09/21**
				15/10/21

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		evident in the duty nurse room and on the ward areas*.		
				15/10/21
		21. Divisional memo to be circulated to reaffirm the escalation procedure for on-call arrangements.		
		22. To include this issue in the communication and engagement session with the ward/unit leads.		
		23. To ensure this is included in the Hergest SOP.		
		24. Review the current staff mapping undertaken during the second surge of Covid-19 for all staff within the Division for options of deployment.		
HIW were not assured that there were established Infection Prevention and Control measures in place to manage and mitigate		The safe management of Covid-19 in the MH&LD Division has incorporated a Covid-19 Social		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
the risks posed by Covid-19. The health board must ensure that all internal and national Covid-19 policies and measures are complied with to ensure the safety of patients, staff and visitors.		Distancing Action Checklist and Action Card which provides assurance the Covid-19 guidance has been applied across the Division. An escalation, communication and cascading process is in place with ACM, Daily Safety Huddles, Divisional Huddles, MH&LD Briefings and BCUHB announcements. Daily submission of SITREP including PPE audits, monthly Infection Prevention and Control (IPC) audits and walk around of IPC in all inpatient areas. MH&LD Division has the highest compliance in BCUHB for Covid-19 risk assessments.*		
On arrival the inspection team questioned if there were any Covid-19 cases on the ward and were told of one positive patient being nursed in isolation. However, the inspection team were later advised by another staff member that two further members of staff had tested positive across the unit. We were not assured that all staff were aware of the cases on the unit or that correct reporting mechanisms were in place.		**Current position aligned to Covid-19 Cases** A patient tested Covid-19 positive on admission on 24/08/2021. In line with policy, the patient was		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
As visitors on the unit we were not advised to adhere to Covid-19 protocols, such as hand hygiene compliance.		isolated and nursed for the incubation period, returning to the ward once this had ended and advice sought from our IPC team. There were two patients who were considered contacts; one with this particular patient and another who had a socially distanced visit outside with her father, under staff supervision. Her father subsequently tested positive for Covid-19, and following advice from our IPC team the patient was considered to be a contact as a precaution. Both patients were nursed individually in their rooms as per guidance by the IPC team and the unit Covid-19 Standard Operating Procedure (SOP). Neither patients have subsequently tested positive for Covid-19 and the patients are now able to utilise the ward area, with the 2:1 support arrangements to manage the situation, ending on Monday 06/09/2021. This		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		corresponds with the reported daily SITREP position.*		
		No staff were working at the time of the inspection who were Covid-19 positive.		
		Current position aligned to visitors to the Unit Covid-19 Guidance posters are clearly visible which are displayed at the Hergest entrance and within the foyer. Each ward entrance also has posters aligned to hand washing and mask wearing. An IPC station is immediately noticeable upon entering the Hergest unit at the foyer, with a stock of hand sanitizer and masks.		
		Aligned to current guidance all visits to the MH&LD are prearranged with agreement by the staff on the unit. A visiting record is completed by the staff and visitors and the visitor log		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		updated. Corporate Covid-19 signage and posters have been provided to all units to advise visitors of the IPC requirements in place when visiting units. There is a requirement that all visitors to the unit are booked in advance.*		
		Guidance on visitors to wards has been shared with staff via the MH&LD Staff Briefing, BCUHB announcements and email to all Ward managers.	HON

HOP | 31/10/21

30/09/21 |
| | | The SLT undertakes a 3 monthly self-assessment of 40 standards related to Safe Clean Care and progress against assurance standards reviewed. | DOP | Completed |
| Security Guards were observed coming onto the unit from another area of the hospital. | | The SLT provides an exception report on IPC to the monthly Divisional IPC meeting. Key metrics requiring improvement and renewed focus is on ensuring | HOP

HOP/HON | 15/09/21

17/09/21 |

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
They were not wearing their masks correctly and went straight onto a ward without complying with hand hygiene protocols.		daily Covid-19 and hand hygiene audits are consistently undertaken and mandatory IPC training Level 1 and 2 is increased throughout the unit. **Action** 25. To achieve required improvements aligned to IPC key metrics. 26. To review the Covid-19 Action Card and update aligned to the MH&LD Winter Plan.		
Staff were being utilised from other areas of the hospital and across the health board to assist with staffing issues on Hergest unit. It was unclear what procedures were in place to prevent any potential transmission of infection.		27. To liaise with the IPC Associate Director in relation to any additional IPC advice, guidance or support to the unit. 28. Recirculate memo, via Safety Huddle, regarding completion of the Visiting Record Checklist and Visitors' Log.	**ACSM** **HOP/HON**	**17/09/21** **21/09/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		29. All staff to be reminded when receiving visitors into units, that BCUHB IPC guidance is followed at all times, inclusive of hand hygiene. **Current position -** The issues aligned to lack of hand hygiene protocols and inappropriate wearing of face masks by the security guards has been escalated to the appropriate BCUHB department. A Datix has been raised and a 'Make It Safe+' is being progressed aligned to this incident. This will identify any additional learning from this episode**.** **]Action**	**HOP**	**15/10/21**

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		30. PTR process to be fully implemented to enable the MIS+ to be completed. 31. Scrutiny of MIS+ investigation to identify any learning from this episode by the West SLT. **Current position regarding Staff utilised from other areas** Any staff who are redeployed across the Division are deployed in accordance with the health board staffing escalation policy and the latest IPC Covid-19 guidance. 32. Local SLT to have monitoring and review arrangements in place to ensure the IPC Covid-19 guidance is consistently implemented aligned to staff deployment.		

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
No Immediate concerns identified at this time.				

Service / health board Representative:

Name (print): **Carole Evanson**

Role: **MH&LD Director of Operations (interim)**

Date: **17/09/2021**

Appendix C – Improvement plan

Service: **Betsi Cadwaladr University Health Board**

Ward/unit(s): **Hergest Unit**

Date of inspection: **6 – 8 & 20 – 22 September 2021**

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that the bath is fixed on Cynan Ward.	4.1 Dignified Care	The bath within Cynan was LOLER inspected and Planned Maintenance checked by Caretech on 11/08/21, with no faults noted. Additional check of bath on 21/09/21 during HIW Inspection, and no faults noted. Review the need for this bath in the ward area, and progress with informed decision.	Head of Operations	15/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that the blocked toilet on Aneurin Ward is fixed.	4.1 Dignified Care	Toilet was unblocked during the HIW visit	Head of Operations	Completed
The health board must ensure that the bathrooms are not used as storage areas.	4.1 Dignified Care	Site review to be completed to ensure appropriate storage facilities identified for any mobility aids and equipment on site	Head of Operations	30/11/21
The health board must ensure that the Section 136 suite remains open and there are sufficient staff available to cover admissions.	5.1 Timely access	To ensure effective E-roster planning, aligned to KPI's. To ensure efficient planning to known absences through allocation of duties locally, bank, overtime or agency where required. To continue with a daily review of staffing through the Acute Care Meetings and Safety Huddles to support resolution of any staffing issues locally. To ensure any outstanding staffing issues are escalated into the Divisional Huddle for resolution/mitigation For out of hours, escalation to MH&LD Divisional Bronze/Silver on call for resolution/mitigation	Head of Operations/ Head of Nursing	Completed and reviewed daily

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that there is appropriate privacy measure for the toilet located in the Section 136 Suite.	5.1 Timely access	Ensure dignity screens are in place at all times to enable appropriate privacy	Head of Operations	Completed
The health board must ensure that a pathway is developed in the health board for older adult care.	5.1 Timely access	OPMH Pathway: Divisional meetings have commenced with clear terms of reference. Second meeting held 26/10/21.	OPMH Pathway Lead	Completed and monthly meetings
		Options appraisal to be completed based on the qualitative baseline data for the area.	OPMH Pathway Lead	30/11/2021
		Project plan to be developed and progressed via monthly OPMH meetings.	Head of transformation	30/12/2021
		OPMH service model development to be identified and progressed through the Clinical Strategy Group.	OPMH Pathway Lead	30/06/2022
The health board must ensure that capacity assessments are completed and recorded in patient records.	6.2 Peoples rights	Bulletin to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of capacity assessments.	Head of Operations	15/11/21
				15/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		MH&LD Staff Briefing to include above correspondence.	Head of Operations	15/11/21
		Further development of the patient notes audit checklist to ensure inclusion of all necessary standards, including capacity assessments.	Head of Nursing	
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation.	Head of Nursing	30/11/21
		Copies of the bulletin are displayed on ward notice boards and discussed at handovers.	Head of Operations	16/11/21
The health board must put a system in place for patient meetings with ward staff.	6.3 Listening and Learning from feedback	Develop fortnightly group meetings between patients and staff, using the model developed by Rehab Services.	Head of Operations	30/11/21
Delivery of safe and effective care				
The health board must ensure that staff confirm the identity of visitors prior to allowing access on to the ward.	2.1 Managing risk and promoting health and safety	Email circulated to all service areas on 14/09/21 reaffirming guidance for any visitors to units.	Head of Operations	Completed 14/09/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Review Visitor Logs and Visitor Record Checklist to ensure correct completion weekly.		Completed and ongoing
		Reaffirm visitor process and procedures in MH&LD Staff Briefing.		15/11/21
		Include email in staff handover document.		15/11/21
The health board must ensure that sticky tape residue marks where items had been stuck to doors and windows is removed.	2.1 Managing risk and promoting health and safety	Domestic supervisors emailed on 27/10/21 to support full review of all doors and windows, to ensure rectified.	Head of Operations	15/11/21
The health board must ensure that the plaster flaking on walls both sides of the garden entrance door to Cynan Ward is resolved.	2.1 Managing risk and promoting health and safety	Identified during estates senior walk about on 21/09/2021 and is included in full estates plan for the Hergest site, which is currently going via tendering processes. Continued progress to be monitored via Local Area Estates monthly meetings.	Head of Operations	30/11/21
The health board must ensure the plaster flaking and dampness near the external door to the 136 suite is resolved.	2.1 Managing risk and promoting health and safety	Identified during estates senior walk about on 21/09/21 and is included in full estates plan for the Hergest site, which is currently going via tendering processes.	Head of Operations	30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Continued progress to be monitored via Local Area Estates monthly meetings.		
The health board must ensure that the cluttered storage cupboards are organised.	2.1 Managing risk and promoting health and safety	Full site mapping of all identified storage cupboards that require organising Delegate task of organising cupboards to named member of staff. Ensure spot checks of storage cupboards are incorporated in monthly Matron unit walkabout.	Head of Operations	15/11/21 22/11/21 30/11/21
The health board must ensure that the hot water tap is fixed on Aneurin Ward.	2.1 Managing risk and promoting health and safety	Fixed on 24/09/21.	Head of Operations	Completed
The health board must ensure that the patient bathrooms are not used as storage areas.	2.1 Managing risk and promoting health and safety	The disabled bathrooms are currently not in use where items are stored. Assess the alternative storage requirement needs on a site wide basis. Identify alternative storage and move all items that need to be stored on site.	Head of Operations	30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that risk assessments are undertaken for all individuals on a ward when a high/low profiling bed is being used.	2.1 Managing risk and promoting health and safety	Ensure the risk assessment and Bed Escalation Decision Making Guide is completed for every admission to identify the most appropriate bed.	Head of Nursing	15/11/21
		Further development of patient notes audit checklist to ensure inclusion of all required standards, risk assessments for high/low profiling beds.		30/10/21
		Routine checks to be added to the manager's weekly ward round and monthly Clinical Site Manager walkabout		30/10/21
The health board must ensure that there are regular environmental audits to identify any unreported damaged areas.	2.1 Managing risk and promoting health and safety	Environmental Audits to be completed monthly by the Clinical Site Manager, or designated manager in his/her absence.	Head of Operations	30/12/21
		The Audit outcome will be an Agenda item in the monthly Quality, Safety and Experience (QSE) meeting to ensure actions have been taken, and monitoring and review arrangements are in place.	Head of Nursing	30/12/21
			Head of Nursing	30/12/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Continuation of the Credits for Cleaning bi monthly audits take place and feed into QSE meetings. To introduce quarterly senior management Hergest walk about together with Estates.	Head of Operations	30/12/21
The health board should ensure that there is representation from ward staff at meetings.	2.1 Managing risk and promoting health and safety	Review the Terms of Reference for core meeting to ensure there is appropriate representation from ward staff.	Head of Nursing	15/11/2021
The health board must ensure that all staff check visitor's compliance with COVID-19 procedures.	2.4 Infection Prevention and Control (IPC) and Decontamination	Email circulated to all areas on 14/09/21 reaffirming guidance for any visitors to the units. Reaffirm visitor process and procedures in MH&LD Staff Briefing. Delegate task of Notice Board responsibility to named member of staff, to ensure regular updates, refresh documents and items are clearly visible	Head of Operations	Completed 15/11/21 15/11/21
The health board must ensure that the isolation suite has suitable storage for PPE.	2.4 Infection Prevention and	Full review of this area has been completed with Infection Prevention	Head of Operations	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
	Control (IPC) and Decontamination	Lead, Acute Care Site manager, Head of Nursing and Head of Operations. Specific storage containers fixed to walls and in designated areas within this environment		
The health board must ensure that HIW are provided with details of improvements made to the isolation suite.	2.4 Infection Prevention and Control (IPC) and Decontamination	As noted in 2.4. Additionally, designated doffing and donning area is now available. Sink for effective hand hygiene is now in place. Clear signage visible to ensure staff compliance at all times.	Head of Operations	Completed
The health board must ensure that staff record fridge and clinical room temperatures.	2.6 Medicines Management	Communication to be circulated to all inpatient staff in relation to ensuring that staff record fridge and clinical room temperatures. Communication to be discussed during staff handovers. Nominated ward lead for the day to be allocated the responsibility that daily	Head of Nursing	22/11/21 22/11/21 Completed 31/10/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		fridge audits are completed and discussed at all handovers.		
		Acute Care site Manager to routinely undertake spot checks to ensure implementation		Completed
		Continued support from pharmacy leads to ensure compliance during their weekly ward visits.		Completed
The health board must ensure that any fridge or clinic room temperatures outside the required range are addressed.	2.6 Medicines Management	Any fridge or clinic temperatures outside the required range, following the routine checks highlighted above, to be addressed immediately or escalated as required if unable to be resolved. This issue identified during the HIW inspection was resolved at the time, via support from lead pharmacist.	Head of Operations	Completed
The health board must ensure they investigate the raised temperature in the clinical room.	2.6 Medicines Management	Undertake room temperature audit over a month, discuss results with Estates department for informed decision of next steps.	Head of Operations	30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Include clinical room temperature review on the Agenda of local area Estates meeting to ensure action progresses.		
The health board must ensure that dated of opening liquid medications are recorded.	2.6 Medicines Management	Communication circulated to reaffirm Medicines Management policy, including additional communication aligned to dating of opened liquid medications. Include spot checking of dates recorded on open medication on weekly ward manager walkabout.	Head of Nursing	05/11/21
The health board must ensure that any allergies are clearly specified on drug charts.	2.6 Medicines Management	Communication circulated to reaffirm Medicines Management policy, including additional communication aligned to allergies.	Head of Nursing	05/11/21
The health board must ensure that staff are aware of the location and content of the medication management policy.	2.6 Medicines Management	Communication circulated to reaffirm the location and content of Medication Management policy. Ensure location and content of Medication Management policy is included in staff Induction.	Head of Nursing Education and training lead	05/11/21 31/03/22

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Ensure the Medication Management policy is continually clearly displayed in all ward areas and clinical rooms.	Clinical Site Manager	05/11/21
The health board must ensure that the unmet needs are evidenced and documented within patient care plans.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of unmet needs.	Head of Operations	15/11/21
		MH&LD Staff Briefing to include above correspondence.	Head of Operations	15/11/21
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/21
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation.	Head of Nursing	30/11/21
		Copies of correspondence are displayed on ward notice boards and discussed at handovers.	Clinical Site Manager	6/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that observation record sheets are accurately recorded.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of therapeutic, observation and engagement documentation requirements.	Head of Operations	15/11/21
		MH&LD Staff Briefing to also include above correspondence.	Head of Operations	15/11/21
		Further development of patient notes audit checklist to ensure inclusion of all required standards,	Head of Nursing	15/11/21
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/21
		Copies of correspondence to be displayed on ward notice boards and discussed at staff handovers.	Clinical Site Manager	16/11/21
		Review of the current MH&LD Therapeutic, Observation and	Head of Operations	31/12/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Engagement policy and training plan to support implementation.		
The health board must ensure that food and fluid charts are completed in full and accurately recorded.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of food and fluid charts documentation is completed for relevant patients.	Head of Operations	15/11/2021.
		MH&LD Staff Briefing to include above correspondence.	Head of Operations	15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/2021
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/2021
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Clinical Site Manager	16/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that review dates are recorded in care plans.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of care plans.	Head of Nursing	15/11/2021.
		MH&LD Staff Briefing to include above correspondence.		15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards		15/11/2021
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation		30/10/2021
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.		16/10/2021
The health board must ensure that patient records have evidence of physical assessments taking place.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of the risk booklet on admission	Head of Operations	15/11/2021.

Improvement needed	Standard	Service action	Responsible officer	Timescale
		MH&LD Staff Briefing to include above correspondence.	Head Of Operations	15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/2021
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/2021
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Clinical Site Manager	16/11/2021
The health board must ensure that capacity assessments are completed.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of capacity assessments.	Head of Operations	15/11/2021.
		MH&LD Staff Briefing to include above correspondence.	Head of Operations	15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/2021
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Clinical Site Manager	16/11/2021
The health board must ensure that COVID-19 care plans are fully completed.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of Covid 19 care plans.	Head of Operations	15/11/2021.
		MH&LD Staff Briefing to include above correspondence.	Head of Operations	15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/2021
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Head of Nursing	16/11/2021
The health board must ensure that care co-ordinators are identified and named in patient records.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of details of all professionals involved in patients' care.	Head of Operations	15/11/2021.
		MH&LD Staff Briefing to include above correspondence.	Head of Operations	15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/2021
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/2021
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Clinical Site Manager	16/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
The health board must ensure that management and ward staff work together to build up confidence and trust.	Governance, Leadership and Accountability	Together with staff identify how confidence and trust can be strengthened.	Head of Operations	31/12/21
		Communicate and engage with staff to listen to and understand how this can be achieved.		16/11/2021
		To review the outcome of the MH&LD Reflect and Learn Survey, currently being undertaken across the Division.		31/12/21
		Increased visibility and accessibility of Senior Leadership Team across the unit.		Completed
		Implement 'You Said, we did' notice boards, and to enable staff to make suggestions install Suggestion boxes across the ward areas.		31/12/21
The health board must ensure that senior management improve communication with staff.	Governance, Leadership and Accountability	Increased presence on the wards by Senior Leadership Team.	Head of Operations	Develop cycle of visits by 30/11/21 30/11/21

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Improvement needed	Standard	Service action	Responsible officer	Timescale
		Review and strengthen MH&LD Communication and Engagement plan.	Director of Nursing/Director of Operations.	30/11/21
		Continue with annual MH&LD Staff Briefing cycle of business.	Director of Operations	30/11/21
		Review outcomes of the MH&LD Staff survey themes.	Head of Workforce	30/11/21
		Develop staff focus groups to ascertain preferred communication methods for staff.	Head of Operations	
The health board must ensure that MDT work collaboratively with ward staff.	Governance, Leadership and Accountability	Review current function and Terms of Reference of Weekly MDT meetings, to ensure full engagement and collaboration with all disciplines.	Head of Nursing	16/11/2021
The health board must ensure that a consistent and stable senior management team is maintained.	Governance, Leadership and Accountability	The Division recognises the importance of stable leadership, and are actively progressing through workforce processes to enable the long term	Director of Operations/ Director of Nursing	31/03/2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		stability of the Senior Leadership team to be affirmed. In the meantime, consistency of interim arrangements will continue.		
The health board must ensure that staff do not work excessive hours.	7.1 Workforce	Memo circulated on 28/10/21 to all MH&LD staff. Memo to be displayed on notice boards and discussed in handovers. To continue with a daily review of any staff working excessive hours through the Acute Care Meetings and Safety Huddles to support resolution of any issues locally.	Head of Operations	Completed 05/11/21 Completed
The health board must ensure that staff have breaks and feel confident leaving the ward for breaks.	7.1 Workforce	Memo circulated on 28/10/21 to all MH&LD staff. Memo to be discussed at staff handovers. Memo to be displayed on ward notice boards.	Head of Operations Clinical Site Manager Clinical Site Manager	Completed 15/11/21 15/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		To continue with a daily review of any staff who are unable to take their breaks through the Acute Care Meetings and Safety Huddles to support resolution of any issues locally.	Head of Operations	Completed
		Ensure escalation to SLT in hours, or bronze if out of hours, if staff unable to take their breaks.	Head of Operations	Completed
The health board must ensure that there are appropriate areas where staff can take their breaks.	7.1 Workforce	Review of current staff rooms and facilities on site. Continue with the development of Wellness room on site.	Head of Operations	05/11/2021
The health board must ensure that staff rota records are robustly managed and that any changes or amendments to staffing are accurately recorded.	7.1 Workforce	Review of E roster KPI compliance on a weekly basis, to ensure actions taken where compliance it not met. Additional E roster training to be completed in order to ensure all managers are aware of KPI's and guidance.	Head of Nursing	Completed 30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that there are adequate staffing levels to maintain a safe environment at all times including additional staff to cover observation times.	7.1 Workforce	To continue with a daily review of staffing levels through the Acute Care Meetings and Safety Huddles to support resolution of any issues locally.	Head of Operations/Head of Nursing	Completed daily.
		Staffing establishment review commenced to enable creation of an agreed model, and understanding of staffing requirements to ensure safe delivery of care in all Divisional inpatient settings.	Director of Nursing	30/1/2022
The health board must ensure that mandatory training figures are improved.	7.1 Workforce	Mandatory Training compliance monitored and reviewed weekly at Operational Leadership meeting. Local Area Performance report provides an in-depth summary of mandatory training for all staff disciplines, discussed and reviewed at the monthly Quality, Operational and Delivery meeting, recommended actions to be implemented as required.	Service Managers Head of Operations	Completed and continue to monitor weekly Completed monthly

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Divisional Mandatory training compliance reviewed at DSLT Finance and Performance meeting, recommended actions to be implemented as required.	Head of Operations	Continue monthly
The health board must ensure that regular team meetings take place for staff.	7.1 Workforce	SLT to work with ward managers to support full implementation of team meetings for all disciplines in their areas	Head of Operations.	15/11/2021

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Name (print):   **Carole Evanson, MH&LD Director of Operations (Interim)**

Mike Smith, MH&LD Director of Nursing (Interim)

Date: 01/11/2021

Learning Disability Inspection (Unannounced)

Tan y Coed, Bryn y Neuadd Hospital

Inspection date: 19-20 October 2021

Publication date: 21 January 2022

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Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

Provide assurance:	**Provide an independent view on the quality of care**
Promote improvement:	**Encourage improvement through reporting and sharing of good practice**
Influence policy and standards:	**Use what we find to influence policy, standards and practice**

1. What we did

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of Tan y Coed Residential Unit based in Bryn y Neuadd Hospital on the 19-20 October 2021. We attended the unit briefly on the evening of the 18 October to confirm the COVID-19 status of the unit and to observe how the service delivered patient care during evening hours.

