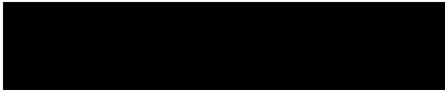
Health and Social Services Group Welsh Government SPECIAL MEASURES INTERVENTION Betsi Cadwaladr University Health Board	 Llywodraeth Cymru Welsh Government



REVIEW OF CONCERNS RAISED AROUND BETSI CADWALADR UNIVERSITY HEALTH BOARD AFFILIATED PATIENT SAFETY: INITIAL FINDINGS

Submitted: 16 June 2023

Author: , Independent Advisor

Health and Social Services Group **Welsh Government** **SPECIAL MEASURES INTERVENTION** **Betsi Cadwaladr University Health Board**	 Llywodraeth Cymru Welsh Government

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1.0 BACKGROUND AND RATIONALE FOR WORK

1.1 On 27 February 2023, the Minister for Health and Social Services announced that she was escalating the intervention status of Betsi Cadwaladr University Health Board (BCUHB) to Special Measures with immediate effect. This decision reflected serious and outstanding concerns about board effectiveness, organisational culture, service quality and reconfiguration, governance, patient safety, operational delivery, leadership, and financial management.

1.2 A number of Independent Advisors (IAs) have been appointed to form a BCUHB improvement and support team to provide the support and advice necessary to enable BCUHB to implement the changes required to deliver improvements. The support and advice in this instance refer to an objectively derived blend of measures (monitoring, assurance, evaluation, guidance, encouragement, and support) which in combination will provide assurance to stakeholders (including patients, staff and the wider public).

1.3 Additionally, discussions with staff and previous Independent Members (IMs) disclosed a number of concerns around BCUHB affiliated patient safety, although no details were shared about these concerns. The Minister when escalating the health board to Special Measures requested that a separate assessment be conducted into whether or not these concerns were valid and if so whether further investigation was required.

2.0 APPROACH TO THE WORK

2.1 BCUHB is a significantly large and complex organisation and as per agreed Terms of Reference (*Appendix one*) the first function of this review is to understand more in relation to the issues raised and the associated investigative work which requires to be progressed. This initial work has been to gain detail of the information which was previously confidentially disclosed in relation to concerns of BCUHB affiliated patient safety. This was also to ensure that any potentially identified deficiencies or risks in process were as a priority escalated and mitigated.

2.2.1 As this work has progressed, it has also helped to provide additional focus within the ongoing response to the requirements of Special Measures of the work being undertaken on clinical governance, patient experience and safety.

2.2 The Terms of Reference also state that it is considered that the work of the patient safety review will constitute several components, including but not limited to:

- Speaking in confidence with staff who previously raised the concerns to understand and identify any deficiencies in the patient safety process.
- Reviewing relevant data surrounding incidents such as complaints, Datix, serious incidents, and never events to consider establishment of any patterns.
- Reviewing and considering current and proposed future clinical governance components as a collective effective organisational process and system, including safeguarding infrastructure.

- Reviewing and considering whether current and proposed future systems and procedures are consistent with the recent Duty of Candour[1] guidance issued by Welsh Government.
- Considering clinical staff capability in relation to understanding, implementing, and embedding quality monitoring, assurance and improvement in everyday practice, learning, and culture.
- Reviewing how patient experience is being used to support and inform quality processes.
- Reviewing and considering the local Putting Things Right[2] (PTR) process including PTR compliance, associated inquests and claims management, complaints and serious incidents and external investigation processes.
- Reviewing and considering the extent to which organisational learning is taking place and is embedded.

2.2.1 This report sets out initial findings related to these areas and the recommended areas for further focus and investigation. *Appendix three* provides a checklist of progress.

2.3 It must also be noted that in relation to the significant breadth of the issues raised, it is likely that further information exists within the Health Board which could provide additional information, although this was not easily found. Consequently, assessment could only currently be made on the information available, and at this stage, commentary and conclusions are drawn with the appropriate caution and caveats aligned to this.

2.4 It should be recognised that the context of discussion by the majority of individuals was rooted within the work that has been implemented so far in relation to the BCUHB new operating model and particularly the development of the Integrated Health Communities (IHCs). The document "*BCUHB People Strategy and Plan 2022/25 Mewn Undod mae Nerth | Stronger Together How We Organise Ourselves - Our New Operating Model* (January 2023)" sets out Central, East, and West IHCs having both a clinical delivery hierarchy and a system oversight function.