Our team for the inspection comprised of two HIW Senior Inspectors and one Clinical Peer Reviewer. The inspection was led by a HIW Senior Inspector.

HIW explored how the service met the Health and Care Standards (2015) and other relevant guidelines.

Further details about how we conduct hospital inspections can be found in Section 5 and on our website.

2. Summary of our inspection

Overall we found evidence that the service provided a positive patient experience, with a good level of safe and effective care delivered to its patients.

We have recommended several areas for improvement which will strengthen existing practice at the unit in line with the Health and Care Standards.

We found evidence of a well-established management team, which was supported by a committed workforce and sound local governance arrangements.

This is what we found the service did well:

- We observed kind and respectful interactions between staff and patients at all times

- There were regular and effective service user group meetings, facilitated by therapeutic support services

- There was a suitable range of standardised assessment processes in place to support patient care

This is what we recommend the service could improve:

- Develop and implement a clear service model and ethos

- Aspects of care planning, including strengthening care and treatment plans

- Aspects of risk management, particularly in relation to the environment.

Refer to Appendix C for the full improvement plan.

3. What we found

Background of the service

Tan y Coed Residential Unit is based within the wider Bryn y Neuadd Hospital site and provides a rehabilitation service for people with learning disabilities. It can provide care for up to ten patients and is divided into four separate bungalows, however only three bungalows were in use at the time of our inspection due to maintenance issues.

At the time of our inspection, there were eight people staying at Tan y Coed, including one patient who was on authorised leave. This included people who had been at Tan y Coed for short and longer periods of time.

The staff team includes a unit nurse manager, deputy managers, registered nurses and healthcare support workers. Student nurses are also encouraged to work on the unit as part of their training. The unit is supported by a range of medical and therapeutic teams, including psychiatry, psychology, speech and language therapy.

The service sits in the Mental Health and Learning Disability Directorate within Betsi Cadwaladr University Health Board.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

Overall we found that Tan y Coed was providing patients with a positive patient experience. We observed staff engaging with patients in a caring and respectful manner at all times.

Patients were able to provide their feedback through regular service user group meetings, with evidence of actions taken based on this feedback.

We identified a small number of improvements to further promote a quality patient experience.

We spoke to some patients and observed numerous interactions between staff and patients as part of forming a view on the quality of patient experience.

Staying healthy

We found good evidence of standardised physical health care bundles[1] in all patient care records that we reviewed. These had been reviewed at appropriate intervals, with the exception of one plan where we noted there was confusion in relation to the frequency of blood sugar monitoring.

GP services are contracted through a local GP practice who attend the wider Bryn y Neuadd site on a weekly basis. Ward staff were complimentary about the service provided by the practice.

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[1] Care bundles are used across healthcare settings with the aim of cohesively preventing and managing different health conditions

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We reviewed a sample of three health passports[2] and found that these were comprehensive and up-to-date. This ensures that other health professionals are able to quickly identify the care preferences and medical needs of patients in a timely and effective manner.

Staff told us that access to other health professionals is arranged when required. For example, we confirmed patients are able to access the community dental health team based at the Bryn y Neuadd site.

> Improvement needed
>
> The Health Board must ensure that staff knowledge in relation to the frequency of individual patient blood monitoring is clarified.

Dignified care

We observed kind and respectful interactions between staff and patients at all times throughout the course of the inspection.

The environment benefited from a small number of patients residing in each bungalow, with space across the unit maximised for individuals to all have access to their own bedrooms and smaller, shared facilities.

All patients had their own bedrooms and we found that some rooms had been personalised to provide a more homely feel. However, we noted that other rooms lacked a sense of personalisation.

We found that patients were assisted with their personal hygiene needs when required and that staff were responsive in meeting these needs. For example, we observed one patient requesting a shave, who was then promptly helped by a member of staff.

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[2] The hospital passport is designed to give hospital staff helpful information that isn't only about illness and health, but likes, dislikes and preferences.

Visiting had re-started following its pause during the pandemic. Patients were able to see relatives in a designated building a short distance from the unit. We were told that this had been welcomed by patients and their relatives.

> Improvement needed
>
> The Health Board should explore creative ways to enable patients to personalise their rooms during their stay at the Unit.

Patient information

We did not see information relating to the Putting Things Right[3] scheme or to the health boards own feedback process on display. However, we confirmed that there were suitable provision for this patient group. Patients had access to advocacy services to support them in decisions relating to the care and treatment. We also confirmed that there was an effective service user group in operation, which met the needs of the patient group in a timely and consistent manner.

Communicating effectively

We observed staff engaging with patients at a suitable pace and communication style according to their needs. We also noted that a first language Welsh speaking patient was able to hold conversations in Welsh with a number of staff.

The patients that we spoke with told us about some of the activities that they like to participate in and we found that activity schedules had been tailored to meet these needs.

We found evidence that patients were encouraged to attend multi-disciplinary team (MDT) meetings and service user group meetings. Relatives were invited to attend where appropriate.

3

Individual care

Planning care to promote independence

Staff we spoke with had an in-depth knowledge of the patients, which demonstrated a commitment towards providing patients with individualised care.

We found that therapeutic support services (TSS) scheduled a range of on-site activities for patients on a weekly time-tabled basis. It was positive to note that patient wishes from the service user group directly fed into the activity offering supported by TSS and the unit.

We were told that there was no dedicated occupational therapy service (OT) available on the unit, instead the resource operated across the wider Bryn y Neuadd site on a referral basis. In one patient record that we reviewed, we noted that there was a lack of sensory assessment for the patient, which highlighted a potential gap in service provision. We also noted that a lack of provision of OT services was highlighted as part of the units recent ward accreditation.

We found that there were active discharge planning arrangements in place for patients who were ready for discharge. We confirmed that decisions in relation to discharge and future placements were discussed with the patients, and relatives where appropriate, as part of their MDT reviews.

We noted that one patient had expressed dissatisfaction with their intended placement. However we were informed that proactive steps had been taken by the unit to assess the on-going suitability of the placement. In this instance unit staff had visited the intended premises. Unit management assured us that the patient would remain at the centre of the decision making process to ensure their needs and wishes were acknowledged.

We observed staff respecting patient privacy. For example, by understanding when patients preferred their own space and facilitating this whilst maintaining appropriate levels of observation.

Improvement needed

The Health Board must review the capacity of its occupational therapy service at the unit to ensure that patient needs are fully met.

People's rights

We reviewed a sample of three patient records and found that all patients who were subject to Deprivation of Liberty Safeguards (DoLS)[4] had received timely assessments. All patients had access to advocacy services, although we were told that access to advocacy is used by some patients more than others.

Staff told us that patients are invited to be part of their MDT meetings and that the involvement of family members of advocates was encouraged where possible. One patient confirmed that they had been invited to their MDT meeting, but had declined on the most recent occasion.

Listening and learning from feedback

It was positive to find that therapeutic support services had resumed service user group meetings, which we were told had been paused during the pandemic. We found that the group enabled patients to voice their views and opinions on a range of topics, including how safe they feel, what they would like to see improved and views on the activities provided.

The meetings had been held regularly and contained clear outcomes for patients. There were minutes written after each meeting, which made use of symbol based communication to help patients to understand.

4

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

Overall we found that Tan y Coed was providing patients with a good level of safe an effective care. We observed direct care needs being met at all times by a staff team who had an in depth knowledge of individual patient preferences and needs.

However, we identified some areas for improvement in relation to care and treatment planning, and the need to implement an audit programme to monitor these.

Safe care

Managing risk and promoting health and safety

We found that the outside environment and interior of each of the bungalows was in generally good condition and met the needs of the patients.

However, we found that bungalow three was awaiting urgent remedial works. As a result, two patients had been temporarily located in bungalow two, which was co-located with the unit manager's office. We confirmed that remedial works were due to start imminently and that there were active plans in place to re-locate these two patients to a more suitable location on the unit.

The environmental risk assessment had been reviewed the month prior to the inspection, however, consideration had not been given to the risk of patients being able to access sharp items. We noted an inconsistent approach to securing these items that could potentially compromise the safety of staff and patients. Whilst we were told that this risk was mitigated by 1-1 observations, a consistent, risk assessed approach must be adopted towards the storage of these objects.

Storage of kitchen detergents must also be COSHH[5] risk assessed in all areas of the unit.

We checked up to date ligature risk assessments. Whilst these appeared to be comprehensive, we found some inconsistencies which must be reviewed. These include:

- Each assessment and action plan identified areas where a review is required of a ligature risk, and alternative arrangements are to be considered, but no dates of action were recorded

- Where reference to alternative arrangements is documented, it is not clear that any follow-up action has been taken, with the exception of maintaining observations.

We identified a fire extinguisher located in bungalow two that had not been serviced since February 2020. The need for annual servicing of fire extinguishers had not been identified as part of a recent fire risk assessment. We immediately raised this with management to ensure prompt action was taken.

We found that emergency resuscitation kit checks were undertaken using an electronic system and that these checks had been undertaken on a regular basis. We noted that the adrenalin within the resuscitation kit was expiring during the month of the inspection (October 2021). We brought this to the attention of management so that a replacement could be ordered in a timely manner.

> **Improvement needed**
>
> The Health Board must:
>
> - Provide HIW with an updated schedule for the completion of the on-going remedial works at the unit.
>
> - Review the environmental risk assessment to ensure that all risks have been identified and mitigated.

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[5] Control of substances hazardous to human health

- Review the COSHH risk assessment to ensure that all risks have been identified and mitigated.

- Review the ligature risk assessments to ensure that the follow-up actions have been appropriately actioned and recorded.

Infection prevention and control

We found a range of infection, prevention and control policies, processes and procedures were in place to protect staff, patients and visitors. In addition there were a number of audits in place to monitor and review compliance with these policies.

Overall, we found the environment to be clean and tidy. There were some minor cleanliness issues that we brought to the attention of staff who immediately remedied these. We observed domestic services staff attending and cleaning the bungalows at the time of our inspection.

We reviewed a sample of cleaning records and schedules. We found evidence that staff were not completing the schedules in full, particularly on night shifts. In response, staff told us that there are occasions when cleaning is not undertaken to protect patients sleep. We emphasised the need to maintain complete and accurate cleaning schedules and the requiremem to note in full the reasons why cleaning was not rescheduled or undertaken.

It was positive to note that there had been no patient cases of COVID-19 on the unit throughout the pandemic. We found that staff and patients had received the COVID-19 vaccination. We saw that there was access to appropriate personal protective equipment (PPE) in all bungalows and staff were observed wearing this correctly at all times.

We found that there was a dedicated visiting space, which had its own visiting policy and risk assessment. This ensures patients can receive visitors in a safe environment.

We reviewed a sample of IPC related audits, including hand hygiene, and found high levels of compliance. These were supported by regular ward manager and matron audits.

> **Improvement needed**
>
> The Health Board must ensure that the cleaning schedules have been completed fully, including reasons why areas may not have been cleaned.

Nutrition and hydration

We found that patients had access to a small range of daily meal options, which catered for different dietary requirements and preferences. We saw examples of preferences being taken into account through the service user group meetings.

We observed that patients were supported in a flexible manner at meal times. This helped to meet the nutritional needs of patients, as they were able to eat in an unhurried and individualised manner.

We were informed that the family of one patient regularly provided meals that embraced the family's culture. To support this, arrangments had been made to allow the family and patient to enjoy the meals together on the Bryn y Neuadd site.

We reviewed a sample of three patient records and found that nutritional needs had been assessed, with evidence of a recent review and monitoring of weight, bowel movement and body mass index.

We confirmed that access to speech and language therapy (SALT) services was available and we saw evidence in the sample of records that we reviewed that relevant assessments had been completed.

We noted that staff provided snacks to patients in between meal times and that patients could access the on-site canteen with staff members.

Medicines management

We reviewed three medication charts and found that these were completed appropriately, including notes and reasons where medications had been refused.

We found that there was an appropriate electronic medicines management system in place at the unit. We confirmed that nursing staff had responsibility for checking and ordering medication on a weekly basis and there was evidence of staff checking stock as it arrived at the unit.

Stock control of clonazepam, which is a controlled drug, required improvement. We identified it was not always checked and counter signed in line with controlled

drugs procedures. We also noted incomplete stock control records for the same drug.

We saw evidence that patients had individualised medications management plans and medication reviews in place. However, there was no indication that these plans had been discussed with patients to help them understand what medicines they take and their effects.

In the sample of patient records that we reviewed, we found that there were low uses of PRN medication[6] on the unit and we found no evidence of an overuse or reliance on this as required sedation.

We found evidence of an appropriate pain assessment tool being used on the unit, which assists in the management of pain for patients who may be unable clearly articulate their needs.

Improvement needed

The Health Board must ensure that:

- Standards for stock control controlled drugs are maintained in accordance with its own medications management policy

- Appropriate communication with patients regarding their medication plan is undertaken and suitably documented.

Safeguarding children and adults at risk

The staff we spoke with were aware of how to access the local safeguarding procedure. All staff told us that they felt supported by management and confirmed they would feel comfortable to raise any concerns they had.

We saw training records that showed that the vast majority of staff had completed adult safeguarding training.

There we no open safeguarding cases at the time of the inspection.

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[6] Medication that is administered when required by the patient, rather than at scheduled times.

Effective care

Safe and clinically effective care

We found that all patients had care and treatment plans in place, which were coherent and had been subject to MDT review. However, care planning could be strengthened by placing emphasis on the voice of the patient (and relatives where appropriate) and ensuring a person-centred approach towards goals and objectives. We noted:

- Care plan goals and objectives did not always contain a strength and independence focus, but instead were problem orientated

- In one record, the clinical review contained a review of incidents. However, the community and engagement section had been copied and pasted from a previous version. Therefore, the same goal was in place for a three month period

- In another record, there was a breadth of positive understanding and clinical formulation that gave a real sense of understanding of this patient, yet this was not translated into their care plan goals and objectives

- Staff expressed a clear understanding of patient wishes. However, there were missed opportunities to translate these into care plan goal and objectives.

The unit told us that aspects of care planning were identified as an area to strengthen in their recent ward accreditation and that they are keen to strengthen this within the staffing team.

We advised the health board to look at learning from previous audits (e.g. Welsh Government Delivery Unit All-Wales Care and Treatment Plan audit) undertaken on the site to aid and facilitate learning where applicable.

We further reviewed a sample of patient records and made the following observations regarding the documentation of evidence in relation to the management of patients care and treatment needs:

- In one record, there was no documented evidence that a sepsis screen had been undertaken, despite a high NEWS[7] score

- There was a strong urine odour in one of the bungalows on the evening of our arrival. We later found that a patient had recently became incontinent, as a result of a hernia. However, there was a lack of documented evidence on file to indicate how this had been investigated and diagnosed

- One incident involved a patient viewing sensitive material. Whilst we saw that an outcome had been documented, we considered there to be a lack of documented investigation or evidence of appropriate support or intervention following this incident.

> **Improvement needed**
>
> The Health Board must undertake an audit of the care and treatment plans on the unit, with a view to:
>
> - Ensuring that plans and objectives are goal and person centred
>
> - Ensuring evidence relating to care and treatment is appropriately and clearly documented at all times

Safe and clinically effective care – Behaviours that challenge

Upon our arrival at the unit and throughout the course of the inspection, the environment was calm and settled. We saw no evidence to indicate patients were distressed or overly challenging.

We saw evidence that patients were supported through use of a positive behavioural support (PBS) plan. This provided consistent information to help staff understand patients' likes, dislikes and causes for behaviours that challenge.

7

It was positive to note in the PBS plans we reviewed that proactive and reactive strategies had been considered, with effective formulations seen in relation to causes of identified behaviours. New staff on the unit were able to demonstrate their familiarity with the detail of these plans.

We confirmed that the strategies for managing behaviours that challenge had been considered in the sample of records that we viewed. However, in some cases there was a lack of evidence that care and treatment plans had been made accessible for patients to assist in their understanding and involvement in their care and treatment. Similarly, in two of the records, there was a lack of evidenced family involvement, despite staff confirming that there had been on-going family involvement.

We found that there was a minimal use of restrictive practice interventions (RPI's) on the unit, with staff using least restrictive de-escalation methods. Where physical interventions were deemed necessary, we found that these were documented in the patients care plans and that individual best interest decisions towards interventions were documented by the MDT.

It was positive to note that there was access to a behaviour analyst on the unit to support the MDT approach to supporting patients. We confirmed that all incidents of behaviours that challenge and interventions are recorded on behavioural charts. These are reviewed at weekly behaviour management support group (BMSG) meetings, with action plans drawn up where necessary.

We found that staffing on the unit permitted one to one care to be provided. We were told that this was used as an enabling experience for patients, whilst providing patients with the opportunity to undertake additional on and off site activities. However, through our observations, we considered the effectiveness of the one to one care whilst on the unit could be strengthened. This is to ensure that all interactions are consistently used as a positive form of engagement through an active model of care.

Improvement needed

The Health Board must ensure that care and treatment plans have been made accessible and communicated appropriately to patients (and relatives where applicable).

The Health Board must explore how one to one observations can be strengthened to ensure that they are consistently used as an active and positive form of engagement.

Quality improvement, research and innovation

It was positive to note that the unit had recently received its bronze accreditation as part of the Health Board's quality measure accreditation scheme. The Ward Manager and staff nurse who co-ordinated the accreditation demonstrated a clear knowledge of the unit's strengths and areas to improve upon.

Members of the unit and senior management that we spoke with spoke openly and were receptive to the suggestions and recommendations put forward by the HIW inspection team.

Record keeping

We found that patient files were structured and easy to navigate and that all members of the multi-disciplinary team recorded notes in a consistent format. This helps to ensure that there is a consistent approach to patient care.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

Overall we found a committed staff team, many of whom were long-standing members on the unit. The team was supported by a dedicated unit manager, who staff told us was supportive and visible on the unit.

We found good working relationships within the unit, other inpatient wards and the wider management structure within Bryn y Neuadd, with clear local governance arrangements in place to support this.

However, we have highlighted areas for improvement that aim to strengthen existing practice at an operational level. We also identified the need for the Health Board to support the unit at a strategic level by developing and implementing a clear service model and ethos.

Governance, leadership and accountability

Tan y Coed provides a residential rehabilitation service to its patients. However, we found that some legacy issues had resulted in a mixed service model, which had not been reviewed for some time. As a result, there was an inconsistent approach to the care provided on the unit based on patient profile. For example, the unit provides care to some older patients who would likely stay at the unit for the foreseeable future, but also to a younger patient group who require a more comprehensive and active offer of rehabilitative care to aid their transition back into the community.

We acknowledge that ward management have a vision for the future service and that some discussions had already taken place with staff and senior management to develop ideas.

The unit is managed on a day-to-day basis by a Band 7 ward manager and supported by two deputy ward managers, all of whom are registered nurses.

On our arrival at the unit, we found that there was an experienced Band 5 nurse in charge who was overseeing that particular night shift. The nurse was able to respond to all of our queries regarding patients in a clear and comprehensive manner, and was able to escalate and communicate our arrival to senior on-call management without difficulty or delay.

During our inspection we spoke to a range of staff on the unit. Feedback received from staff was overwhelmingly positive. Without exception, all staff told us that they felt supported in their roles and that there was visible and accessible management on the unit.

All staff told us that they would feel comfortable to raise any concerns that they had, which helps to demonstrate a positive culture on the unit.

We found a clear management structure and staff we spoke with were aware of the roles and responsibilities of senior colleagues. The ward manager was complimentary of the support provided by the clinical services manager, who was enthusiastic and proactive in delivering their role.

There were appropriate governance arrangements in place in the unit and the wider structure that it is part of. We observed meetings, reviewed meeting minutes, and found that there was a suitable day-to-day flow of information between the ward and senior management:

- Team meetings on the ward included a comprehensive and relevant agenda

- Daily inpatient meetings enabled the inpatient wards and units at Bryn y Neuadd to feedback any immediate issues or concerns to the clinical site manager

- Twice daily safety huddles across the site were focused and well attended. We observed issues being raised in the morning huddle, with an effective resolution to these issues being given at the huddle prior to the night shift.

Improvement needed

The Health Board must support the unit in developing and implementing a clear service model and ethos.

Staff and resources

Workforce

We reviewed a sample of staffing rotas, including an analysis report, and found no indication of staffing issues on the unit. The staffing numbers and skill mix appeared to be sufficient to meet patient needs and required observation levels. The staff we spoke with expressed positive comments in relation to staffing levels and the ability to provide patents with a good level of care on the unit. We found there to be a suitable process in place for the escalation of staffing issues

We found that there were a number long-standing and committed staff at the unit, which helps to provide important continuity of care for this patient group. There were a small number of nursing and healthcare assistant vacancies on the unit, but we noted that recruitment was progressing well.

We noted that there were a number of opportunities on the unit for the training and development of new and existing staff and the unit manager expressed an enthusiasm for this. We found that students are able to undertake placements on the unit as part their nurse training and we were told that the unit had previously been able to employ some of these students following their placements.

The unit manager placed emphasis on the importance of staff development. We found that a number of healthcare support workers had completed, or were in the process of completing, their diploma certifcates which enables them to progress onto a nurse training degree.

The unit had achieved a good level of compliance regarding mandatory training, with the majority of staff having achieved the health board standard of 85%. We explored the reasons why some staff members had fallen below the required level of compliance and were provided with appropriate reasons by the ward manager, which included staff who had very recently joined the unit, long term absences and the impact of COVID-19 on the delivery of face-to-face training.

We found that 72% of staff had an up-to-date personal appraisal development review (PADR). Whilst this was below the health board target of 85%, we were provided with appropriate reasons by the ward manager and noted that appraisals were on-going at the time of the inspection.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection

- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking

- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales

- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed

- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation

- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect hospitals

We have a variety of approaches available to us when we inspect NHS hospitals, including:

- In-depth single ward inspection: we undertake a thorough and detailed review of one ward

- Multi ward inspection: we visit a number of wards and departments within one hospital site to identify issues or themes which may apply to the whole hospital

- Multi hospital inspection: we visit a number of hospitals within the same health board to assess the governance and delivery of whole services.

Hospital inspections are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

We check how hospitals are meeting the Health and Care Standards 2015. We consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within hospitals.

Further detail about how HIW inspects the NHS can be found on our website.

HIW report template version 2

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
We found that the adrenalin within resuscitation kit was expiring during the month of the inspection (October 2021).	Expired medication may impact its upon effectiveness.	Whilst the adrenalin had not yet expired, we brought this to the attention of the Ward Manager so that they could re-order this ahead of its expiration.	The Ward Manager informed us that an order would be immediately placed for a replacement.
We identified that one of the fire extinguishers had not been serviced since February 2020 and the fire risk assessment did not identify the need to review the fire extinguishers in the bungalow concerned.	Potential risk to staff and patients in the event of a fire	We immediately brought this to the attention of ward and site management.	The issue was escalated to the health board fire safety / estates department

Appendix B – Immediate improvement plan

Hospital:

Ward/department:

Date of inspection:

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard	Service action	Responsible officer	Timescale
No immediate improvements were identified.				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role:

Date:

Appendix C – Improvement plan

Hospital: Bryn y Neuadd Hospital

Ward/department: Tan y Coed Unit

Date of inspection: 19-20 October 2021

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The Health Board must ensure that staff knowledge in relation to the frequency of individual patient blood monitoring is clarified.	1.1 Health promotion, protection and improvement	• Weekly recording form introduced (embedded), weekly blood sugar monitoring frequency clarified with staff. • Currently only required for identified patient. • Process will be introduced for future patients if clinically indicated.	Ward Manager. Matron.	Completed 25/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
The Health Board should explore creative ways to enable patients to personalise their rooms during their stay at the Unit.	4.1 Dignified Care	• The named nurse for each individual will regularly review the appropriateness of patient's room aligned to changing need and patient's wishes. • This will be reviewed at Multi-Disciplinary Team (MDT) meetings as part of the Care and Treatment Plan (CTP). • Other important people in a patient's life will be involved where appropriate, to support and explore ways of creating a personalised environment.	Ward Manager. Matron.	28/02/2022
The Health Board must review the capacity of its occupational therapy service at the unit to ensure that patient needs are fully met.	6.1 Planning Care to promote independence	• Occupational Therapy (OT) capacity will be prioritised across the site to ensure timely assessment and responsive care planning. • A meeting with Head of Operations and OT has been arranged to discuss capacity issues.	Head of Operations.	March 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		• SBAR to be developed and presented to the Divisional Senior Leadership Team to highlight any unresolved issues.		
Delivery of safe and effective care				
The Health Board must provide HIW with an updated schedule for the completion of the on-going remedial works at the unit.	2.1 Managing risk and promoting health and safety	• All works completed at Tan Y Coed and signed off on 19/11/2021.	Estates	Completed 19/11/2021
The Health Board must review the environmental risk assessment to ensure that all risks have been identified and mitigated.		• Environmental risk assessment has been reviewed. • Risk identified in relation to kitchen drawers not being locked. • Risk assessment completed on 25/11/2021: • All drawers on Tan Y Coed are now locked. • Individual risk assessments will be developed to enable access to cooking utensils when identified as a requirement.	Ward Manager. Matron.	Completed Completed Completed Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
				December 2021
The Health Board must review the COSHH risk assessment to ensure that all risks have been identified and mitigated.		• All risks identified, risk assessed and mitigated. Process in place to ensure regular review of COSHH risk assessment – reviewed on monthly ward accreditation audit.	Ward Manager. Matron	Completed 24/11/2021
The Health Board must review the ligature risk assessments to ensure that the follow-up actions have been appropriately actioned and recorded.		• Ligature Risk assessments were being reviewed at the time of the inspection. Monthly reviews in place by Ward Manager; these are sent monthly to Head of Nursing and Head of Operations for review.	Ward Manager. Matron	Completed
The Health Board must ensure that the cleaning schedules have been completed fully, including reasons why areas may not have been cleaned.	2.4 Infection Prevention and Control (IPC) and Decontamination	• Monitoring and review arrangements are being introduced to ensure adherence to cleaning schedules. • The cleaning schedule recording form will be redesigned to ensure reason cleaning has not been undertaken is clearly documented - this will be reviewed regularly via Ward Manager and Matron Audit.	Ward Manager. Matron	January 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
The Health Board must ensure that: • Standards for stock control controlled drugs are maintained in accordance with its own medications management policy • Appropriate communication with patients regarding their medication plan is undertaken and suitably documented.	2.6 Medicines Management	• All controlled drugs are stored in accordance with the BCUHB policy. • A project will commence in January 2022 developing communication with patients regarding their medication, using resources including Books Beyond Words, and Easy Health.	Ward Manager. Matron Staff across site/ Student nurses.	Completed March 2022
The Health Board must undertake an audit of the care and treatment plans on the unit, with a view to: • Ensuring that plans and objectives are goal and person centred • Ensuring evidence relating to care and treatment is appropriately and clearly documented at all times	3.1 Safe and Clinically Effective care	• Each patient on the ward will have a CTP review led by their Care Coordinator and MDT to ensure that plans and objectives demonstrate positive goal planning and are person centred. • CTPs will be reviewed monthly by the Care Coordinator to ensure evidence is provided against outcomes identified.	Ward Manager. Matron. Head of Nursing.	February 2022 Monthly December 2021
The Health Board must ensure that care and treatment plans have been made accessible and		• Care Coordinators will ensure that patients or their representatives are part of the development of their CTP, and that accessibility and	Head of Nursing	February 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
communicated appropriately to patients (and relatives where applicable).		understanding are key to the implementation of care. • Utilising inpatient forums, patients will support services to develop a more inclusive approach, to make care planning documentation accessible to patients across site.		February 2022
The Health Board must explore how one-to-one observations can be strengthened to ensure that they are consistently used as an active and positive form of engagement.		• A programme of work is being undertaken across the Division to enhance positive engagement as outlined in the Therapeutic Observation Policy. • Therapeutic observation documentation will be audited monthly aligned to the policy and will feed into MDT meetings to inform CTP planning and effectiveness of one-to-one support, engaging patients as part of their treatment journey. • Best practice around activity scheduling and therapeutic	Ward Manager. Matron. Head of Nursing LD.	February 2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		engagement to be used to inform CTPs.		
Quality of management and leadership				
The Health Board must support the unit in developing and implementing a clear service model and ethos	Governance, leadership and accountability	• Development of the model and ethos of Tan Y Coed has commenced and will continue to be developed in 2022. This is part of a wider LD transformation project.	Ward Manager. Matron. Clinical Operations Manager. LD Senior Leadership team	September 2022

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): CAROLE EVANSON,   MIKE SMITH

Job role: Interim Director of Operations MHLD, Interim Director of Nursing MHLD

Date: 30/11/ 2021

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

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee (QSE) **5th May 2022**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad Report Title:	Mental Health & Learning Disabilities (MHLD) an update regarding ligature reduction, cohorting and the divisional improvement plan
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Teresa Owen, Executive Director for Public Health, (Executive Lead for Mental Health and Learning Disabilities)
Awdur yr Adroddiad Report Author:	Mike Smith, Interim Director of Nursing, MHLD
Craffu blaenorol: **Prior Scrutiny:**	The paper has been written specifically for QSE
Atodiadau Appendices:	None

Argymhelliad / Recommendation:
The committee is asked:-   **To accept this update on the continued progression of previously reported issues namely,**   • **Ongoing ligature reduction and other harm reduction activity within the MHLD Division**   • **The ending of mixed cohorting in Hergest unit from 21.2.22, and the ongoing planning of the subsequent phases.**   • **Progres relating to the divisional improvement plan (presented at the last meeting of this Committee in March 2022).**

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion	x	Ar gyfer sicrwydd For Assurance	x	Er gwybodaeth For Information	
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 is an exception report to provide an update on the risks related to ligature incidents, mixed patient cohorting in the Hergest unit and overall Divisional improvement work in MHLD. This report highlights the key issues of significance to the Quality, Safety and Experience (QSE) Committee.

Cefndir / Background

This report updates the QSE Committee on the Divisional MHLD progress and delivery of previously reported issues and plans.

Ligature removal

One of the ongoing challenges presented to professionals working within the field of mental health, is managing the risks associated with self-injury. Ligatures have been a recognised risk for many years within mental health services. It is not the only risk present in our services, but sadly, hanging is recognized as the most common method of self-harm, which has resulted in fatal outcomes amongst inpatients nationally both suicidal and accidental.

An "All Wales" analysis of in-patient suicides over the past 5 years is currently underway. The Division is awaiting the final feedback from this analysis.

Between 2016 and 2018, the Health Board spent £8.56 million across adult Mental Health (MH) and Childrens & Adolescent Mental Health Services (CAMHS), adapting our estate and fixtures to remove the highest risks in inpatient areas. Using the best practice at the time, these were focused on "private" clinical areas such as bedrooms and bathrooms, because these were associated with a higher likelihood of being a location for self-injury, than communal areas. At that time, the height of ligature points from the floor was also factored into risk assessments, with the research showing that higher ligature points (above 0.7metre) presented the greatest risk. Behaviour has changed over time given the removal of ligature points, and the risk is now from lower level and non-fixed points.

We have previously reported that the there was an NHS safety alert March 2020 NHS England » Ligature and ligature point risk assessment tools and policies , regarding the practice of using risk assessment tools which led to (potentially erroneous) conclusions on the level of risk presented in the environment, where ligature points height from the floor was impacting on the risk formulation. The Care Quality Commission in England then provided advice to English Mental Health Trusts, around the regulatory approach to providers who do use height as an escalating factor in calculating risk level and the consequent practice of ligature removal and enforcement. The BCUHB MHLD Division was involved in the dialogue which followed across the UK. Healthcare Inspectorate Wales (HIW) were approached for guidance at that time, but no similar instruction had been provided to Health Boards in Wales. The MHLD division took part in active dialogue with English and Welsh Trusts to assess which risk assessment tools could best be utilised, because all of the accepted tools at that time used height as a multiplying and escalating factor to assess likelihood and impact.

In November 2020, following advice from other Mental Health Trusts we were collaborating with, the emerging position was to remove "height" as the escalating factor completely in all risk assessment processes was the emerging position. We reviewed all our control documents to remove height, and also reassessed our environmental risks and sought assurance from our inpatient areas.

The Division developed a fixed term project to support and implement the actions to reduce ligature risk across the Division.

This project plan identified 29 separate actions and programmes of work. 28 actions were completed by February 2022, and the remaining action is the audit in 2022 of the effectiveness of the actions completed.

The scope of this group's work includes:-

- A review of and audit of adherence with the acute care pathway (this was also reviewed and renamed the Harm reduction pathway) in light of the baseline audit.
- A review, refresh and relaunch via a whole divisional learning event of the therapeutic observation and engagement policy (Completed 22nd November)
- A ligature and anchor point risk reduction policy was drafted and ratified, and monthly ligature risk reduction meetings were established, reporting into Operational Leadership Meeting (OLM) and Divisional Quality, Safety & Experience (QSE).
- A high quality ligature risk reduction audit was commenced, to be revisited each year (as detailed above – the one outstanding action for 2022).

Necessary estates work has been undertaken and furniture replaced where needed. A ligature footprint was completed, to inform staff of any potential risks in their areas of work, and confirmation sought and received that all areas have ligature cutters and the staff know how to access and use them.   A sum of £230,531 was spent in 2021-22 to enable the actions to complete this project. Large capital works i.e. windows are excluded from this sum the sum reported herein being on top of that existing amount.

Larger capital works were also enabled to support the harm reduction activity, such as exchanging serviceable windows, which now were seen to present a higher risk. This work has cost £766,000 in 2021-22, and a further £528,000 expected cost in 2022-23.

It is important to note in this update that the Health Board has invested at least £9.7 million specifically in ligature harm reduction (some wider Board expenditure excluded), since 2016. This is only one part of the Health Board's investment to reduce avoidable patient harm.

Specific training around ligatures has been developed with the Divisional Training and Workforce group, to be provided to existing staff and to new staff on induction.

The ligature harm reduction project also considered the impact of ligature risk reduction presented by the equipment needed throughout the wards for mixed cohorting of functional older persons to the Hergest unit, and risk assessments around the use of profiling beds specifically were introduced in May 2021.   The senior leadership teams in MHLD now conduct walkabouts with a specific theme of risk reduction.

The final step for the project was to determine the effectiveness of the ligature audits and their mitigations through further audit as mentioned above.

The project and overall emphasis on ligature risks has resulted in a higher level of awareness and surveillance across the division as new risks emerge. For instance, soap dispensers, waste bins, notice boards within in-patient areas have all emerged as risks and all have been recently addressed.

The Division are sharing information through the Divisional Putting Things Right (PTR) weekly meeting and "learning from incidents" such as Rapid Learning Panels and 7 minute briefings. The Oxford learning events have been introduced as a standing item in the division's monthly QSE.

Furthermore, significant capital works have been planned and specified in partnership with our colleagues in Estates, and are now in the process of being delivered in the 20/22 capital programme. This is the removal and replacement of higher risk windows as identified in the new assessment

process (for example in patient bedrooms and private areas). This work is currently underway in the Heddfan unit (a relatively new environment) and this is being carefully managed, so as not to impact patient flow nor risk and disturb the ward environment. The work will then be completed in the Ablett unit in late 2022.

Removing environmental risks is only one aspect of reducing the risk of harm. Each person's risks are unique, although we do know that certain times such as the first 7 days after admission and the first three days after discharge tend to be higher risk times (The All Wales review mentioned above, may inform this). To effectively manage the risks faced by each individual, teams must develop an understanding of their unique profile. Building robust therapeutic relationships and producing accurate assessments of risk are an essential part our activity.

While ligatures have been a high profile risk, and a significant amount of work has been undertaken to reduce the associated risk, we are also continuing to monitor and address the other types of self-injury which occur in our inpatient environments (eg head banging, cutting and deliberate obstruction of airways). We are working within the division, to reduce the risk of cutting, by looking at safer alternatives to safety razors.

It is important to state that the risks cannot reasonably be totally eradicated. Indeed it is well recognised that this can be counter-productive There is an expectation that mental health organisations appraise the risk as described and then mitigate the risks proportionately and reasonably in a way that is describable and defensible. The approach that has been taken by the division so far is to make the inpatient environment as safe as possible, whilst balancing this with the need to treat individuals with humanity, preserve their dignity and support their recovery.

Mixed Cohorting of Older Adults with a Functional Mental illness within the Hergest Unit

As mentioned earlier, there has been a long standing issue within the Health Board, with the mixed cohorting of older adults with a functional mental illness being admitted in the West area - primarily to the Hergest unit. This was highlighted historically in the Holden report in 2013, as not being within the scope of current good practice due to both the risks to older adults and younger people of the mixed cohorting, the nature of staff skills and the nature of the environment.

Regrettably, because older people have remained routinely admitted to the Hergest unit, beds to support the needs of frailty associated with age were widely available within the general areas of the wards within Hergest.

Following a SUI in April 2021, the division had already introduced a thorough risk assessment of the use of profiling beds and had mitigations in place following this incident (as per the ligature work addressed above). The Older Adult (OA) pathway group were tasked with considering and planning the potential options to end mixed cohorting, however this group was stood down in the pandemic and restarted in November 2021.

An external SUI report of the April 2021 events in Hergest, concluded that the mixed cohorting, still in practice was a contributory factor to this incident. This report was received in the division and the Board in December 2021. The OA pathway group were tasked with urgently producing options to end this practice. They met in December 2021 and proposed that cohorting be planned to stop in Hergest unit via a four phase proposal :

- Phase 1 to stop admission to Hergest subject to acute care meeting discussion re clinical need and best interests

- Phase 2 to restore some admission capacity in the west area within specialist older peoples MH services in Cefni Hospital

- Phase 3 to propose to re-provide services above from Cefni hospital to the Hergest site in the former Gwalchmai ward

- Phase 4 to consider the long term strategy and need for the service in the West area as part of the division's estate work

Update

Phase 1 This <u>was enacted</u> from 21st February 2022 as an urgent change based on patient safety. The Health Board has committed to fulfilling all obligations, given the service change.

All Admissions since the 21st February have been to Ablett or to Heddfan with 1 exception. The profiling beds have been removed from the Hergest unit except 1 bed which has been retained and may be used if required in a side room, with the risk assessment in place for patients using this bed and the mitigation of 1:1 staffing also if this bed were to be utilized. (Profiling beds are occasionally needed for adults for instance, with comorbidity or bariatric needs but are utilised as described above within a side room. When the bed is not clinically needed they are "swapped out" for lower ligature beds with the profiling bed stored outside the ward area).

The OA pathway group considered that there may be a number of exceptions that could indicate, it may still be in the best interests of an older persons individual needs, to be admitted into Hergest. This decision was to be best made by the daily Acute Care meeting (ACM) in the division with the clinical advice from the OA "Home Treatment" team who know the patient and are best placed to make this clinical and risk decision. For this reason of assurance re the mitigations in place, the division has further required that any proposed exceptions are immediately escalated to Divisional Director(s) in the day time, MH silver on call at other times, and Datix entered as a an "inappropriate patient pathway".

The Divisional Director of Nursing in a walkabout in Heddfan (04.04.2022) met and spoke with people in the Older Adult wards who were from the West area. They were complimentary, and adaptations were being made for their visiting for e.g. "no problems seeing my family, but I do want to go home" and the facilities were said to be "beautiful, a very quiet and peaceful place" No formal concerns or complaints have been raised or received from relatives or patients as at 15.04.2022 regarding the diversion of admission to Ablett or Heddfan, which is of course discussed with patients and families by clinical staff in the pre admission process with the rationale explained. .

Phase 2

This work is being prepared. This will require 2 bathrooms in Cefni hospital (Cemlyn ward) to be built to enable the area to be managed separately from the other patients. This move was planned to be in March 2022, but has been further delayed to May 2022 because of Court of Protection proceedings which have primacy

Phases 3 and 4 are proposals that require much more detailed engagement and potential consultation (for example a totally different option may emerge from the consultation). This work is currently being supported by both the Board's planning and engagement colleagues and is in the developing stages of the project plan .