3.0 ONE TO ONE DISCUSSION AND PROPOSED ASSOCIATED CATEGORIES/THEMES

3.1 A number of individuals who had previously disclosed concerns regarding BCUHB affiliated patient safety had indicated that they could be contacted in confidence to further discuss these concerns. Additionally, discussions were also held with a small number of staff who had relevant experience or roles aligned to the subject matter of this review and who had also agreed to contribute to this work and offer their own, at times, confidential views. It should be noted that the number of people spoken to in totality at this stage is only fourteen, which is a small sample size, and it should also

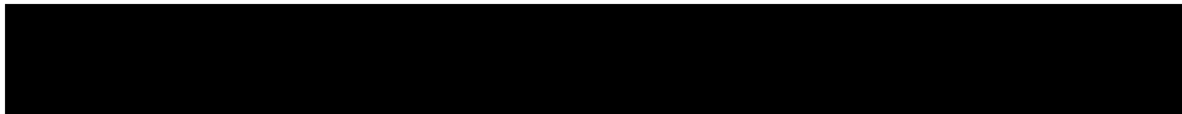
[1] https://www.gov.wales/nhs-duty-candour

[2] https://www.gov.wales/sites/default/files/consultations/2022-09/amendments-and-updates-to-the-putting-things-right-ptr-guidance_0.pdf

be noted who were or are working at a senior level (range from Band 8 to Very Senior Manager).

3.2 Timetable of one-to-one discussions: *table one*

	Date	Descriptor of person's experience or role
1	April 2023	Quality improvement
2	April 2023	Quality improvement
3	April 2023	Safeguarding
4	April 2023	Occupational health, safety, and security
5	April 2023	Senior leadership
6	April 2023	Patient experience
7	April 2023	Quality improvement
8	April 2023	Senior leadership
9	April 2023	Senior leadership
10	May 2023	Senior leadership
11	May 2023	Senior leadership
12	May 2023	Senior leadership
13	May 2023	Senior leadership
14	May 2023	Patient experience

3.3 

3.4 Meetings were held in confidence with an assurance that no comments would be attributable to individuals. There was no sense of reticence of providing commentary arising within the discussion and in fact, a number of individuals were very vocal around the issues they wanted to raise.

3.5 Discussion covered timelines both historical and of a more recent or contemporary way of working. There should also be recognition of the context of working within the pandemic and the associated restrictions that were in place during that time. It should be highlighted that some of the concerns raised are being or have been addressed within current BCUHB quality improvement work, and section five of this report provides more information on this. However, it is considered that this should not preclude information being included or associated recommendations being made, but that any specific points identified, whether historical or aligned to a more current timeline, can still provide helpful learning and benchmarks for the relevant quality improvement work.

3.6 There was no formal analytical or statistical resource aligned to this exploratory stage of this work, nor was there regarded a need for it at this time. Information gathered was principally qualitative, with much of it based within a broad narrative, rather than the reporting of specific incidents. Therefore, it is proposed that concerns disclosed can be principally divided up within this initial work, into the following categories/themes:

- Infrastructure
- Culture
- Specific Specialties of concern
- Other issues raised or commented upon

3.7 It should also be particularly noted that workforce was identified by all, as a 'golden thread' of both opportunity and risk. The significant BCUHB vacancy rate was raised as a concern, although a strategy is noted to be in place to address recruitment, with associated timelines. All types of staff vacancies were raised as being correlated to risk, however, the fact that there is legislation[3] around nurse staffing was particularly referenced. The indicators of patient well-being are noted within that legislation as being particularly sensitive to care provided by a nurse. This includes pressure ulcers, medication administration errors, patient falls, infiltration/extravasion injuries (paediatric inpatient), and others such as, patient experience, unmet care needs and failure to respond to patient deterioration. Staff experience, staff well-being, staff ability to take annual leave entitlement, and staff compliance with mandatory training and performance development reviews are also included within the legislation.

3.7.1 The requirement for compliance with the Nurse Staffing Levels (Wales) Act 2016 was highlighted as not just a non-compliance risk of the Act, but comments were made in relation to the underlying quality rationale not being met of having the requirements of the Act in place. These included:

- An associated direct risk in relation to not having enough staff and the inability to deliver the fundamentals of care was raised in areas such as risk of avoidance of hospital acquired pressure ulcers, prevention of falls, ensuring nutrition and hydration; alongside the undertaking of required observations and in general the ability to deliver quality patient safety, experience, and outcomes.
- The rate of staff sickness was also highlighted as a risk, and the effect of staff having worked during Covid and without a 'proper' opportunity to re-charge batteries, with morale being considered a potential safety risk correlated to staff exhaustion, and potential burnout or leaving.
- Additionally, the need for ongoing staff education and training, supporting staff well-being, ensuring staff retention, and the need for mature and compassionate leadership and succession planning at all levels were raised as high risks.