Divisional improvement update

The division has begun to implement the improvement plan together with partners in the Workforce & Organisational Development Division (Stronger Together) and the Transformation Division (Improvement) .

There has been considerable discussion prioritised by all, with a full face to face discussion and planning day on 1st April 2022 to enable the project planning. The days have been facilitated by Michael Shaw, Strategic Organisational Development Consultant.

 The first steps have focussed on the plan to address the "change enabling foundations", on which the improvement will build, and a full project plan is being developed.

To ensure timely progress, it has been agreed that the transformation team will secure an interim resource, embedded in their team (described below), whilst they recruit substantively to build their own capacity.

- Programme Lead – Directing and coordinating the short term effort described below and to shape the longer term transformation and improvement programme.
- Project manager 1 – Work package on "People" – A project wrap around recruitment drive (the division has over 200 front line vacancies in recruitment).
- Project manager 2 – Work package on "Estates" – To resolve issues around office and clinical areas being inappropriate.
- Project manager 3 – Work package on "Operating Model" – supporting the MHLD leadership team in their on-going engagement and with the Betsi wide operating model work.

The other fundamentals agreed were the ongoing need for a bespoke OD project to partly begin to address the numerous past legacy issues in the division (Holden, Ockenden, HASCAS). This will be in tandem with project 3 above.

Finally as a fundamental building block there is a need to drive a "Digital" work package, prioritising MHLD, the Division will first explore what support the Informatics team can provide as the plans are progressed.

The improvement plan has been updated to reflect this work, and will be shared at the next QSE meeting if the Committee agrees.

Asesu a Dadansoddi / Assessment & Analysis

Ligature removal

The division has maintained a systematic plan of improvement of its risk assessment, harm reduction pathway, therapeutic engagement and observation policy and other programmes of work

including ligature risk removal, estates and equipment work described herein. Members of the division attend the All Wales Senior Nurses advisory group for MH and the All Wales Serious Untoward Incident (SUI) group, which is developing the practice principles and guidance. The Divisional Director of Nursing's team have been part of an All Wales rapid review of in-patient suicides considering the last 5 years data to share learning, and to inform a coherent all-Wales approach.

Mixed cohorting

The division stopped the routine admission of and mixed cohorting of older adults with a functional mental illness into the Hergest unit from the 21.2.22. There has been 1 exception to this in March, achieved safely with mitigations and there is now further enhanced divisional scrutiny of all exceptions with no repetition.

The plan to redevelop Cemlyn ward in Cefni hospital with 2 new bathing areas to allow admission of older people back into the West area, has been impacted by covid outbreaks and COP proceedings.

There are detailed plans emerging for the consultation and engagement for the proposed stages 3 & 4 to improve patient care and journey in the West area of the division longer term.

Divisional improvement

There has been considerable engagement with and support from the Stronger Together and Transformation teams, to assist the division to deliver the divisional improvement approach reported to QSE on the 1st March. The "Change enabling foundations" are identified and agreed with resource being now identified and deployed to develop the project plan**.**

Goblygiadau Strategol / Strategy Implications

The division will need to refresh its strategy, when we have the confirmation of the Ablett unit redevelopment proposal being approved and agreed capital support from Welsh Government. This will enable the division to consider with stakeholders the need across the whole of North Wales for in-patient care, and the specific needs within the West area for a modern and appropriate in-patient environment (MHLD).

Opsiynau a ystyriwyd / Options considered

None appropriate

Goblygiadau Ariannol / Financial Implications

The cost of ligature improvement work in 21-22 for the MHLD division was £230,531 excluding Capital. There is further planned capital investment in the 2022-23 Capital plan for Heddfan and Ablett unit window replacement.

Dadansoddiad Risk / Risk Analysis

The risk presented by ligature for MHLD inpatients is described in the risk register as a tier 1 risk, being managed in the MHLD division with the mitigation actions described in this update paper. The risk was discussed within the March corporate risk group, and from this a wider BCU Health Board-wide risk is in development.

The risk presented to adults in the Hergest units by mixed cohorting has diminished significantly due to the change decision taken on the 21.2.22 . This risk analysis was described in the draft EQIA.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Asesiad Effaith / Impact Assessment

Clinical Effectiveness Group - Chair's Report to QSE

Alert Assurance Achievement (AAA) report

Reporting Group	
Name of Reporting Group	Clinical Effectiveness Group (CEG)
Responsible Director	Dr Conrad Wareham, Deputy Medical Director (report submitted by Chair of CEG)
Date of meetings	14th April 2022
Version number	1
Appendices	N/A

Reporting To	
Name of meeting	Quality, Safety and Experience (QSE) Committee
Date of meeting	3rd May 2022
Presented by	Dr Conrad Wareham

1. Alert – include all critical issues and issues for escalation

- The April Clinical Effectiveness Group (CEG) meeting was quorate, however due to low numbers in attendance on previous dates, the day of the meeting had now been changed to a Tuesday, moving forward, which will be monitored to ensure attendance is improved.

  There were concerns noted that several actions such as completion of the Terms of Reference (TOR) and NICE Policy and Terms of Reference, could not be completed due to the need for clarification of organisational structure review.

  Action:

  To bring them back to the June CEG meeting, when the new structure was confirmed and the documents could be finalised for review and approval for presenting at the following Quality, Safety Experience (QSE) Committee.

- There was a concern raised that the Ultrasound Governance Group have not had medical representation within the group, and Overarching Radiation Protection Committee which that group reports to, had asked to bring this to

CEG for guidance in who should be supporting this clinical component. Need clinical users as some governance issues around ultrasound, how they identify and who should it be, which only meets once a quarter, so not a heavy commitment.

Action:

To bring back as an agenda item at June meeting, with paper and proposal steps that need to happen, this was agreed for Helen Hughes, Professional Service Manager Radiography, to present.

2. **Assurance** – include a summary of all activity of the group for assurance

The agenda items are summarised below:
The following Chairs reports were received and included in the meeting papers sent to all members prior to the meeting. The authors presenting were not present for the first four noted.

- Reducing Avoidable Mortality Steering Group
- East Locality Clinical Effectiveness Group
- Central Locality Clinical Effectiveness Group
- West Locality Clinical Effectiveness Group
- Medical Education

The chair asked for the papers to be noted, and referred to each one for any points the group wanted noting – nothing was raised.

Draft audit plan was brought to Clinical Effectiveness Group for discussion and to confirm that it would be presented at the Quality, Safety and Experience Group on 3rd May. Tier 1 are mandated audits to be completed and submitted to Welsh Government, and Tier 2 audits significance is that they align as much as possible with organisation priorities and risks. There is unclear area around this tier for audits that require accreditations in house, which were not included in the list for this year. he approach we have taken.

This raised discussion where they should be as if not labelled as Tier 2 that they would still be completed as requirement to be done. A decision was made that any audits that fitted this criteria, would be captured within the Cycle of Business (COB) quarterly for feedback to be given on progress and on target to complete for accreditation.

There was a number of policies circulated in advance of the meeting for review and approval, which were noted as read and approved due to meeting being quorate. There were three policies that had not submitted papers in time, which were referred to June.

It was noted that Pathway for Prescribing Domperidone was to be put on hold as there were points needed to be clarified, once these were done, can be resubmitted.

Standard Agenda Items

- Quarter 2 Clinical Effectiveness Report & Quarter 3 Clinical Effectiveness Report – (b/f February – for noting) to be taken to 3rd May QSE
- Draft Clinical Audit Annual Plan 2022/2023 for discussion and to be taken to 3rd May QSE for ratification
- Research & Development Update (verbal update) no comments or actions noted
- Quarterly Mortality Report – no comments or actioned were raised
- HCAI Covid Death Review Process for Agreement – to be presented at June CEG

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3. Achievement – include any significant achievements and outcomes

Reducing Avoidable Mortality Steering Group

- The Framework Panel are now a regular fixture and meet fortnightly. There is a huge potential in this panel for disseminating learning – and a Comms strategy around this is being discussed and evolved. The Panel also allows the opportunity for organisational memory and will produce summative reports.

The current themes emerging:

- Acute Stroke Care- deep dive in terms of triangulating ONS, CHKS, cases being prepared to highlight some themes around Acute Stroke Provision and time to thrombolysis.
- DNACPR – large percentage of ME cases around this- particularly in light of Covid-visiting restrictions etc. Ben Thomas is doing a huge amount of work around this- so aiming to dovetail into his work rather than create another work stream- but have feedback into the Panel.
- Palliative Care- again on similar lines to above – emerges in multiple areas in ME reports – Gemma Lewis and Alison Foster are looking at this across North Wales- aiming again to feed into the Panel and not duplicate but represent work ongoing and try and disseminate and network support for these initiatives.
- Contribute to National Meeting – Will be presenting the BCUHB interpretation of the Framework- and the particular strength of developing a network and lining up right to the M&M's. The model we are trying to achieve is ambitious- but the potential gains in having a whole system approach to learning and the ability to cascade across BCUHB is worth the efforts in my opinion.
- There has been significant work around embedding the new Datix module. The aim is to have ALL mortality reviews are completed on this module – training throughout the Health Board has been distributed improve uptake. It is potentially the only 'paperless' review system in Wales and hopefully this functionality will improve engagement.

East local Clinical Effectiveness Group

Medicine

- Dr Orod Osanlou, Consultant Physician, Site Innovation Lead, Acute Medicine, has been recognised for his tireless efforts for the biggest vaccine trial in Wales.

Surgery

- Elective Inpatient Orthopaedic Surgery – Inpatient activity restarted on the 17th February.
- Roll Out of EPRO – EPRO is a digital dictation system which allows our admin teams to produce URGENT/SPECIFIC letters and eliminate typing delays.

Emergency Medicine

- Commencement of criteria led discharge competencies on AMU SS – training programme in place with consultant support and engagement.
- Recruitment – A number of senior ED nurses have been appointed, funded through the ED business case. First physician associate has started within ED, managing her own case load.

Other achievements

- We are pleased to announce that Mrs Geeta Kumar has been appointed to the post of National Clinical Lead for Planned Care Programme in Gynaecology in Wales.
- Human Factors Training – has gained speed. HF steering group is regularly attended by Geeta Kumar, representative for the East. There is a core HF MDT group being identified for training. The group were asked to identify those member of staff who may be interested, especially within nursing and our allied professional group—work progressing rapidly with planned training by AQUA.

Central CEG

- Recognition in December 2021 from Glyndwr University to Professor Hobson for his commitment and contributions towards research and education. Professor Hobson has been deeply involved in research surrounding Parkinson's disease and other movement disorders and neurocognitive disorders for several years. He has also played a crucial role in supporting the Movement Disorder Service in YGC clinically and educationally.

- A new Frailty service has commenced in YGC Emergency Quadrant on 9th Feb 2022 with EDOU as the footprint for the Frailty Unit. It is envisaged that the service will improve quality of care for older (≥ 75yrs) people with moderate frailty and co-morbidities offering Comprehensive Geriatric Assessment (CGA) and focussed rehabilitative interventions to reduce length of stay and facilitate prompter discharge with community support. Formal evaluation of the service will be undertaken in due course.

West Quality and Safety/ Clinical Effectiveness Group

- Co-location of AMU services has been achieved

Medical Education

- A pan-BCUHB medical education 'away day' was held in late 2021 with the whole medical education team invited. This work has co-produced a draft vision and strategy with a wide range of education leaders, management and administration

colleagues. It has produced a list of priorities and this has formed the basis of continuing pan-BCUHB medical education team meetings and work.

- Advocate of Well-being and Safe-working appointed – this role is to provide a further avenue for support of doctors around their well-being, safe hours of working and psychological safety. It is not intended to replace existing governance frameworks in the HB

- Health Board agreement to fund a 12 place new Physician Associate graduate programme. The PA Steering Group will set standards and oversee the quality of these placements with the intent of mirroring the FY programme for doctors and thus developing safe and supported PAs for permanent roles in the HB

- Health Board agreement to fund a PA Programme Lead sitting in Med Ed to oversee the above and the BU student course to full employment

- SEREN Project. Existing excellent work for this widening access programme between WG, Higher Education and the HB for school pupils has now been rolled out to all HB sites and now includes dentistry. Local teams have really worked inspirationally on this and should be congratulated
- Bespoke courses for example IMPACT (medicine), Excellence in Surgical Supervision, Non-Operative Technical Skills, Transformative Medical Reflection, Acute Common Stem courses amongst others have been hosted and funded by medical education

- Master's Level Medical Education module – 4th running of the course as part of our ongoing faculty development programme has meant further colleagues stepping forward for important medical education leadership roles and a real Community of Practice amongst the medical education team across the Health Board. Plus bespoke 2 day leadership course for all junior doctors leads across BCU to develop their skills, support them in their roles and also as a thank you for giving up their time

Review of Quality Governance Arrangements – Betsi Cadwaladr University Health Board

Audit year: 2019

Date issued: March 2022

Document reference: 2471A2021-22

Contents

Summary report

About this report

1 Quality should be at the 'heart' of all aspects of healthcare and putting quality and patient safety above all else is one of the core values underpinning the NHS in Wales. Poor quality care can also be costly in terms of harm, waste, and variation. NHS organisations and the individuals who work in them need to have a sound governance framework in place to help ensure the delivery of safe, effective, and high-quality healthcare. A key purpose of these 'quality governance' arrangements is to help organisations and their staff both monitor and where necessary improve standards of care.

2 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act strengthens the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes but is not limited to the effectiveness and safety of health services and the experience of service users.

3 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships, and care settings. In recent years, our annual Structured Assessment work across Wales has pointed to various challenges, including the need to improve the flows of assurance around quality and safety, the oversight of clinical audit, and the tracking of regulation and inspection findings and recommendations. There have also been high profile concerns around quality of care and associated governance mechanisms in individual NHS bodies.

4 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality in responding to the COVID-19 pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with COVID-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.

5 Our audit examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting. Our review did not include assessment of specific ongoing quality concerns or complaints. This report summarises the findings from our work at Betsi Cadwaladr University Health Board (the Health Board) carried out between May and August 2021. To test the 'floor to board' perspective, we examined the

arrangements for general surgical services, this included conducting a survey of operational staff working across general surgery. The survey findings are shown at **Appendix 2**.

6   As part of our audit approach, we have worked closely with Healthcare Inspectorate Wales (HIW) to ensure relevant information is shared and to prevent any duplication of activity. In accordance with COVID legislative requirements and guidance at the time of fieldwork, all audit work was undertaken remotely.

Key messages

7   Overall, we found that the **Health Board is taking steps to improve quality governance by redeveloping its Quality Improvement Strategy and plans, reviewing its governance processes and systems, and investing in and reorganising resources that support it. There is good Board and committee level scrutiny of quality information and reports. However, there are opportunities for improvement, such as ensuring the new quality priorities reflect quality and harm risks relating to current significant service pressures, establishing multidisciplinary mortality reviews, improving organisation-wide learning and addressing inconsistencies in resources for quality improvement activities.**

8   The Health Board is taking a proactive approach to refreshing its Quality Improvement Strategy and supporting quality framework and is seeking to manage quality risks operationally. It is investing in quality improvement and embedding its culture and behaviours through its Stronger Together programme. Corporate and operational quality and safety governance arrangements are being strengthened, for example through the Health Boards new integrated governance framework. The Health Board has adequate corporate and operational resources to support quality governance, which it is reorganising and strengthening to ensure consistency across the organisation and avoid silo working and duplication. The Board receives a good level of information to scrutinise harm from COVID-19 and the Health Board is taking steps to improve quality dashboards. The Quality, Safety and Experience Committee is well served with quality information, and this is resulting in a stronger focus on improvement.

9   However, there are opportunities for improvement. The Health Board's new Quality Improvement Strategy needs clear outcomes that can be monitored, and new quality priorities will need to reflect COVID-19 recovery plans. Whilst risk management arrangements are improving, we found variation in risk management resource and training at an operational level. We also found that the Health Board needs to better deploy its resources for quality improvement activities such as clinical audit and mortality reviews and ensure it demonstrates learning and impact from these activities. A relatively high proportion of Health Board staff responding to the NHS Wales staff survey said they had experienced bullying, harassment or abuse. Given less than half of the respondents felt the organisation takes effective action when it did occur, the Health Board needs better systems for managing,

addressing, and learning from these concerns. To reduce the risk of quality and safety issues being missed the Health Board needs to provide staff with guidance on using its new 'triple A' template, which highlights critical issues (Alert), summarises activity (Assurance) and outlines significant achievements (Achievements), especially setting out how much detail is expected and how to agree which issues should be escalated. Whilst the Health Board is taking steps to improve its quality and patient safety dashboards, further work is needed, and operational data analytics support needs to be reviewed. The measures in the integrated quality and performance report aligns with the NHS delivery framework, but there are no locally agreed quality measures or wider measures of performance such as for community services. The Health Board's also needs a stronger focus on outcomes, local measures, and the quality of wider of services that the Health Board delivers and commissions.

10   Noting the work which is already underway within the Health Board to strengthen quality governance arrangements, the improvement requirements highlighted in this report should be used to further focus that work, and to ensure that when concerns arise in specific areas, as they have within mental health and vascular services, the Health Board has the necessary arrangements to quickly identify and respond to them and to prevent similar issues occurring in future.

Recommendations

11   Recommendations arising from this audit are detailed in **Exhibit 1**. The Health Board's management response to these recommendations is summarised in **Appendix 1**.

Exhibit 1: recommendations

Recommendations
Quality and patient safety priorities
R1   We found that the Health Board did not formally review its quality improvement priorities in light of the consequences of COVID-19. The Health Board should ensure its new Quality Improvement Strategy sets out how the Health Board will manage and mitigate the potential harms associated with the COVID-19 pandemic.

Recommendations

Risk management training

R2   We found that not all operational staff are trained to record clinical and non-clinical risks and compile risk registers. The Health Board should ensure staff have adequate levels of risk management training so that they can confidently contribute to the risk identification and escalation process.

Quality improvement support

R3   The Health Board's Quality Improvement Hub (BCUQI) has developed a quality improvement database to allow staff to share, adopt and learn from existing quality improvement projects. However, we found that the database is not well used. The Health Board should promote and encourage routine use of the database by setting targets for participation, by keeping the level of engagement under regular review and by taking action if engagement is too low.

Clinical Audit

R4   The Health Board has restarted clinical audits after most activity was paused during the pandemic. The Health Board should look to use its programme of clinical audit work to focus on the risk of harm as a result of the pandemic. For example, to better understand the consequences of long waits or exacerbation of chronic conditions. The audits could be targeted at high-risk specialities.

Mortality reviews

R5   We found that mortality reviews are not reported to the QSE Committee in a timely manner. The Health Board should ensure the QSE committee receives a quarterly mortality review report, which highlights learning and what action has been taken.

R6   We found that, generally, mortality reviews are medically led, but there is an appetite for multidisciplinary mortality reviews. The Health Board should look to establish a system where a multidisciplinary mix of staff are routinely involved in mortality reviews.

Recommendations

Sharing learning and good practice

R7   The Health Board recognises that it does not yet have a process to systematically share learning across the organisation. The Health Board should use the new integrated governance framework and the Quality Improvement Hub (BCUQI) as tools to support organisational learning and sharing good practice across the organisation.

Values and behaviours

R8   Only 37.9% of Health Board staff responding to the NHS staff survey agreed or strongly agreed that the organisation takes effective action when bullying harassment or abuse occurred. The Health Board should review its systems for managing, addressing, and learning from the concerns of staff in relation to bullying, harassment, or abuse.

Complaint handling

R9   We found that operational teams did not know what proportion of staff had been trained to investigate complaints, incidents, and root cause analysis. The Health Board should review levels of complaints handling training across the organisation. If this shows shortfalls, the programme of training should be expanded.

Flows of information and assurance

R10   Less than half (42%) of respondents responding to our survey agreed or strongly agreed that they receive regular updates on patient feedback for their work area. Whilst patient feedback is shared with wards monthly, the Health Board needs to ensure all ward staff are aware of this feedback and that it is easily accessible to staff.

R11   The Health Board introduced a new reporting format (triple A) to improve the flow of quality assurance. But we found some variation in the levels of detail provided in the reports. To reduce the risk of quality and safety issues being missed or not correctly escalated the Health Board should provide staff with guidance on using the new template, especially setting out how much detail is expected and how to agree which issues are escalated.

Recommendations

Quality and patient safety performance measures

R12   We found that whilst the measures in the integrated performance report aligns with the NHS delivery framework, there are no locally agreed quality measures or wider measures such as for community services. Through the new Quality Improvement Strategy, the Health Board should review current quality measures with a view to developing measures that reflects the services it provides and commissions across primary, community and secondary care.

Detailed report

Organisational strategy for quality and patient safety

12   Our work considered the extent to which there are clearly defined priorities for quality and patient safety and effective mitigation of the risks to achieving them.

13   We found that **the Health Board is building its strategic approach to quality improvement and is managing quality risks corporately and operationally. But there are opportunities for improvement such as ensuring the new Quality Improvement Strategy has measurable outcomes, reduces the occurrence of concerns and incidents and responds to the increased direct and indirect of harm as a result of the pandemic.**

Quality and patient safety priorities

14   **The Health Board is taking a proactive approach to refreshing its Quality Improvement Strategy and supporting quality framework. However, there are opportunities to ensure the new strategy has clear outcomes that can be monitored.**

15   In 2017, the Board agreed a three-year quality and improvement strategy, which ended in March 2020. The strategy remains extant whilst the Health Board develops a new strategy. It sets out five quality improvement priorities, these are to:

- **Reduce mortality** – reduce avoidable deaths.
- **Reduce harm** – continuously seek out and reduce patient harm.
- **Improve reliability of care** – achieve the highest level of reliability for clinical care.
- **Deliver what matters most** – work in partnership with patients, carers, and families to meet all their needs and better their lives.
- **Deliver integrated care** – deliver innovative and integrated care close to home which supports and improves health, wellbeing, and independent living.

16   Work on the new Quality Improvement Strategy was paused to allow staff to respond to the COVID-19 pandemic. It was restarted in April 2021 but there have been further delays. The Health Board is expecting to finalise the new strategy by summer 2022. Although the strategy has been delayed, the Health Board has continued to review and refine its quality assurance and governance processes. The Health Board is reviewing, developing, and aligning key plans and frameworks which will support the new Quality Improvement Strategy. The following plans will be ready for approval at the same time as the strategy:

- Patient Safety Plan
- Patient and Carer Experience Plan
- Clinical Effectiveness Plan

- Quality Assurance Framework

17　In March 2020, Internal Audit issued a limited assurance report on the 2017-20 Quality Improvement Strategy. It highlighted several issues such as a lack of an implementation plan, lack of regular progress reporting and no formal launch. The review made two high priority recommendations. These related to ensuring clear monitoring and reporting arrangements for the next Quality Improvement Strategy and ensuring the data on ward welcome/quality boards are kept up to date. The Health Board has looked to strengthen its approach in developing its new strategy. The strategy will be accompanied by an implementation plan, delivered through divisional annual quality plans and the Health Board's new integrated governance arrangements (see paragraph 67) will provide oversight of the strategy's implementation. The new strategy is being developed with good internal stakeholder engagement, including operational staff and involvement from the Quality Safety and Experience (QSE) Committee which is helping to shape priorities and outcomes. The Health Board's 2021-22 Annual Plan sets out a vison to deliver 'high quality services, which deliver safe, compassionate and effective care' but it does not detail quality improvement priorities. However, since the Annual Plan was approved by the Board in July 2021, the Health Board has developed interim quality priorities and associated actions for 2021-22, these were approved by the QSE Committee in November 2021.

18　At the height of the pandemic, the Health Board did not formally review its existing quality priorities to reflect challenges posed by COVID-19. But operationally the general surgery services and acute division strengthened existing priorities to focus on infection prevention and control, maintain urgent surgical care, clinical prioritisation, and service recovery. There are significant challenges and service pressures ahead. As a result, the quality improvement priorities in the new strategy will need to reflect the context of resetting and recovering services and the consequences of delayed access across primary, community and acute services (**Recommendation 1**). There are also a range of well-documented quality concerns in specific areas such as mental health and vascular services, as well as increasing concerns relating to urology services. The strategic quality priorities will need to ensure that these issues are learnt from to prevent similar issues occurring in future.

19　Operationally, the three acute divisions[1] and associated general surgery services have quality and safety priorities and plans to deliver them, but we found inconsistencies. The priorities for two of the three acute divisions (Ysbyty Gwynedd and Wrexham Maelor) do not align with those in the previous Quality Improvement Strategy. This is mirrored in the general surgery services. Generally, quality priorities for the acute divisions and general surgery services are reviewed annually, but we found inconsistent methods for identifying them. These ranged from adopting the corporate quality and safety priorities to reviewing national

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[1] Ysbyty Glan Clwyd, Ysbyty Gwynedd and Wrexham Maelor Hospital.

standards and Welsh Government targets. Staff gave several reasons for the differences, which included unclear corporate priorities whilst the new strategy is developed and that services have some autonomy to set their own priorities. Whilst we accept the actions to deliver the priorities will be tailored to individual service areas, there should be a direct link to the corporately agreed priorities. The Health Board's intention to develop an overarching implementation plan for the new quality strategy with supporting divisional delivery plans should provide a mechanism to achieve this.

Risk management

20 **The Health Board is seeking to operationally manage quality risks and these link into divisional quality group meetings, but there are inconsistencies in the level of operational resources to support risk management and a need for further staff training.**

21 The Health Board is improving its risk management systems and in October 2020 launched its updated risk management strategy and policy. The policy appropriately covers both clinical and non-clinical risks and describes a low-risk appetite for patient and staff safety and quality and patient outcomes. The Health Board's Risk Management Group oversees risk management arrangements, specifically monitoring directorate level risks and the Corporate Risk Register (CRR) prior to scrutiny by the Audit Committee. The Health Board manages its risks through the Datix system, and the process is well documented in its risk management strategy. The new risk management process is still bedding in, we observed members of the QSE Committee seeking clarification on the format and management process for both the CRR and BAF.

22 In our 2020 Structured Assessment we reported that the Health Board introduced specific arrangements for managing COVID-19 risks supported by additional training for those leading command and control and workstreams. COVID-19 risks are now incorporated into and managed through the BAF and CRR.

23 Operationally, risks are reviewed by the secondary care management team, acute divisions and at a service level, for example at quality and patient safety meetings. We found that operational resources for risk management varies. For example, all acute divisions and most general surgery services have designated risk management leads (all except Ysbyty Gwynedd general surgery service). But only the leads at Ysbyty Gwynedd Acute Division and Wrexham Maelor General Surgery Service have protected time to fulfil their role. The risk management team's six members of staff provide support and training for operational staff although the team's capacity was reduced because of the need to respond to the pandemic. We also found inconsistencies in the levels of corporate support received and a need to ensure adequate support and training in risk management (**Recommendation 2**). Those we spoke to recognised and welcomed the improvements to risk management, but also felt further work was needed, this included further staff training in identifying risk.

Organisational culture and quality improvement

24   NHS organisations should be focused on continually improving the quality of care and using finite resources to achieve better outcomes and experiences for patients and service users. Our work considered the extent to which the Health Board is promoting a quality and patient-safety-focused culture, including improving compliance with statutory and mandatory training, participating in quality improvement processes that are integral with wider governance structures, listening and acting upon feedback from staff and patients, and learning lessons.

25   We found that **the Health Board is investing in quality improvement and is seeking to embed a positive culture and behaviours through its Stronger Together programme. But the Health Board needs to deploy its resources more effectively and ensure it demonstrates learning and impact from its activities.**

Quality improvement

The Health Board is driving a good approach to strengthen quality improvement but needs to maximise the value from clinical audit and mortality reviews.

Resources to support quality improvement

26   The Health Board is reviewing its quality improvement resources as part of a wider programme of change. The Health Board realised that the existing system of having three quality improvement teams (Nursing Quality Improvement Team, Medical Quality Improvement Team and Service Improvement Team) was not working effectively or being used as intended, in addition the teams were collectively holding a high number of vacancies (14.8 WTE). As such, the Health Board is currently establishing a Transformation and Improvement Team. Led by the Director of Transformation and Change, this team will centralise quality improvement, service improvement and project management office functions. The new team will incorporate the previous quality improvement functions, ensuring resources are strategically targeted.

27   Improvement in Practice is the national quality improvement training programme for NHS staff in Wales, it replaced Improving Quality Together (IQT) in January 2020. The goal of the programme is to develop quality improvement capability within NHS Wales using a common language for quality improvement. The Health Board delivers this programme locally and training is run throughout the year. Clinical staff deliver the programme, but during the pandemic they have found it difficult to be released from their clinical duties, although the training is now delivered virtually. Considering the size of the organisation, very few Health Board staff have completed this training, in total, 124 staff have completed the silver Improving Quality Together training and to date, 147 staff have completed the Improvement in Practice training.

28   The Health Board's Quality Improvement Hub (BCUQI) is a network to support staff with quality improvement through access to training, information and resources. Staff can also support Health Board Quality Improvement by sharing good practice and learning. To support training, BCUQI has developed a quality improvement database. The database allows staff to share, adopt and learn from existing quality improvement projects. However, the Health Board reported that the database is not well used, this being a consequence of having different improvement teams across the organisation and no central overview (**Recommendation 3**). This does not mean the Health Board does not take part in quality improvement projects, for example it runs a successful ward accreditation scheme and matrons conduct regular audits to identify ward-based issues and learning.

Clinical Audit

29   Clinical audit is an important way of providing assurance about the quality and safety of services. The Executive Medical Director is the executive lead for clinical audit and effectiveness. The Health Board has a clinical audit policy which is currently being reviewed, it was last reviewed in January 2020. The clinical audit plan for 2021-22 was approved by the Audit Committee in June 2021. The plan, which covers national (tier 1), corporate (tier 2), and local audits (tier 3), was also approved by the QSE Committee in July 2021. Whilst the plan has been approved, it remains a 'live' plan with some discussion about whether some tier 3 audits should be upgraded to tier 2 during the year. Most clinical audit activity was paused during the pandemic, with 2020-21 activity being carried forward into the clinical audit plan for 2021-22. Operationally, we found all acute divisions and general surgery services have clinical audit programmes, which cover tier 1-3 audits. The Health Board reported that audit activity is restarting gradually. As such, there is an opportunity for the Health Board to develop clinical audit work focusing on the risk of direct or indirect harm as a result of the pandemic (**Recommendation 4**).

30   The Health Board's Clinical Effectiveness Department supports operational staff to design and deliver audits relevant to their practice. It also offers training, for example a clinical audit e-learning module has been running for the past year and the team holds virtual cafes to support staff. The team employs 6.8 WTE staff but at the time of our review the team held two vacancies; for the Head of Clinical Effectiveness, which is being covered on an interim basis, and for a Clinical Effectiveness Facilitator. We also understand that the lead for clinical audit is retiring. This may present a further risk to the effective delivery of the clinical audit plan.

31   The Health Board recognises that the clinical effectiveness resource is not big enough to adequately support clinical audit and as a result the support offered by the team is variable. For national audits the team will project manage the audit and submit data when requested. But there is limited support for corporate and local audits, which generally includes data processing, some analysis and designing proformas. The level of support offered is agreed by the Head of Clinical

Effectiveness on a case-by-case basis. The Health Board is reviewing this resource and developing proposals to maximise existing resources within the quality and clinical effectiveness departments.

32   The Clinical Effectiveness Department keeps a database of clinical audits. To improve the process, the Health Board is implementing a recently purchased clinical audit management and tracking system. The system will allow the Health Board to capture tier 1-3 audit findings and monitor actions and compliance with clinical guidance for example guidance from the National Institute for Health and Care Excellence (NICE). The new clinical audit management system will make it easier to identify learning which can be triangulated with other sources of quality assurance. Progress against the clinical audit plan is reported quarterly to the QSE Committee and annually to the joint QSE and Audit Committee.

33   Aside from Glan Clwyd general surgery service, the acute divisions and general surgery services have systems for tracking clinical audits. Currently, these paper-based systems track programme delivery and actions to address findings. But there is a lack of consistency about which system is used, that being the divisional/service system, corporate system, or both. The new clinical audit management system will streamline and standardise this process at an operational and corporate level.

34   Generally, findings, learning and good practice from clinical audits is shared and discussed. For example, assurances flow to the QSE Committee through its Clinical Effectiveness sub-group and clinical effectiveness groups held by the acute divisions and Secondary Care Executive Team. Findings are discussed at site and service level for example through matron and managers meetings. However, services are facing operational pressures which can affect quality and outcomes. The Health Board should therefore strengthen how it uses clinical audit intelligence for assurance purposes.

Mortality reviews

35   Mortality review meetings provide a systematic approach for the peer review of patient deaths to reflect, learn and improve patient care. The Health Board is taking steps to improve mortality reviews. In October 2021, it appointed a Clinical Mortality Lead to lead on improving systems and processes and on clearing the Health Board's backlog of stage 2 mortality reviews.

36   Mortality reviews are a regular feature on the QSE Committee agenda, but reporting is not timely. In 2020-21, the committee only received mortality review reports covering the period between January and June 2020. It also received a separate report detailing COVID-19 mortality rates between March 2020 and February 2021. So far, in 2021-22, the committee has only received the 2020 mortality review annual report, covering January to December 2020. Whilst the pandemic has disrupted mortality reviews, the Health Board should be returning to routine and regular reporting. For continued assurance, the committee should

receive mortality review reports every quarter, which highlight learning and actions taken as a result (**Recommendation 5**).

37 Operationally, all three acute divisions and general surgery services have a programme of mortality review meetings. The findings are discussed at the clinical effectiveness groups, which are mirrored at divisional, secondary care and QSE Committee sub-group levels. During the pandemic, whilst the general surgery services sustained mortality review meetings, not all acute divisions did. Review meetings have since been reinstated. Generally, the review meetings are medically led but from our interviews there is an appetite for these to be multidisciplinary reviews (**Recommendation 6**).

38 Good practice and learning from mortality reviews is shared via several routes. For example, through the medical directors' weekly email, departmental briefings, quality, and safety meetings and at clinical conferences. But the Health Board recognises that it does not yet have a process to systematically share learning across sites (**Recommendation 7**). This is not unique to mortality reviews. Those we interviewed felt that more learning could be gleaned from mortality reviews, feeling that because the Health Board has a backlog of stage 2 mortality reviews, caused by COVID-19, there is an emphasis on 'getting them done' and less focus on understanding the learning. Notwithstanding the issues with timeliness of mortality reporting mentioned earlier, the Health Board is starting to improve its mortality review reporting in respect of learning and improvement actions, which can be shared through clinical effectiveness groups. Themes highlighted in the 2020 annual report included missing second signatures on do not attempt cardiopulmonary resuscitation paperwork and the condition of case notes.

Values and behaviour

39 **The Health Board is using its 'Stronger Together' organisational approach to improve values and behaviour, but there are opportunities for improvement.**

40 The Health Board is embarking on a major organisational development programme called Stronger Together, which focuses on improving quality, productivity, and engagement. Central to the programme is improving the organisation's culture by ensuring the right behaviours, structures and processes are in place. The 'discovery phase' of Stronger Together, which included staff engagement, lasted three months, ending in October 2021.

41 Our work revealed a mixed picture in relation to the culture around reporting errors, near misses or incidents and raising concerns. Of the staff who completed our survey[2], 77% agreed or strongly agreed that the organisation encourages staff to

[2] We invited operational staff working across general surgery services to take part in our online attitude survey about quality and patient safety arrangements. The Health Board publicised the survey on our behalf. Although the findings are unlikely to be representative of the views of all staff across general surgery services, we have used

report errors, near misses or incidents. Just over half (55%) of respondents agreed or strongly agreed that staff involved in an error, near miss or incident are treated fairly by the organisation. Two thirds of respondents (65%) agreed or strongly agreed that the organisation acts to ensure that errors, near misses or incidents do not happen again.

42   Staff are encouraged to report incidents, and at the time of our review the Health Board had just established a new serious incident's panel. The panel, which is jointly chaired by the Executive Director of Nursing and the Executive Medical Director, is convened within 24 hours of a serious incident and a rapid review is held with the team concerned. Overall, the rapid review is a supportive process to aid learning, which operational staff were positive about. But this process only works well when a culture of open, honest discussion is encouraged. Only a third (32%) of staff responding to our survey agreed or strongly agreed that communication between senior management and staff is effective. Learning from complaints and incidents is disseminated in several ways such as at putting things right, mortality meetings and ward managers meetings. But as highlighted earlier, whilst the Health Board shares learning locally, it does not yet have a systematic way of effectively sharing learning across sites and services.

43   Staff responding to the recent NHS Wales staff survey[3] reported their experiences of bullying, harassment, or abuse by a line manager (12%) or member of the public (16%) or a colleague (21%) over the past year. Given the proportion of respondents saying they had experienced this behaviour we would expect the Health Board to take action when it happened. But fewer than half (37.9%) agreed or strongly agreed that the organisation takes effective action when it did occur (**Recommendation 8**), indicating the need to strengthen focus on this important area.

44   All staff have access to the Datix system to report incidents and near misses. Acute division staff receive training on how to use the system to report concerns and near misses. However, training has been affected by COVID-19 and the work needed to prepare for the new all Wales Datix system which went live in July 2021. This has affected the Datix team's capacity to train although virtual training and support is available.

45   Statutory and mandatory training is important for ensuring staff and patient safety and wellbeing. In July 2021, the Health Board's mandatory training compliance was 83.39%, which is near the 85% target and one of the highest compliance rates in Wales. Whilst the compliance rate is positive, only 32% of general surgery staff responding to our survey agreed or strongly agreed that they have enough time at

them to illustrate particular issues. 164 members of general surgery staff responded to our survey.

[3] The NHS Wales staff survey ran for three weeks in November 2020 at the same time as the second surge in COVID-19 transmission and rising numbers of hospital admissions. The survey response rate was 18%.

work to complete any statutory and mandatory training. Although operational teams allot time for staff to complete training, teams should ensure adequate time is allowed.

46   Personal Appraisal and Development Reviews (PADR) is a two-way discussion which helps staff understand what is expected of them in their role and become more engaged and take responsibility of their own performance and development. The Health Board PADR rates have dipped slightly since the pandemic. In July 2021, the Health Board achieved 69.4% against a target of 85%. The Health Board plans to improve compliance rates through communications and tailoring support for areas with especially low compliance rates.

Listening and learning from feedback

47   **The Health Board has a good approach to listening and learning from feedback, which it is seeking to strengthen further. However, the Health Board needs to ensure learning is consistently triangulated, shared, acted on and embedded, and that staff are informed of feedback.**

Patient Experience

48   The Health Board's Patient and User Experience Strategy (2019-22), which sets out how it collects and uses patient and user feedback is under review. The redeveloped strategy, called the Patient and Carer Experience Strategic Plan, will support the new Quality Improvement Strategy. The Health Board expects the new plan will be finalised by summer 2022.

49   The Quality Safety and Experience Committee (QSE) receives a quarterly Patient and Carer Experience report, which covers complaints performance, ombudsman cases and an update on patient feedback. This report identifies lessons learned, emerging themes and remedial actions taken. The committee also receives an assurance report from its Patient and Carer Experience sub-group, which is presented in the Health Board's 'triple A' report format. The Executive Team's weekly quality bulletin also includes high-level details about complaints, serious incidents and never events.

50   The Health Board's Patient Experience Team has 17.8 WTE members of staff and supports services to capture feedback. The Health Board also has a Patient Advice and Liaison Support Service (PALS) which facilitates patient and carer feedback with a view to early resolution. There are three PALS officers for each locality. PALS officers meet as a team to share learning and experience but also meet with the wider Patient Experience Team, so they are not working in isolation. To further enhance the patient experience resource and build expertise throughout the organisation, the Health Board is recruiting 100 patient experience champions. The champions will be a team of multidisciplinary staff volunteers based in each clinical team. The initiative will increase ward level visibility and ownership of patient experience activities. Currently, the Patient Experience Team reports to the acute

divisions, who report directly to the QSE Committee's Patient and Carer Experience sub-group on patient experience matters. This means reporting by-passes both the secondary care management structure and the Executive Team. This will be improved greatly as the Health Board's new governance structure starts to embed (see paragraph 67).

51   The Health Board has good resources for managing complaints and concerns in accordance with the Putting Things Right process. There are 29 WTE staff in the complaints handling team. In May 2021, the Health Board introduced a new complaint handling process, which has a greater focus on early resolution. The central complaints team receives and logs complaints before forwarding to the relevant ward or service for resolution. The PALS officers are central to the new process. When we interviewed staff, the new complaints process had only been in place for two weeks. We found that staff were supportive of the new process and were adjusting to its use. However, there were concerns raised that the process was time consuming for lead nurses. Generally divisional teams did not know what proportion of staff had been trained to investigate complaints, incidents, and root cause analysis (**Recommendation 9**). The majority (70%) of general surgery staff responding to our survey agreed that the Health Board acts on concerns raised by patients. In September 2021, 65.93% of complaints were responded to within 30 days, this is below the Welsh Government target of 75%. But the number of early resolutions has increased since the new complaints handling process was introduced.

52   The Patient Experience Strategy sets an annual target to capture 20% of patient/care/user experience. Understandably, COVID-19 caused a significant drop in patient feedback and the target had not been measured for 12 months, however prior to the pandemic the target was not being met. In July 2021, the Health Board successfully implemented phase one of the new CIVICA Once for Wales Patient Feedback System. The new system aims to support real-time patient and service user feedback, making it easier for the Health Board to reach its target.

53   Operational teams seek patient and staff feedback in several ways, such as on-site comments cards, postal and online patient satisfaction surveys and patients speaking directly with matrons. In April 2020, the Health Board stopped using 'happy or not' customer feedback kiosks to aid infection prevention and control, but tablet computers continue to support digital feedback. As well as working closely with the complaints team, PALS officers hold engagement events across community and acute wards to give patients and carers the opportunity to discuss their concerns. These events called Care to Share continued during the pandemic but were less frequent, held virtually and targeted areas where there were concerns. Whilst patient feedback is shared with wards monthly, our survey of general surgery staff indicates that more needs to be done to disseminate patient experience information given less than half (42%) of respondents agreed or strongly agreed that they receive regular updates on patient feedback for their work area (**Recommendation 10**).