3.8 The information below which was raised in discussion, is set out in no proposed specific order of risk or opportunity, but mainly as it was extracted from the transcripts of discussion.

3.9 <u>Infrastructure</u>

[3] https://www.gov.wales/nurse-staffing-levels-wales-act-2016-statutory-guidance-version-2-html

3.9.1 A concern repeated within a number of the discussions was in relation to the need for a robust quality infrastructure which ensured that patient safety was understood to be everyone's responsibility, no matter what role staff held or where they worked. One person described the structure as "chaotic". Another stated that they had at times felt professionally compromised due to inadequate leadership with poor behaviours and concentration on the wrong things at the wrong time when the fundamentals of quality and safety required to be in place properly. They also stated that they considered that the monitoring of performance had been neglected during the pandemic and that there was a lack of infrastructure in place when 'coming out' of the pandemic to be able to plan and examine and understand the data and where work required to be focussed.

3.9.2 The quality of and accessibility to data arose frequently as requiring significant improvement. It was raised that there is a number of data inputs and outputs such as Civica, AMaT, Datix and for workforce data etc. However, it was considered that although data can be extracted, that it is not present collectively in 'one place' and does not easily allow staff to identify hotspots and exemplars in 'real-time'. A lack of triangulation and 'joining of the dots' including data such as Mortality and Morbidity meeting information, was also highlighted as an issue. It was flagged that a helpful Board workshop led by what was recalled as probably being the English lead for *Making Data Count*[4] had previously taken place, however, it was considered that after this "nothing changed".

3.9.3 The use and interrogation of Datix as a system was also a recurring theme, with a number of issues raised associated with this. It was highlighted that currently the new Datix system is an issue in that only 25% of the staff have had permissions profiled[5] and the Patient Safety Team is working with the national team to resolve. A lack of take up in training in the full use and structure of Datix for its' full capability and approach of use was also mentioned on a number of occasions. It was suggested that Datix is not always used 'properly' for notes, plans, reviews, although an exemplar was identified as East Acute who were described as "superb" in their use and application. There was no suggestion of under-reporting, however, more of a requirement to ensure that the system was used to its' potential and that action plans were updated and suchlike.

3.9.4 It was highlighted by a number of people that in some areas of practice there has been no formal analytical support in place, and this was also aligned to concerns of that area becoming an outlier where robust analysis of the data may provide more meaningful information to help with the necessary improvement work. Falls was raised as one of those areas of practice which it was suggested could benefit from a deeper dive and concerns raised as to practice and how significant improvements can be made. The same concern

[4] https://www.england.nhs.uk/wp-content/uploads/2019/12/making-data-count-getting-started-2019.pdf

[5] At the time of that discussion.

was also raised around improvement work required in relation to the management of hospital acquired pressure ulcers (HAPU). It was noted that the nursing team in particular, has not had the use of any staff member to undertake formal data/information analysis to allow robust triangulation of all data and intelligence/information as well as providing comparison. Attention was also drawn to the representation of falls and pressure ulcers as a high percentage within recorded Datix incidents as an indicator that more preventative work was required to be undertaken. It was also suggested more widely that the use of Plan, Do, Study, Act (PDSA) cycles as a model for improvement were not in place.

3.9.5 Concerns arose from a few people as to the efficacy of interventions, such as those used for falls, and hospital acquired pressure ulcers (HAPU). It was suggested by more than one participant that scrutiny, transparency, and independence could be more robust. It was queried as to how impacts of initiatives were evaluated, and if no significant improvements were being identified, how alternative interventions or innovations were then considered and implemented. It was acknowledged that recurring themes had been at times presented at various meetings with often no learning apparent from similar previous incidents, and that quality reports often focus on the harms which generally have the most available data, and perhaps at the expense of other areas where data is not that evident or available. It was also suggested that it is easier to identify services “under distress” and that there is a clearer process for at-risk services.

3.9.6 An inequity of approach to quality and patient safety across BCUHB as an organisation was mentioned several times by different people. A description of a silo approach to working, and success often appearing relationship-based rather than structural, as well as reports of historical ‘power bases, and a large geographical footprint to navigate and bring together as ‘one’. The lack of sharing of intelligence, was also repeated by several people who raised concerns as to the negative effect this had on the opportunity to be recognised as a learning organisation and that good practice was often over-shadowed by poor.