Listening to staff

54   The Health Board is committed to listening to staff so it can learn from their experiences and concern. But less than half (45%) of staff responding to our survey agreed that the organisation acts on the concerns raised by staff.

55   The Health Board reviewed its raising concerns process and in April 2021, launched its Speak Out Safely process. The new process offers staff several avenues to raise concerns in confidence. For example, staff can speak to a Speak Out Safely guardian or champion, anonymously raise concerns through a platform called Work in Confidence and approach their managers and trade union representatives. Work is still ongoing to fully implement the policy, for example two Speak out Safely Guardians have recently been recruited and the Health Board is planning to recruit locally based speak out safely champions.

Patient stories

56   The Health Board is taking steps to improve the reach of patient stories. Whilst the QSE Committee has received stories at most meetings since March 2019, the Board has only recently started to receive them (September 2021). The Health Board also has plans for stories to feature at executive team meetings.

57   The Health Board is also improving the way patient stories are told and organised. Since May 2021, QSE Committee members listen to the story beforehand and an accompanying paper outlines the emerging themes, learning points and suggested service improvements which members discuss. This is a more productive use of committee time. The Health Board is planning to make these recordings available to the public from early 2022. Currently, patient stories are chosen at random, but the Health Board is developing a 12-month schedule and has ambitions to align stories to themes from complaints and incidents. As most patient stories will be digital the Health Board is investing in digital storytelling equipment and training staff to use it. There are also plans to develop a library of stories to use for training purposes.

Patient Safety Walkabouts

58   As with other health bodies, executive and independent member safety walkabouts had to be stopped during the pandemic. Prior to this, walkabouts were ad-hoc in nature and feedback was not collated in a structured way. Staff we spoke to felt that that aside from the Chair, Chief Executive Officer and Executive Director of Nursing, Board members were not visible. Positively, the Health Board has recognised these weaknesses and in July 2021 launched its new Quality and Safety Walkabouts. A standard operating procedure provides clarity on the process, sets out expected frequency, ensures coverage across service areas and templates standardise how feedback is captured and reported. Any actions noted during walkabouts are recorded and monitored through Datix. The Patient Safety and Quality Group received its first quarterly patient safety walkabout report in

October 2021. Between July and September 2021, eight walkabouts had taken place capturing 14 improvement actions. The walkabouts covered a range of services and hospitals including outpatients at Gwynedd Hospital, pharmacy at Glan Clwyd Hospital and the Stanley Eye Unit at Abergele Hospital. This should go some way to improve Board member visibility and further triangulate learning.

Governance structures and processes

59   Our work considered the extent to which organisational structures and processes at and below board level support the delivery of high-quality, and effective services.

60   We found that **there is good ongoing work to strengthen corporate and operational quality and safety governance arrangements and whilst the Health Board has a good level of resources to support quality governance it is taking action to ensure resources are used effectively.**

Organisational design to support effective governance

61   **Ongoing changes to quality governance arrangements are designed to support integrated and collective accountability for quality arrangements.**

62   The Health Board has a complicated organisational structure with multiple tiers, which can make lines of accountability difficult to understand, especially at an operational level. To test the 'floor to board' perspective, this review examined the arrangements for general surgical services, as such **Exhibit 2** shows the current organisational structure for acute services. The Health Board has a similarly complex structure for primary and community services. However, since our fieldwork the Health Board has developed and is currently implementing a new operating model (see paragraph 66).

Exhibit 2: current organisational structure for acute services

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                    │     Executive Team       │
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                    ┌─────────────────────────────────────┐
                    │         Secondary Care              │
                    │ Nurse Director and Medical Director  │
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                    │      Hospital services       │
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                    │ services                     │
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Exhibit source: Audit Wales analysis of Health Board organisational structure

63   The Executive Director of Nursing and Midwifery is the named lead for quality and patient safety. But day to day responsibility is shared with the Executive Medical Director and the Director of Therapies and Health Sciences. Below the executive team, sits the secondary care structure, which has a Nurse Director and a Medical Director. Hospital site and community 'Area', responsibility for quality and patient safety mirrors the corporate arrangement. Lead site or service nurses and medical directors or clinical leads take joint ownership for quality and patient safety. Feedback from the services suggests this arrangement works well.

64   The QSE Committee has begun to improve its quality governance structure to improve assurance systems. In August 2020, the committee approved the establishment of four new sub-groups:

- Patient Safety and Quality
- Clinical Effectiveness
- Patient and Carer Experience

- Strategic Occupational Health and Safety

65   Each of the sub-groups has a terms-of-reference and have been meeting since October 2020, although some meetings were cancelled because of COVID-19. In April 2021, we observed a Quality and Patient Safety group meeting. It was clear that the group was still establishing, for example, some of the groups reporting into the sub-group had only met once or twice. Some of the sub-group's administration was not well organised for example the action log was partially complete, which meant the 5-minute item took 40 minutes. The monthly meeting has a very heavy agenda. It receives assurance reports from its sub-groups these include infection prevention and control, personal protective equipment and safer medicines sub-groups. It also receives reports from the secondary care tier, the three acute divisions, women's services and mental health and learning disabilities. The Health Board reported that the QSE Committee sub-groups have since started to settle. Moving forward, the four sub-groups will formally report to the new Executive Delivery Group for Quality as part of the new integrated governance framework.

66   In addition to the ongoing service pressures caused by the pandemic, the Health Board is going through a period of change. It recognises that its current structure is too complicated making oversight and information flow difficult. As such, Stronger Together, the Health Board's organisational development programme, has developed a new operating model. The new model moves towards integrated health communities and some pan-North Wales regional services. The Health Board is currently implementing the new structures and is aiming to have a shadow form operating from 1 April 2022.

67   The Health Board is also beginning to implement its new integrated governance framework, which was approved in July 2021. One of the aims of the new framework is to allow a clearer focus on floor to Board oversight of service quality. The new structure will involve establishing three executive delivery groups, one of which is focused on quality improvement. Reporting into the executive delivery groups will be 10 tactical delivery groups, four of which relate to quality and patient safety, these are: patient safety, patient experience, clinical effectiveness and infection prevention and control groups. To aid clear lines of reporting the tactical delivery groups will be mirrored at an operational level. These will replace and standardise the current divisional and service level quality and safety and clinical effectiveness meetings and improve lines of sight. A similar governance review is underway for divisional teams. As of February 2022, the new executive delivery groups had held or were about to hold their first meetings.

68   To aid the flow of assurances the QSE Committee also approved the 'triple A' reporting model, which filters assurances from operational teams up to the QSE Committee. But some interviewees felt that guidance was needed when introducing the template, as there can be some variation in the level of detail provided (**Recommendation 11**). Without guidance there is the risk that quality and safety issues are missed or not escalated correctly. The Health Board needs assurance that the right information is filtering up.

Resources and expertise to support quality governance

69   **The Health Board has a good level of corporate and operational resources to support quality governance, but there are inconsistencies in levels of resource across the organisation, and concerns that existing resources are not being used to their full potential. The Health Board is taking action to address these concerns.**

70   Corporately, the Acting Associate Director of Assurance manages three heads of service covering quality assurance, patient experience and patient safety. Together the team provide a good level of support for quality governance and patient safety and experience. Across the organisation approximately 130 staff support quality assurance. Staff are generally based within specific service areas, with some being a corporate resource and others local resources. The Health Board has recognised that existing arrangements can result in silo working and duplication and is reviewing its resources and how they are organised. The Health Board is in the process of implementing a business partner model in which staff would be part of a corporate team but still be based in their localities. The aim of this model is to drive consistency, make it easier to share good practice and learning and reduce duplication and silo working. There is also a wider review of divisional governance structures underway which will further clarify roles and structures.

71   All three acute sites have quality governance lead nurses, who are members of the corporate patient safety team and work across clinical teams. They are supported by a team of eight to ten staff. However, the perception of this support varies across the organisation. For example, in our data collection survey[4], all three acute divisions said they had a dedicated quality and patient safety lead, but only Ysbyty Glan Clwyd Acute Division said the lead was part of the corporate team. For general surgery, only Ysbyty Gwynedd said they did not have a dedicated quality lead. This variation suggests that the resource is not well organised or recognised, causing inequities across the organisation, as well as affecting the ability for teams to consistency manage quality improvement and provide the assurances required to the Board and its committees. Overall, the Health Board has a good level of quality governance capacity, but it needs to ensure the review it has undertaken results in these resources being used to best effect.

[4] We asked the Health Board to complete data collection surveys which captured information about corporate resources to support quality and patient safety and quality governance arrangements for the acute divisions and general surgery services.

Arrangements for monitoring and reporting

72   Our work considered whether arrangements for performance monitoring and reporting at both an operational and strategic level provide an adequate focus on quality and patient safety.

73   We found that **the Health Board is adapting and improving its quality monitoring and reporting, recognising the challenge of COVID-19 and wider quality risks.**

Information for scrutiny and assurance

74   **The Board receives a good level of information to scrutinise harm from COVID-19. The Health Board is taking steps to improve quality dashboards, but further work is needed to ensure a more consistent approach is adopted across the organisation and to strengthen operational data analytical capacity.**

75   The Health Board has made a commitment to assessing harm from COVID-19 built around the four quadrants of harm model[5] and has ensured information is reported widely. The Board, QSE Committee and Executive Team receive a COVID-19 update report at each meeting. The report covers the prevalence and impact of the virus, overall risks and issues and an update on the test trace and protect and vaccination programmes. Recent update reports outline the work being done to better understand long-Covid such as data modelling and developing long-Covid patient pathways. The Quality and Performance report also details how COVID-19 is impacting on key performance measures. In addition, the Board receives exception reports for example on how COVID-19 is affecting primary care services. The Health Board has established a team to review nosocomial COVID-19 cases. Like others, the Health Board continues work to establish how best to assess wider harm from COVID-19.

76   The Health Board holds a wealth of data on its 'IRIS' business intelligence data warehouse. But without the correct expertise it is difficult to extract and make use of this information. Whilst there is some corporate informatics support and a small Quality Data Analytics Team (four members of staff), operational staff we interviewed expressed their frustration at the lack of data analytics support.

77   The lack of data analytics support has meant that divisions and service areas have developed their own quality and patient safety dashboards. This means there is inconsistency across the organisation, making it difficult for teams to compare between service areas. The Health Board has recently introduced a new quality dashboard, which houses 15 metrics and can be sorted by ward, speciality, and

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[5] NHS Wales COVID-19 Operating Framework: quarter 1 2020 to 2021 sets out the four types of harm cause by COVID-19, these being: harm from COVID itself, harm from overwhelmed NHS and social care system, harm from reduction in non-COVID activity and harm from wider societal actions /lockdown.

site. Whilst the dashboard needs further development, this is a positive start. The new Quality Improvement Strategy will look to address further improvement.

78   Not all the divisions and general surgery services have developed quality and patients' safety dashboards. Where they have, the dashboards are discussed at monthly divisional quality and patients' safety meetings and the Acute Division Management Team meetings. Of the three acute divisions, only Glan Clwyd does not discuss a dashboard at its quality and patient safety meeting. And for general surgery only Wrexham Maelor holds a dedicated quality and patient safety meeting, where their dashboard is reviewed. The Quality Data Analytics Team has been tasked with standardising operational quality dashboards. And as the new integrated governance framework embeds the Health Board should see improved levels of consistency of reporting across operational teams.

Coverage of quality and patient safety matters

79   **The Quality, Safety and Experience Committee is well served with quality information, and this is resulting in a stronger focus on improvement. But there needs to be a stronger focus on outcomes, local measures, and the quality of services that the Health Board commissions from other organisations.**

80   The Health Board's Quality and Performance report focuses on the NHS delivery framework and its measures are aligned to the quadruple aims within A Healthier Wales. The Board receives the report at each meeting. For assurance purposes the measures are divided amongst the committees, with the QSE Committee scrutinising quality measures. The report has a clear format, grouping measures and narrative by theme and showing performance trends. The narrative highlights key performance risks and actions to address them. While this report aligns with the NHS delivery framework measures, there are no locally agreed quality measures for acute or community services (**Recommendation 12**).

81   The QSE Committee has a large remit and routinely receives quality and patient safety assurance reports. Routine reports received by the QSE Committee include:

•   Patient Safety report - provides quarterly information on aspects such as patient safety incidents, litigation, and patient safety alerts.

•   Serious incident report – provides information and analysis on serious incidents and never events over a two-month period.

•   Patient and Carer Experience report – covers complaints, ombudsman cases and patient and user feedback.

82   The committee also receives detailed reports on specific current issues such as COVID-19 outbreaks, vascular surgery, urology services and mental health. However, generally there is a greater focus on secondary care services than on community and primary care and the committee does not receive any assurance on the quality of services the Health Board commissions from other organisations.

83	The Health Board is in the process of improving its performance reports. We reviewed recent quality and patient safety assurance reports and the improvements are clear, such as an emphasis on learning and highlighting themes. This is a positive start, but the Health Board accepts there is more to do, such as developing patient-related outcome and experience measures (PROMS and PREMS).

Appendix 1

Management response to audit recommendations

Recommendation	Management response	Completion date	Responsible officer
Quality and patient safety priorities R1 We found that the Health Board did not formally review its quality improvement priorities in light of the consequences of COVID-19. The Health Board should ensure its new Quality Improvement Strategy sets out how the Health Board will manage and mitigate the potential harms associated with the COVID-19 pandemic.	We accept the priorities were not formally reviewed although we did seek to prioritise the mitigation of the four harms from COVID as part of our organisational strategy. We will ensure the new Quality Strategy under development reflects this recommendation. We have set interim quality priorities while the strategy is being developed which are based on the key quality risks and concerns that have been identified.	September 2022	Associate Director of Quality
Risk management training	The Health Board has updated its Risk Management Strategy and training has been made available. The Risk	Completed – ongoing	Director of Governance

Recommendation	Management response	Completion date	Responsible officer
R2 We found that not all operational staff are trained to record clinical and non-clinical risks and compile risk registers. The Health Board should ensure staff have adequate levels of risk management training so that they can confidently contribute to the risk identification and escalation process.	Management Group has refreshed terms of reference and a new executive lead has been appointed (the Executive Medical Director). The Health Board is also working to implement the new Once for Wales Risk Register module as part of the Datix Cymru system and is likely to be the pilot site.	training offer and monitoring via Risk Management Group	
Quality improvement support R3 The Health Board's Quality Improvement Hub (BCUQI) has developed a quality improvement database to allow staff to share, adopt and learn from existing quality improvement projects. However, we found that the database is not well used. The Health Board should	The Heath Board has created a new Transformation and Improvement Directorate bringing together the different teams involved in quality improvement, service improvement, transformation and programme management. This will replace the BCUQI Hub. The team will develop a fundamentally different approach to sharing improvement opportunity and which will be overseen by the Executive Delivery Group for Transformation.	Completed – new Transformation and Improvement Directorate in place.	Director of Transformation and Improvement

Recommendation	Management response	Completion date	Responsible officer
promote and encourage routine use of the database by setting targets for participation, by keeping the level of engagement under regular review and by taking action if engagement is too low.			
Clinical Audit R4 The Health Board has restarted clinical audits after most activity was paused during the pandemic. The Health Board should look to use its programme of clinical audit work to focus on the risk of harm as a result of the pandemic. For example, to better understand the consequences of long waits or exacerbation of chronic conditions. The audits could be targeted at high-risk specialities.	The Health Board will develop a quality and risk informed programme of clinical audit. The Quality Department and Clinical Effectiveness Department are working to develop proposals on closer collaboration and a new clinical audit system is in the process of roll-out.	June 2022	Head of Clinical Effectiveness

Recommendation	Management response	Completion date	Responsible officer
Mortality reviews R5 We found that mortality reviews are not reported to the QSE Committee in a timely manner. The Health Board should ensure the QSE committee receives a quarterly mortality review report, which highlights learning and what action has been taken.	The Health Board will introduce reporting on mortality reviews to the QSE Committee either through a dedicated report or the Patient Safety Report.	30 June 2022	Associate Director of Quality & Associate Medical Director of Mortality Review
Mortality reviews R6 We found that, generally, mortality reviews are medically led, but there is an appetite for multidisciplinary mortality reviews. The Health Board should look to establish a system where a multidisciplinary mix of staff	The Health Board has appointed a new Associate Medical Director for Mortality Review to provide strategic leadership and is in the process of embedding the new Learning from Deaths Framework. The Reducing Avoidable Mortality Group has been reformed and the Health Board is working with the national work stream for	30 September 2022	Associate Medical Director of Mortality Review

Recommendation	Management response	Completion date	Responsible officer
are routinely involved in mortality reviews.	the new Mortality Module of Datix Cymru. The overall new system will enhance multi-professional involvement.		
Sharing learning and good practice R7 The Health Board recognises that it does not yet have a process to systematically share learning across the organisation. The Health Board should use the new integrated governance framework and the Quality Improvement Hub (BCUQI) as tools to support organisational learning and sharing good practice across the organisation.	The Health Board will implement a learning library through its new Intranet, BetsiNet rather than the external BCUQI Hub web site which will become part of the new Transformation and Improvement Service. In addition, the revised Incident Policy and Complaints Policy will set out new approaches to sharing learning systematically including Learning Events and a Learning Bulletin. The Safety Alert process is also to be revised. These actions form part of the mitigation actions for the risk on the Board Assurance Framework.	30 September 2022	Associate Director of Quality
Values and behaviours	The Health Board has adopted the all-Wales Respect and Resolution Policy. The Health Board has launched a new	Completed – and continued	Associate Director of HR

Recommendation	Management response	Completion date	Responsible officer
R8 Only 37.9% of Health Board staff responding to the NHS staff survey agreed or strongly agreed that the organisation takes effective action when bullying harassment or abuse occurred. The Health Board should review its systems for managing, addressing, and learning from the concerns of staff in relation to bullying, harassment, or abuse.	Speak out Safely Policy and framework including the appointment of Speak out Safely Guardians, a Multi-Disciplinary Team to oversee concerns and a new secure platform for staff to anonymously raise concerns. Additionally, significant work is underway as part of Stronger Together to explore and improve staff engagement and support.	through the Stronger Together programme	
Complaint handling R9 We found that operational teams did not know what proportion of staff had been trained to investigate complaints, incidents, and root cause analysis. The Health Board should	The Health Board has refreshed its complaint handling training, and this was re-launched in spring 2022 (following deferment over post-winter pressures). Training will be recorded within the ESR system. In addition, virtual complaint support clinics are held weekly to support staff.	Completed	Associate Director of Quality

Recommendation	Management response	Completion date	Responsible officer
review levels of complaints handling training across the organisation. If this shows shortfalls, the programme of training should be expanded.			
Flows of information and assurance R10 Less than half (42%) of respondents responding to our survey agreed or strongly agreed that they receive regular updates on patient feedback for their work area. Whilst patient feedback is shared with wards monthly, the Health Board needs to ensure all ward staff are aware of this feedback and that it is easily accessible to staff.	The Health Board has implemented the new all-Wales Civica Real Time Feedback System. All services are available in this system with all team/ward managers and above given access to the dashboard. Monthly Reports are also sent to services. Patient and Carer Champions are being recruited with over 100 now in place. To complement this a new framework for collecting and acting on patient feedback is being developed setting out standards and good practice for teams to follow.	30 September 2022	Associate Director of Quality

Recommendation	Management response	Completion date	Responsible officer
Flows of information and assurance R11 The Health Board introduced a new reporting format (triple A) to improve the flow of quality assurance. But we found some variation in the levels of detail provided in the reports. To reduce the risk of quality and safety issues being missed or not correctly escalated the Health Board should provide staff with guidance on using the new template, especially setting out how much detail is expected and how to agree which issues are escalated.	As part of the new Operating Model being developed as part of the Stronger Together programme, a new integrated governance and assurance framework will be developed setting out a new governance framework, and standards and principles for governance across the organisation including reporting, escalation, and accountability.	30 June 2022	Director of Governance

Recommendation	Management response	Completion date	Responsible officer
Quality and patient safety performance measures R12 We found that whilst the measures in the integrated performance report aligns with the NHS delivery framework, there are no locally agreed quality measures or wider measures such as for community services. Through the new Quality Improvement Strategy, the Health Board should review current quality measures with a view to developing measures that reflects the services it provides and commissions across primary, community and secondary care.	A new Quality Highlight Report has been produced for the Board. New quality measures will be included in the new Quality Strategy.	30 September 2022	Associate Director of Quality

Appendix 2

Staff survey findings

Exhibit 4: staff survey findings

Attitude statements	Number of staff agreeing or disagreeing with statements					
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Total respondents
Delivering safe and effective care						
1. Care of patients is my organisation's top priority	58	70	21	7	5	162
2. I am satisfied with the quality of care I give to patients	67	57	11	20	7	162
3. There are enough staff within my work area/department to support the delivery of safe and effective care	13	39	30	39	40	163
4. My working environment supports safe and effective care	27	65	30	24	17	163

Attitude statements	Number of staff agreeing or disagreeing with statements					
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Total respondents
Delivering safe and effective care						
5. I receive regular updates on patient feedback for my work area / department	14	54	38	37	14	162
Managing patient and staff concerns						
6. My organisation acts on concerns raised by patients	37	77	25	7	3	162
7. My organisation acts on concerns raised by staff	16	56	41	26	18	159
8. My organisation encourages staff to report errors, near misses or incidents	45	79	25	5	5	161
9. Staff who are involved in an error, near miss or incident are treated fairly by the organisation	21	68	36	17	7	161

Attitude statements	Number of staff agreeing or disagreeing with statements					
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Total respondents
Managing patient and staff concerns						
10. When errors, near misses or patient safety incidents are reported, my organisation acts to ensure that they do not happen again	27	77	33	8	5	160
11. We are given feedback about changes made in response to reported errors, near misses and incidents	19	58	45	26	7	161
12. I would feel confident raising concerns about unsafe clinical practice	32	70	32	15	10	163
13. I am confident that my organisation acts on concerns about unsafe clinical practice	28	67	37	13	11	164
Attitude statements	Number of staff agreeing or disagreeing with statements					

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Total respondents
Working in my organisation						
14. Communication between senior management and staff is effective	14	39	38	45	28	164
15. My organisation encourages teamwork	27	70	38	16	11	163
16. I have enough time at work to complete any statutory and mandatory training	9	43	34	43	35	164
17. Induction arrangements for new and temporary staff (e.g. agency/locum/bank/re-deployed staff) in my work area/department support safe and effective care	12	60	46	15	16	163[6]

6 14 respondents responded, 'don't know'.

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We welcome correspondence and
telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a
galwadau ffôn yn Gymraeg a Saesneg.

Management response to audit recommendations

Recommendation	Management response	Completion date	Responsible officer
Quality and patient safety priorities R1 We found that the Health Board did not formally review its quality improvement priorities in light of the consequences of COVID-19. The Health Board should ensure its new Quality Improvement Strategy sets out how the Health Board will manage and mitigate the potential harms associated with the COVID-19 pandemic.	1. We will ensure the new Quality Strategy currently under development reflects this recommendation – the new strategy is intended for finalisation in September 2022. 2. We have set interim quality priorities at the QSE Committee in March 2022 while the strategy is being developed which are based on the key quality risks and concerns that have been identified including those related to the pandemic.	1. September 2022 2. Completed	Associate Director of Quality
Risk management training R2 We found that not all operational staff are trained to record clinical and non-clinical risks and compile risk registers. The Health Board should ensure staff have adequate levels of risk management training so that they	1. The Health Board has updated its Risk Management Strategy. 2. Risk management training has been refreshed and is available. 3. The Risk Management Group has refreshed terms of reference. The group has a rolling programme of scrutiny of risk registers to support the proper articulation and management of risk.	1. Completed 2. Completed - ongoing training monitoring via RMG 3. Completed 4. Completed	Associate Director of Governance

Recommendation	Management response	Completion date	Responsible officer
can confidently contribute to the risk identification and escalation process.	4. A new executive lead for risk management has been appointed (the Executive Medical Director). This provides a strengthened clinical oversight of risks. 5. The Health Board is working to implement the new Once for Wales Risk Register module as part of the Datix Cymru system and is to be the pilot site. The exact date is subject to the national roll-out.	5. March 2023 (may be subject to national change)	
Quality improvement support R3 The Health Board's Quality Improvement Hub (BCUQI) has developed a quality improvement database to allow staff to share, adopt and learn from existing quality improvement projects. However, we found that the database is not well used. The Health Board should promote and encourage routine use of the database by setting targets for participation, by keeping the level of engagement under regular review and by taking action if engagement is too low.	1. The Heath Board has created a new Transformation and Improvement Directorate bringing together the different teams involved in quality improvement, service improvement, transformation and programme management. This will fully replace the BCUQI Hub and the database. 2. The new directorate will develop a fundamentally different approach to improvement that will be overseen by the Executive Delivery Group for Transformation. The new directorate will include 5 new teams including a Pathways Team, Continuous Improvement Team, Values Based Care Team, Transformation and Improvement Office and Transformation and Improvement Pipeline and Analytics Team. This approach will include the new Transformation and Improvement Office capturing improvement activity across the Health Board to	1. Completed 2. September 2022	Associate Director of Transformation and Improvement

Recommendation	Management response	Completion date	Responsible officer
	improve spread and sustainability. The exact mechanism which is best for the Health Board is currently being explored. The new team has presented its initial strategy to the Board.		
Clinical Audit R4 The Health Board has restarted clinical audits after most activity was paused during the pandemic. The Health Board should look to use its programme of clinical audit work to focus on the risk of harm as a result of the pandemic. For example, to better understand the consequences of long waits or exacerbation of chronic conditions. The audits could be targeted at high-risk specialities.	1. The Health Board will develop a quality and risk informed programme of clinical audit and this is due for presentation to the QSE Committee in May 2022. 2. A new electronic clinical audit system is in the process of roll-out (AMAT) to improve how audits are recorded and outcomes captured and reported. 3. The Quality Directorate and Clinical Effectiveness Department are working with the Executive Medical Director to develop proposals on closer collaboration, aligned to the Stronger Together programme. This will strengthen the ongoing alignment of audit with quality and risk priorities.	1. May 2022 2. June 2022 3. June 2022	Head of Clinical Effectiveness
Mortality reviews R5 We found that mortality reviews are not reported to the QSE Committee in a timely manner. The Health Board	1. The Health Board will introduce reporting on mortality reviews to the QSE Committee either through a dedicated quarterly report or the bi-monthly Patient Safety Report.	1. June 2022	Associate Director of Quality & Associate Medical

Recommendation	Management response	Completion date	Responsible officer
should ensure the QSE committee receives a quarterly mortality review report, which highlights learning and what action has been taken.			Director of Mortality Review
Mortality reviews R6 We found that, generally, mortality reviews are medically led, but there is an appetite for multidisciplinary mortality reviews. The Health Board should look to establish a system where a multidisciplinary mix of staff are routinely involved in mortality reviews.	1. The Health Board has appointed a new Associate Medical Director for Mortality Review to provide strategic leadership. 2. The Health Board is in the process of embedding the new national Learning from Deaths Framework into local policy. This will be multi-professional. 3. The Reducing Avoidable Mortality Group has been reformed to provide refreshed strategic leadership which is multi-professional. 4. The Health Board is working with the national work stream for the new Mortality Module of Datix Cymru. The overall new system will enhance multi-professional involvement by providing real-time, access from anywhere capability.	1. Completed 2. September 2022 3. Completed 4. September 2022 (may be subject to national change)	Associate Medical Director of Mortality Review

Recommendation	Management response	Completion date	Responsible officer
Sharing learning and good practice R7 The Health Board recognises that it does not yet have a process to systematically share learning across the organisation. The Health Board should use the new integrated governance framework and the Quality Improvement Hub (BCUQI) as tools to support organisational learning and sharing good practice across the organisation.	1. The Health Board will implement a digital learning library through its new Intranet, BetsiNet rather than the external BCUQI Hub web site which will become part of the new Transformation and Improvement Service. 2. In addition, the revised Incident Policy and Complaints Policy will set out new approaches to sharing learning systematically including mandatory Learning Events, a bi-monthly Learning Grand Round, a Learning on a Page Template and a monthly Learning Compendium. 3. The Safety Alert Policy and Procedure is also to be revised and will include a revised process and template for internal alerts.	1. September 2022 2. June 2022 3. July 2022	Associate Director of Quality
Values and behaviours R8 Only 37.9% of Health Board staff responding to the NHS staff survey agreed or strongly agreed that the organisation takes effective action when bullying harassment or abuse occurred. The Health Board should review its systems for managing, addressing, and learning from the	1. The Health Board has adopted the all-Wales Respect and Resolution Policy. 2. The Health Board has launched a new Speak out Safely Policy and framework including the appointment of Speak out Safely Guardians, a Multi-Disciplinary Team to oversee concerns and a new secure platform for staff to anonymously raise concerns.	1. Completed 2. Completed 3. Ongoing via the Stronger Together programme	Associate Director of HR

Recommendation	Management response	Completion date	Responsible officer
concerns of staff in relation to bullying, harassment, or abuse.	3. Additionally, significant work is underway as part of Stronger Together to explore and improve staff engagement and support.		
Complaint handling R9 We found that operational teams did not know what proportion of staff had been trained to investigate complaints, incidents, and root cause analysis. The Health Board should review levels of complaints handling training across the organisation. If this shows shortfalls, the programme of training should be expanded.	1. The Health Board has refreshed its complaint and incident training, and this was re-launched in spring 2022 (following deferment over post-winter pressures). 2. Training will be recorded within the ESR system alongside all other training. 3. Virtual complaint handling clinics and incident investigation clinics are held weekly to support managers and staff. 4. An audit of trained staff will be completed to identify any shortfalls and targeted training will be offered in these cases. 5. Key staff involved in leading the incident process will be enrolled onto the new HSIB specialist training programmes.	1. Completed 2. Completed 3. Completed 4. September 2022 5. Completed	Associate Director of Quality
Flows of information and assurance R10 Less than half (42%) of respondents responding to our survey agreed or	1. The Health Board has implemented the new all-Wales Civica Real Time Feedback System. All services are now available in this system with all team/ward	1. Completed 2. Completed – but ongoing	Associate Director of Quality

Recommendation	Management response	Completion date	Responsible officer
strongly agreed that they receive regular updates on patient feedback for their work area. Whilst patient feedback is shared with wards monthly, the Health Board needs to ensure all ward staff are aware of this feedback and that it is easily accessible to staff.	managers and above given access to the dashboard. Monthly Reports are also sent direct to services. 2. Patient and Carer Champions are being recruited with over 100 now in place. A key priority of the new Quality Strategy is to have a champion in every clinical team. Champions locally promote the collection and learning from feedback, and the display of information on "You Said We Did" boards. 3. A new framework and toolkit for collecting and acting on patient feedback is being developed setting out standards and good practice for teams to follow. This will form part of the new Quality Strategy priorities.	rolling recruitment 3. September 2022	
Flows of information and assurance R11 The Health Board introduced a new reporting format (triple A) to improve the flow of quality assurance. But we found some variation in the levels of detail provided in the reports. To reduce the risk of quality and safety issues being missed or not correctly escalated the Health Board should provide staff with guidance on using the new template, especially setting	1. As part of the new Operating Model being developed as part of the Stronger Together programme, a new integrated governance and assurance framework will be developed setting out a new governance framework, and standards and principles for governance across the organisation including reporting, escalation, and accountability. 2. A new Chair's Report Template is being developed and will be piloted with the QSE Committee. Guidance will be provided alongside this new template.	1. July 2022 2. July 2022	Associate Director of Governance & Board Secretary

Recommendation	Management response	Completion date	Responsible officer
out how much detail is expected and how to agree which issues are escalated.			
Quality and patient safety performance measures R12 We found that whilst the measures in the integrated performance report aligns with the NHS delivery framework, there are no locally agreed quality measures or wider measures such as for community services. Through the new Quality Improvement Strategy, the Health Board should review current quality measures with a view to developing measures that reflects the services it provides and commissions across primary, community and secondary care.	1. A new Quality Highlight Report has been produced for the Board. 2. New quality measures will be included in the new Quality Strategy for each priority area. The reporting of performance against these measures will commence to the QSE Committee as part of regular strategy updates. 3. The Associate Director of Quality and Associate Director of Transformation and Improvement are collaborating on what quality measures can be used to inform future balanced reporting. This will inform a paper and proposals to the Executive Team.	1. Completed 2. September 2022 3. June 2022	Associate Director of Quality

Chair's Report

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting or area reporting in	Patient and Carer Experience Group
Chair of meeting or lead for report	Mandy Jones - Chair (on behalf of Gill Harris)
Date of meeting	17/02/2022
Version number	V1.0
Appendices	N/A

Reporting To	
Name of meeting	Quality, Safety and Experience Committee
Date of meeting	03 May 2022
Presented by	Matthew Joyes – Associate Director of Quality

1. Alert – include all critical issues and issues for escalation

- **Triple A reports from Divisions:**
  - Review representation, the initiatives and work plans in place going forward will require that operational perspective to be part of understanding the work plan.
  - Develop new template and guidance to ensure updates provided are from a patient and carers experience view of care. Ensure reports have consistent and proactive communication.

2. Assurance – include a summary of all activity of the group for assurance

- **Patient Story**: Hunters story -This is a very moving story of the loss of a baby, the parents wanted their story to be heard rather than making complaints. The outcome from this is there have been a number of positive changes and further meetings set up with the parents and Womens services.

- **Bereavement Quality sub Group**: Publication of a National Framework for bereavement care in Wales, which is really welcome and provides support and a set of standards. There is a piece of work going on to develop a national bereavement care pathway for Wales and a model specification.

- **Patient Communication and Readers Panels Sub-group**: The panel membership is increasing and strengthening. A key priority of the service is to ensure all HB leaflets have been through the correct process, to provide high quality accessible information.

- **Carers update** The overarching aim is to improve outcomes for unpaid carers across all our services, develop and co-produce a three year operational carers framework and raising awareness across BCU. A priority is setting up a Carers Lived Experience group to represent the population of North Wales.

- **CANIAD:** Service Users to present stories to a future meeting

- **Community Health Council:** Report submitted outlines concerns from service users regarding Ambulance waiting times, Dentistry provision, access to GP's, hospital visiting, COVID-19, booster vaccinations, flu vaccinations, Ophthalmology and vascular services

- **Long Covid Lived Experience Group:** The Group meet on a monthly basis. This is an excellent example of how we've used the power of the Lived experience to influence, we now have clinical services where one of the fundamentals was that they would have self referral into the system.

- MR also runs the Carers Education Program we we'd like to bring it to this meeting a regular basis because there will be developments happening.

- **Ombudsman Complaints Lessons Learned Report:** This report highlights one aspect which is a regular theme ongoing in the HB and that's lost property, it causes anxiety for families whether it's a lost wedding ring, glasses, whatever this has a huge impact and for the HB there is a financial cost. Captured a story which will be shared at future meetings. The Ombudsman appears to recognise the BCU new Complaints procedure as a positive, fewer cases going to the Ombudsman and we are having fewer second responses

- **Items Approved:**
  - Patient and Carer Experience report : Aug – Nov 2021
  - BCUHB Dealing with Unreasonable demands and/or behaviour

3. Achievement – include any significant achievements and outcomes

- A Bereavement booklet is almost ready for publication.

Health Board *Insert date*	GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

	Committee Chair's Report

Name of Committee:	Infection Prevention Sub Group (IPSG)
Meeting date:	**12 April 2022**
Name of Chair:	Mandy Jones deputising for Gill Harris
Responsible Director:	Gill Harris
Summary of business discussed:	• Review of COVID data and mandatory surveillance organisms and compliance with trajectories. • Infection Prevention (IP) Alert, Assurance and Achievement reporting from all areas (including East Area and Acute, West Area and Acute, Central Area and Acute, Women's, Mental Health, Community Dental Service, Estates and Facilities, Vaccination, Antimicrobial Stewardship, Decontamination, Group, Cancer Division). • Review of new and updated policies, protocols and risk assessments. • Update provided on the new Operating Framework and the plan to discuss the reporting structures in relation to IPSG. • Update provided on compliance with Infection Prevention mandatory training. • The protocol for Ukrainian refugees attending hospital was reinforced. • Feedback provided on key lessons learnt from panels reviewing hospital onset COVID cases and outbreaks.
Key assurances provided at this meeting:	• In comparison with other Health Boards, for surveillance data for April 2021 to March 2022, BCUHB is not an identified outlier for any of the six alert organisms, with our position sitting either second or third. Furthermore, BCUHB demonstrated the lowest rate of *C.difficile* this month when compared to all other Welsh Health Boards. • The response to COVID outbreaks within BCUHB continues to be overseen and managed by Area/pan-BCU outbreak meetings. The meetings have been well organised, well attended and effective. The Consultant Nurse from PHW HARP (Healthcare Associated Infection & Antimicrobial Resistance Programme) Team attended the pan-BCU outbreak meeting and provided positive feedback in relation to excellent communication and working between the IP team and the clinical teams, the comprehensive use of data and analysis which supported a greater understanding of the key issues, and assurance that BCU was managing the outbreaks robustly.

	• Good practice and learning identified from the hospital onset COVID panels was shared with the group; in most of the recent reviews, prompt action was taken and outbreaks were quickly contained. • Maintained bed position to support flow despite significant depleted nursing resources, with no significant breaches in IP practices. • Low rates of infection following caesarean sections compared to the national average. • Improvements seen during recent ward kitchen inspections.
Key risks including mitigating actions and milestones	• IP Risk Assessment Number 4241 'Inability to deliver timely IP services due to limited capacity', scoring 15 was approved at the Risk Management meeting in April. Mitigating actions include recruiting to vacant posts, using IP Champions to promote IP, preparing a business case for expanding the current team, to design a development programme for existing IP nurses and to promote the Bangor University IP education programme amongst non-IP staff. • Decontamination Risk Assessment Number 4325 'Potential that medical devices are not decontaminated effectively so patients may be harmed', scoring 16 was approved at the Risk Management meeting in April. Mitigating actions include, to revise Decontamination Group Meeting terms of reference, Policies and SOPs written and approved for Decontamination and are being implemented, to meet with key individuals to horizon scan for solutions to the decontamination issues at YGC and WM, to review and update the risk register in order to better establish current position of existing risks, approach PHW to carry out a review of Hospital Sterile Service Departments to identify concerns, and to audit ultrasound machines. • Challenges with domestic capacity and cleaning: the recruitment programme is progressing and the current domestic resource is being prioritised e.g. to outbreak areas, with daily input from the IP team. • The procedure for regular flushing of taps and showers that are used infrequently (in line with Legionella prevention strategies) is not robustly undertaken. The Water Safety Group are to meet on 19 April to clarify the process, necessary documentation required, and agree a communication strategy to ensure relevant staff are aware. • There are low rates of vaccination and compliance with mandatory training within the Estates and Facilities team. A renewed focus on improving these rates is planned and an update will be presented to IPSG next month. • Activity in outpatients is increasing. A new generic risk assessment template was approved for use to support areas to increase their throughput safely. • Hydrogen Peroxide Vapour (HPV) deep clean programmes have been hindered by the lack of decant space. A trial of Hypochlorus

	Acid (as a safer and quicker alternative to HPV) was successful and a Task and Finish group is to be set up to roll this out. In addition, a new mobile UVC air purifier is to be piloted in May in a ward in YGC. • Documentation regarding invasive devices is not robustly completed e.g. for catheters, blood cultures and vascular access devices. Learning from PIRs has been fed back to clinical staff and practice continues to be monitored. Practice Development Nurses are supporting improvements in practice and this is to be included as a SCC-HF project next year. • There is increasing pressure from the public to extend visiting, however further direction/guidance from the Welsh Government is awaited. • There are insufficient single rooms with appropriate en-suite facilities to meet requirement for patient isolation (acute and community hospitals). There is a hierarchy of isolation tool available and daily reviews are undertaken supported by advice from the IP team on prioritisation. • Risk assessments of Community Hospitals has been completed to assess if Community Midwifery Services can safely return to their permanent bases (current arrangements did not support social distancing requirements/the building is not fit for purpose). Community Midwifery Services are working with the IP and Estates team to identify potential solutions. • Community Dental Services continue to experience ongoing challenges related to environmental ventilation and decontamination. The Assets and Facilities Group are to meet to support and formulate a strategic plan. Plans for the new development at Bangor are progressing; and will provide six surgeries and a large local decontamination unit once completed. • Test and Trace processes have identified that in some cases, individual healthcare workers continued to work with mild COVID symptoms and did not promptly seek out a test. The 'Q&As' document has been updated and shared, a Global email has been issued, and reminder of the correct procedure has been highlighted at outbreak meetings. • Poor compliance with antimicrobial stewardship in some areas. There is continued focus on 'Start Smart then Focus' audits, Antimicrobial Steering Groups, pharmacy support to wards and microbiology ward rounds in place. A new Antibiotic Resistance Working Group has been established and is to meet monthly. An antibiotic resistance dashboard has also been developed to support Clinicians to highlight antibiotic resistance patterns.
Targeted Intervention Improvement Framework Domain addressed	• Mental Health (adult and children) • Strategy, planning and performance • Leadership (including governance, transformation and culture) • Engagement (patients, public, staff and partners)

Issues to be referred to another Committee	• Summary from IPSG is sent to PSQ.
Matters requiring escalation to the Board:	• Nil
Well-being of Future Generations Act Sustainable Development Principle	• PHW are supporting BCU with assessment of risks and identifying short and long-term priorities in Decontamination. • IP programmes at Bangor University are being promoted in BCU. • Estates and IP are liaising with Ecolab to trial new technologies in air purification.
Planned business for the next meeting:	Range of regular reports plus • A closer review of the cleaning issues, compliance with the Credits for Cleaning (C4C) Framework and gap analysis on COVID-19 Addendum. • Planned capital revenue spending by Estates and Facilities in relation to improving the environment/IP. • IPSG programme of work for 22/23.
Date of next meeting:	10th May 2022

V8.0

Templed adroddiadau'r Bwrdd/Pwyllgor
Board/Committee report template

Mae'r dempled hon yn cyfuno'r dempled flaenorol ar gyfer cloriau blaen ac adroddiadau. Dylai awduron geisio cyfyngu ar adroddiadau i ddim mwy na phedair tudalen lle bo'n bosibl. Gellir atodi unrhyw wybodaeth atodol angenrheidiol fel atodiadau ond dylai Aelodau'r Bwrdd allu deall y prif faterion a gwneud penderfyniad cytbwys o'r adroddiad ar ei ben ei hun.