3.9.7 It was acknowledged that there are a significant number of staff who sit within the Quality Team. However, it was raised that structural operational changes had happened quickly as a move into a new way of working and capabilities were not matched correctly yet to what was required to be delivered, both at a strategic and operational level. Work was addressing this, and the need to upskill many staff had been identified, however, it was estimated that this could take some time to structure and undertake, particularly moving staff from current responsibilities and into a new operational model with some ongoing queries raised as to the previous ways of working and who would undertake work which is still required, such as responding to complaints letters, which was described as previously being aligned to a more administrative way of working. There were also several queries as to how the new operating model in the development of the Integrated Health

Communities (IHCs) was going to be operationalised effectively to undertake the relevant quality improvement work required.

3.9.8 The size of executive portfolios and who was leading on what, was a recurrent theme from several people. The words ‘muddled’ and ‘chaotic’ and once even ‘a sense of arrogance’ were used at different points with frustration voiced by several people as to who they should report to and where the leadership came from. One person reported working to five different executives in three years. However, it must be noted that a number of people in leadership positions themselves also voiced frustration and concern about portfolio size, content, and structure.

3.9.9 The need for clarity in relation to who was leading strategically and operationally within the new operating model was raised on several occasions by various people. A lack of clarity was highlighted in relation to how executive leadership and accountability and the role of the Integrated Health Community (IHC) leadership teams worked with a risk of duplication or confusion highlighted. Additionally, the pace of moving forward within the new operating model was highlighted, with a perceived lack of strategy raised as to what was to be focussed on, and a need to rapidly confirm the scheme of delegation model. It was agreed by all that patient safety should be everyone’s responsibility but there was a need to clarify roles and responsibilities and ways of working in the ‘here and now’. Some people also raised that the IHC approaches themselves were mixed, and that some were better than others regarding ownership of the quality agenda and aligned capacity and capability.

3.9.10 It was questioned by some participants as to how accountability meetings were run with suggestion that they could be too informal. Confusion as to the agreed structure of working with local partnerships and the Local Authorities was also flagged and where this should sit going forward, primarily questioning whether this was an executive function or IHC function or shared.

3.9.11 A number of people highlighted that a quality strategy needs to be applicable for modern system-wide healthcare, not just secondary care and that a whole system approach was not always understood, underpinned by multi-professional working with often a focus more on secondary care. Multi-professional working was also flagged as needing to be truly recognised as a triumvirate of medicine, nursing, and allied health professionals (AHPs); although the inception of a Director of AHPs within the new Integrated Health Communities (IHCs) was praised.

3.9.12 It was suggested that electronic multi-professional records might not have been taken seriously enough by the Health Board and not recognised previously as a risk on the corporate risk register. The importance of a good standard of record keeping and the correlation to safe and quality practice was highlighted along with the fact that record keeping is often mentioned in rapid learning panels. Additionally, it was explained that the newly

implemented Welsh nursing record is at risk of causing more work for allied AHPs as they have to duplicate their recording of care within their own AHP notes and the new nursing one.

3.9.13 A few people raised the quality of paper writing, suggesting that content could be often of a 'lift and shift' approach taken from previous narratives; as well as the need for meeting attendees to understand that they have an accountability to read the papers beforehand, come prepared and engage properly, as well as having enough time factored in to discuss the issues. It was understood that the executives sign off papers but due to size of portfolios, it was suggested that delays happen which might lead to a lack of scrutiny.

3.9.14 Some frustrations were raised around business processes and associated delays and lack of decision-making. The IV Access Service was given as an example where funding was obtained from the ITT recovery fund and the business case subsequently passed but it was considered that a lack of ownership had occurred within the timelines of the implementation of the new operating model, and this was delaying progress. It was explained that it is considered that there are clear benefits and outcomes to such a service for example decreasing pressure on unscheduled care and the lack of progress had a direct effect on this opportunity and there was a need for clarity as to where accountability sat.

3.9.15 The current model in use of ward accreditation was being examined as to whether it was the most effective way of assessing and ensuring quality. Questions were being asked as to what is being assessed within the model to demonstrate quality and the evidence underpinning that assessment. The EDoNM was considering whether an alternative model would be more effective.