This template combines the former coversheet and report template. Authors should attempt to restrict reports to no more than four pages where possible. Any necessary supplementary information can be attached as appendices but the Board Members should be able to understand the key issues and make an informed decision from the report alone.

Cyfarfod a dyddiad: Meeting and date:	**3ʳᵈ May 2022**						
Cyhoeddus neu Breifat: Public or Private:	*Public*						
Teitl yr Adroddiad Report Title:	Ward/unit Accreditation update –April 2022						
Cyfarwyddwr Cyfrifol: Responsible Director:	Mandy Jones						
Awdur yr Adroddiad Report Author:	Diane Read						
Craffu blaenorol: Prior Scrutiny:	*Senior Nursing Leadership Team*						
Atodiadau Appendices:	*N/A*						
Argymhelliad / Recommendation: The committee are asked to accept this update report and continue to support the plans going forward for the coming 12 months with Ward/Unit Accredatiopna progammme for the Health Board.							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	☞
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**N**	

Sefyllfa / Situation:
This paper aims to update the committee in terms of the Ward/Unit Accreditation programme of work over the past 12 months within the Health Board and to inform the committee of the work plan for the programme for the next 12 months.

Cefndir / Background:
As of end of November 2020, all Acute, Community, Paediatrics, Women's, Midwifery and Mental Health / Learning Disabilities wards had received their first Ward Accreditation visit (with the exception of a 2 Intensive Treatment Units and Bromfield Ward in Wrexham Maelor) who could not receive this first visit due to the new Covid restrictions e.g. re profiling of ward, ward closed, restricted red area). Due to the ongoing Covid Pandemic, ongoing pressures following guidance from Infection Prevention team and Senior Nursing leaders the programme was paused at several points during the past 2 years. Only 18% of the wards (n=20) received their second Accreditation visit in 2021 followed by an additional 2% (n=3) to date this year following the restart in April 2022.

Ward Accreditation visits will now increase to 2 per week as of mid-April 2022 with the aim of increasing to 3 per week when an additional 1 WTE Band 7 Quality & Practice Development Nurse is recruited to the Nursing Assurance and Accreditation Team in late Summer 2022. This will see the Team back to full capacity to support the programme visits. In addition the Directors of Nursing and Heads of Nursing not yet part of the programme and following training during April 2022 will become a Ward Accreditation visit team member to further increase capacity and reduce cancellations. |

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

"Ward accreditation is fundamental in contemporary healthcare delivery" (Underwood et al, 2020)[i].
The BCUHB Ward Accreditation awards are defined as follows:

Awarded Status		Definition
Gold		Achieved excellent standards and have clear evidence of sustaining this success in data over 6 months.
Silver		Achieved very good standards and have some data over time to evidence this.
Bronze		Achieved good standards as expected by BCUHB but have no evidence of sustaining this over time or have fallen below expected standards but are completing appropriate actions to address this.
White		Have not achieved the BCUHB minimum standards in at least one area and are not completing appropriate actions to address this issue – some additional support is required.
Red		Serious concerns have been identified in relation to safety or quality that require weekly monitoring and significant support.

The approved Goverence Framework underpins the Accreditation programme. This Framework sets out clear methodology from preparation for an unannounced Accreditation visit to the final outcome/score as above. For wards/units that do not meet the Health Board standard this will be an immediate action that requires a robust improvement plan prior to an unannounced revisit to check progress against the immediate action.

Wards/units that are deemed white or red the Goverence framework sets out clear steps required that include the updating of the validation panel on a monthly basis for white wards or on a weekly basis for red wards.

As of April 2022, BCUHB has the following wards/units of concern flagged by the Ward Accreditation programme:

Ward / unit	Status	Notes
Emergency Department (YGC)	**Red**	- Visited 17.03.22. - Weekly updates required at Validation Panel by Director of Nursing / Head of Nursing over next 4 weeks.
Aneurin, Hergest Unit, YG	**White**	- Visited 24.05.21. - Head of Nursing & Interim Acute Care Manager attended Validation Panel (11.04.22). Agreed to revisit (unannounced) in June 2022.
Cynan, Hergest, YG	**White**	- Visited 26.05.21. - Head of Nursing & Interim Acute Care Manager attended Validation Panel (11.04.22). - Agreed to revisit (unannounced) in June 2022.
Emergency Department (YG)	**White**	- Visited 30.09.20. - Deemed ready for a revisit / sufficient assurance provided to Validation Panel in

		May 2021. However, due to various reasons (cancellation of visits etc) the revisit hasn't yet proceeded.

In addition to the framework and following the implementation of the new Operational Structure the outgoing Executive Nurse Director Gill Harris has written to the Nurse Directors of the above wards / units for their improvement plans and proposed dates for when the wards following review of data and full unannounced Accreditation reassessment.

During 2022, the nursing Standards and Assurance Team will be working with Heads of Nursing (focusing on bronze wards in the first instance) to identify areas for improvement / where support is required to enhance the accreditation status from Bronze to Silver (or indeed Gold).
The Going for Gold methodology is in place which encourages wards/units to apply for an earlier unannounced Accreditation visit if they are meeting Gold standard in all the topic areas. A small number of applications (n=3) to date which following review (with the Ward Managers) additional opportunities to improve were noted for Quality Improvement and data analysis.

All wards are represented within a rota for an unannounced Accreditation visit and visits will depend upon visit team membership and availability, for example the visit team members will not visit a ward/unit that is under their leadership to ensure the visit is impartial and external eyes at all times.

To support with data review and assurance and to provide opportunities for the ward to improve or celebrate the Accreditation metrics (completed by Ward mangers and Matrons) are aligned to the topics reviewed within the Accreditation visit. The Accreditation metrics form part of the ward data pack. Whereby the visit team will review the data pre visit, and during the visit as a way of triangulating the data with the real time observation and discussion with staff, visitors and patients during the Accreditation visit.

Please note the Ward Manager and Matron's Metrics have been comprehensively reviewed and streamlined following discussion with Senior Nursing Leadership and with Ward Managers and Matrons. This will provide Ward Managers and Matrons additional capacity to focus on Quality Improvement with valuable and meaningful data collection. The reviewed Accreditation metrics for Ward Managers and Matrons capture metrics relating to the wards delivery of person centred care, which includes the assessments and interventions to meet individual care needs, eating and drinking, patient safety, patient dignity, Dementia care and documentation standards.
Each ward/unit receives a comprehensive Accreditation feedback report bespoke for each ward and unit. This report provides context and advice on opportunities for improvement for the wards/units to improve their score on subsequent visits. Also contained are any immediate actions and the outcome following an unannounced revisit to review progress against the immediate action. The development of the Quality Assurance Framework (referred to below) outlines clear expectations for sharing, acting on and evaluating ward data including accreditation findings.

To further support our wards/units, the following documents are being developed:
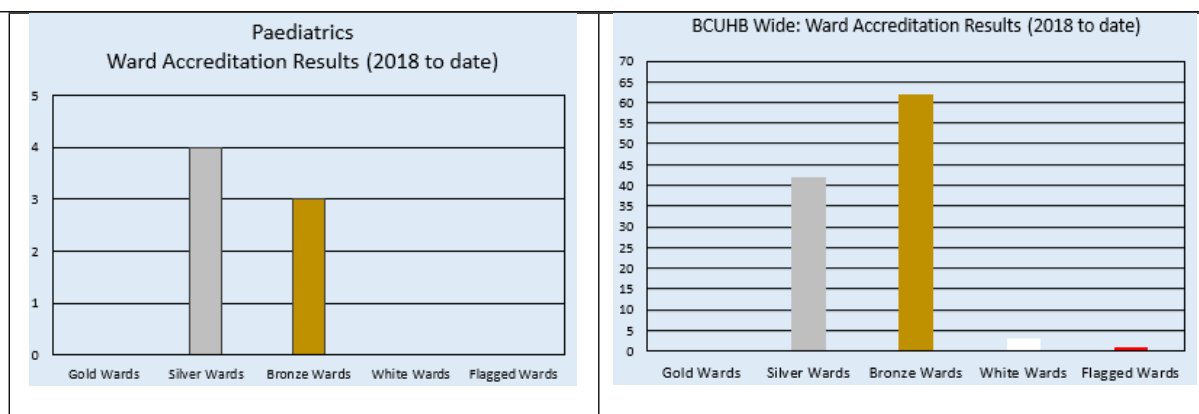1. Ward / Unit data collection handbook:
   Aim: A summary (including hyperlinks and guidance) of the minimum Metrics / Audits, which Inpatient Ward Managers, Matrons and / or Heads of Nursing must complete. The Handbook notes that if a Ward / Unit are asked to complete any additional audits / Metrics not listed in the handbook they contact their Director of Nursing for guidance; this is to reduce the overburden of data collection in the future.

2. Quality Assurance Framework:

Aim: To provide staff with a clearly defined process, which outlines the supportive actions that will be, offered to ensure the delivery of safe effective care. Additionally, the processes noted within the framework will ensure that there is a consistency of approach across BCUHB. Through having clear and robust quality assurance processes, quality improvement can be driven at all levels of nursing; whilst providing the Directors of Nursing / Executive Director of Nursing & Midwifery an accurate analysis of the quality of nursing care being provided to patients and their families. This framework will provide clear processes of accountability for sharing good practice and lessons learned from Accreditation visits.

The current Ward Accreditation position / outcome(s) to date are as follows:

Ysbyty Glan Clwyd:

Ysbyty Gwynedd:

Wrexham Maelor Hospital:

Midwifery & Womens Services:

MH&LD:

Community:

| Paediatrics: | BCUHB Wide: |

Paediatrics
Ward Accreditation Results (2018 to date)

BCUHB Wide: Ward Accreditation Results (2018 to date)

*please note for Paediatrics bar chart in addtion to the Childrens wards the Specail care baby units and Kestrel Unit have received a visit and are included.

During January and February 2022, the Quality Improvement (Corporate Nursing Team) reviewed and updated the Well Led, MDT Communication, Ward Environment and Quality Improvement Handbooks alongside the Ward Managers Toolkit and Governance Framework (see appendices).

A list of immediate actions were published in February 2022 (see appendices) to further support Wards / Units. This list is not exhaustive but highlights areas / actions where a common occurrence had been identified during previous Ward Accreditation visits. Immediate actions can have a significant negative impact on staff and or patient safety (if BCUHB standards are not achieved) and therefore a ward / unit is deemed white if any 1 area is identified (during the visit or by the Validation Panel during discussions).

Opsiynau a ystyriwyd / Options considered

Following formative feedback from Ward Managers and Ward Accreditation visit Team members (November 2021) it was agreed that the 2022 Ward Accreditation Programme would:

3. Return to the pre Covid methodology whereby all 3 members of the visit team arrive unannounced on a ward / unit and complete all elements of the Ward Accreditation visit.
4. Remove the Ward Manager presentation component (completed via Teams in 2021) and instead, wards / units will complete a "portfolio of evidence" to support the Well Led element of the visit (see Appendices). In addition, this portfolio (if completed comprehensively) will provide a valuable resource which may be used (if required), for HIW inspections, CHC visits and / or Leadership Walkarounds.

The Nursing Assurance and Accreditation Team have also been working with Community (District) Nursing Teams to adapt/develop an Accreditation Programme for roll out across all Community Nursing Teams both adults and children . There are 2 proof of concept visits scheduled in Community Nursing planned for the week commencing 25th April 2022. If these visits are successful, Community Accreditation package (e.g. Handbook, Metrics, Prompt Sheets) will be handed over to the 3 Health Economies to proceed with due to capacity within the Corporate Nursing Team to adopt and deliver the Community Accreditation alongside the Ward Accreditation Programme. If successful in Community (District) Nursing, this Accreditation programme can be further developed to accredit other Community Services such as Health Visiting, Midwifery etc.

It is envisaged that the visit team membership will expand to include allied Healthcare Professionals later this year as it is currently nursing only.

Goblygiadau Ariannol / Financial Implications

Wards/units in prepartion for the Accredation or following Accredation may incurr addtional f Financial costs to meet Health Board approved standards. These costs are difficult to quantify at this point in time and in the main will be anticipated as non pay costs .

Dadansoddiad Risk / Risk Analysis

There is a risk that wards/units may not be meeting the Health Board standards if not Accreditated in a timely fashion.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

N/A

Asesiad Effaith / Impact Assessment

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https://nhswales365.sharepoint.com/:b:/s/BCU_Intranet_WA/EVPpVoNRO9RIn5NUeqZQNmQBavYJnFr_MjogR_jxwxECGg?e=AlhOfj

Health Board *Insert date*	 *To improve health and provide excellent care*
Advisory Group Chair's Report	

Name of Advisory Group:	**Strategic Occupational Health and Safety Group**

Meeting date:	**Update report 20.04.22**

Name of Chair:	**Peter Bohan Associate Director of Occupational Health Safety and Security**

Responsible Director:	**Sue Green Executive Director of Workforce and Organisational Development**

Summary of key items discussed:	The next Strategic and Occupational Health and Safety Group meeting is taking place 26 April 2022. This report is supplementary to the previous Chairs report and full details will be provided in the Quarter 4 / annual report. HSE Prior to the COVID-19 pandemic, the HSE announced their planned 'Inspections of Violence, Aggression, and Musculoskeletal Disorders in Healthcare' programme. This is a national programme planned to examine management arrangements for violence and aggression (V&A) and musculoskeletal disorders (MSD's) at care providers in the public sector. Evidence available to the HSE indicates that assaults on staff and MSD's continue to be prevalent in this sector. The HSE inspection of BCUHB took place on 16th – 18th November 2021 and consisted of two inspectors, separately based in Ysbyty Gwynedd (YG) and Wrexham Maelor Hospital (WMH). The inspector on the WMH site was an Occupational Health specialist inspector and in addition to looking at MSK's and V&A, she reviewed the COVID arrangements for the site. The inspector on the YG site had previously served an Improvement Notice on BCUHB in July 2021 for adult in-patient falls and she spent one of the three days reviewing the HB's progress on the YGC site. The HB were issued a Notification of Contravention letter after this inspection, which gave eight areas of required improvements.
Key advice / feedback for the Board:	**Update:** HSE On the 17th of March 2022, the HSE inspector provided a response confirming they were happy that the Health Board had complied with the Improvement Notices. However, the inspector advised she would like to see whether the work completed has resulted in better patient handling

risk assessments. The inspector has requested that a further visit arranged to inspect risk assessments in two areas on one hospital site on the 18th of May 2022, there will be two inspectors in attendance. The agreed site is the Wrexham Maelor site and arrangements are taking place.

To provide a bespoke training programme going forward, a trial was undertaken on two wards, Morris Ward (WMH) and Ward 9 (YGC) with a multi-disciplinary team including staff from the Health and Safety Team, the Nursing Standards and Accreditation Team and the Practice Development Nurses. The team undertook one to one training with nursing staff on the wards going through both the Patient Handling and Falls risk assessments. In preparation for the inspection, further training has commenced on the Wrexham Maelor Hospital site. This will include one to one training for staff completing the assessments and auditing training for matrons and ward managers.

Training Module 000 NHS Wales – Preventing Falls and Management (levels 1a and 1b) has also commenced on the Electronic Staff Record (ESR). Compliance as of the 19th of April 2022 for level 1a falls awareness training, which is mandatory for all staff is 66.16% and level 1b completing the falls risk assessment, which is mandatory for patient facing clinical staff is 56.88%.

A full review of Manual Handling (Patient Handling) Orientation and Refresher training was completed in August 2021 and the new courses were rolled out in October 2021. Both the course content and timings were amended and the training for completing the Patient Handling risk assessments has been strengthened.

RIDDOR

The following table gives the number of incidents reported for Q4, 1st of January 2022 – 31st of March 2022.

Area	COVID-19 RIDDORs	Non-COVID-19 RIDDORs	Total Q4
East	0	2	2
Central	0	3	3
West	0	12	12
Total	0	17	17

Occupational Health Report

Health Surveillance

There are three areas where statutory surveillance is required. These include occupational exposure to noise, respiratory irritants and exposure to hand arm vibration (HAVs). A review of staff requiring assessment for potentially exposure to occupational hazards has been undertaken and those staff at risk are being contacted for further review. A number of OH staff have attended specific training to perform HAVs testing, audiometry and spirometry testing.

	Immunisation gap analysis
	The Service has created a planner for prioritisation to offer vaccination to the workforce. In January 2022, the programme of immunisation focussed on Pertussis (Whooping Cough) with 300 additional Pertussis vaccines having been administered to staff from the OH Department. During Q4, all staff within the priority groups for Pertussis and Varicella vaccination have been contacted and offered an appointment. The Pathology department has also been contacted to clarify those staff at risk for Typhoid and Hepatitis A, and advised to contact and book appointments accordingly.
	Summary
	The Occupational Health & Wellbeing service having achieved accreditation at the start of the financial year have now signed off their first annual assessment to renew the Safe Effective Quality Occupational Health Standard. During Q4, a number of actions have been taken to support staff health & wellbeing and the Core Occupational Health & Wellbeing service has changed focus to undertake statutory essential core activity. This forms part of the OHS and Security 3 year strategy.
	<u>Wellbeing Cell Sub-group</u>
	The Wellbeing Cell Sub Group has continued to undertake pro-active work to support staff including:-
	▪ The tender process for external support is now complete and the contract has been awarded to RCS with the new contract commencing on April 1st for 2 years in the first instance.
	▪ The business case is being reviewed as part of the IMTP. The Wellbeing Cell is awaiting the outcome of this before recruitment processes can get underway re: fixed term posts becoming substantive positions; and before new posts can be recruited to.
	▪ The SWSS Communication group have continued to meet on a monthly basis to keep regular content flowing on BETSINET. The group regularly review the communication plan and are developing posters to be placed across acute and community sites to promote SWSS. This has also been added to the carousel of notices on the ESR landing page as well as having been printed on e-payslips.
Targeted Intervention Improvement Framework Domain addressed	Leadership (including governance, transformation and culture)
Planned business for the next meeting:	• A review of the Security Provision and business case have been provided to the Executives for review and will be discussed at the next SOSH Group. • A review of risks from the Estates Safety Groups will be discussed, specifically asbestos to consider if there are adequate controls in place to reduce the risk scoring. • The 3-year Strategic Occupational Health Safety and Security

	Plan has been submitted to be discussed at the next meeting. • A review of progress on the Patient Handling and Falls risk assessment training and auditing procedures will be undertaken prior to the HSE visit on the 18th May 2022.
Date of next meeting:	26 April 2022

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

Advisory Group Chair's Report Template V6.0 May 2021

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

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Audit Wales Review of Quality Governance Arrangements
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Mathew Joyes, Associate Director of Quality
Craffu blaenorol: Prior Scrutiny:	Mathew Joyes, Associate Director of Quality Gill Harris, Executive Director of Nursing and Midwifery
Atodiadau Appendices:	Appendix 1 – Audit Wales Review Document Appendix 2 – Action Plan

Argymhelliad / Recommendation:

The Committee is asked to note this report and action plan.

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

Sefyllfa / Situation:

This paper provides the Committee with the Audit Wales Review of Quality Governance Arrangements (an independent report) and the accompanying action plan response from the Health Board.

The overall conclusion from Audit Wales is summarised here:

"Overall, we found that the Health Board is taking steps to improve quality governance by redeveloping its Quality Improvement Strategy and plans, reviewing its governance processes and systems, and investing in and reorganising resources that support it. There is good Board and committee level scrutiny of quality information and reports. However, there are opportunities for improvement, such as ensuring the new quality priorities reflect quality and harm risks relating to current significant service pressures, establishing multidisciplinary mortality reviews, improving organisation-wide learning and addressing inconsistencies in resources for quality improvement activities."

The report makes 12 recommendations for improvement. The Health Board response to these recommendations is included at Appendix 2.

Cefndir / Background:

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting to the Senedd on the economy, efficiency and effectiveness with which those organisations have used their resources.

Audit Wales is conducting reviews of this kind across NHS Wales.

The audit examined whether the Health Board's governance arrangements support the delivery of high quality, safe and effective services. The audit focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting.

This report summarises the findings from the work of Audit Wales carried out between May and August 2021. To test the 'floor to board' perspective, Audit Wales examined the arrangements for general surgical services.

As part of the audit approach, Audit Wales have worked closely with Healthcare Inspectorate Wales (HIW) to ensure relevant information is shared and to prevent any duplication of activity.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – The review will be used to inform the ongoing development of the new Quality Strategy.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – The action plan provides the response to identified issues.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.