3.10 Culture

3.10.1 A lack of understanding and lack of ownership at all levels of BCUHB around patient safety was brought up by a number of people during the discussions. The need to develop and embed a learning organisation ethos throughout BCUHB was also stated, as well as suggestion that there was a need for a formal learning strategy; especially when recurring safety themes were occurring and that there was a need to embed a learning culture in everyday practice and that it needed "bottoming out".

3.10.2 A few participants referred to the fact that it appeared that people frequently seemed to feel the need to ask for permission to put processes in place or use their initiative, leading to a reactive rather than proactive way of working. It was also mentioned a few times that new staff who arrived and tried to make changes or improvements were frequently unable to do so, and that they either left, or stayed and 'kept their heads down'. It should be noted that

there was no suggestion of deliberate obstruction but more a sense of often being disengaged or a lack of understanding within the workforce.

3.10.3 The need to have patients as a partner in their own care and in a shared decision-making model also arose within a number of discussions. It was reiterated that the Patient Advice and Liaison Service (PALS) was relatively new to BCUHB and truly person-centred ways of working and involvement in some areas were still fairly embryonic. It was suggested that there was a need for more patients on senior strategic groups, as well as defining what good looks like in relation to shared decision-making.

3.10.4 It was raised that there is a need for further work regarding Welsh language to be undertaken in relation to a number of areas, including the encouraging of local patient participation. It was referenced that there were only eight complaints last year in relation to Welsh language, which was suggested to be low, however, it was acknowledged that data is required to properly understand this and the associated actions which can be undertaken.

3.10.5 Interestingly, only one person raised that the NHS Duty of Candour requires to be understood widely by staff and that work was required to disseminate learning to start to embed this way of working across BCUHB. From April 2023 the duty of candour is a legal requirement for all NHS organisations in Wales. It requires them to be open and transparent with service users when they experience harm whilst receiving health care and builds on the Putting Things Right that has been in place since 2011. They will be required to:

- Talk to service users about incidents that have caused harm
- Apologise and support them through the process of investigating the incident
- Learn and improve from these incidents
- Find ways to stop similar incidents from happening again

3.11 Specific Specialties of concern

3.11.1 During the discussions, a number of concerns were raised, mainly with a general sense of concern, rather than the reporting of specific detail, in relation to certain specialties. Further information is set out within *Appendix two* as to the specialties which were highlighted.

3.12 Other issues raised or commented upon

3.12.1 Other comments made, or points raised were either in relation to wider service provision or specific areas of practice. These are captured separately below.

3.12.2 An issue was flagged in that a number of staff have left, leaving behind a number of reported incidents ‘open’ which they were responsible for actioning and a lack of understanding of which ones and their status. However, it was

explained that this is now significantly declining in numbers but has and does take a great deal of work in addressing.

3.12.3 A suggestion was made that a safety risk which is usually not recorded as an 'official' risk is in relation to patients who are medically fit for discharge and the associated numbers of delayed transfers of care (DToCs) and the associated implications of this. It was considered that this is a quality issue and not a patient flow issue which it is often identified as and highlighted that these patients quickly de-condition and there is no measurement of this as a contemporary risk.

3.12.4 The need to include and recognise medicines management and other pharmacy work as distinct components of quality was highlighted. It was flagged that there is both good practice and risk, and a considered lack of prominence in safety and quality discussion. Although the instigation of the role of Director of Pharmacy and Medicines Management in each IHC was praised.

3.12.5 A recurring theme with participants which came over very strongly was the need for the professions to always work together collectively, and the associated clinical knowledge and experience bringing significant strength to delivering quality in working that way. It was also suggested by several that there were many opportunities in triangulating the quality portfolio across the three professions of medicine, nursing, and allied health professionals (which also includes the health scientists); not just in clinical effectiveness and safety, but also within the aligned research, innovation, and education. A few people queried whether the current construct remained fit for purpose as to who held different components within their portfolios and that there was an opportunity to re-examine and re-fresh.

3.12.6 Health and Safety (H&S) was a recurrent theme within discussion and concerns were raised that the portfolio is currently held outside the 'official' quality portfolio, and this was seen as a missed opportunity to triangulate data and ways of working as a core part of both patient and staff safety. The value that the team brought was raised, such as during the pandemic when the H&S team had undertaken what was described as 'massive engagement' with a programme of fit testing, and a report of 12 thousand staff having been fit tested within 3 months.

3.12.7 The numbers of attacks on staff members were raised as a risk which sits within the H&S portfolio, although it was acknowledged that there is a new team in place which is addressing this. However, it was stated that the CCTV infrastructure is still poor. [redacted] which was described as being many years behind in approach and risk management.

3.12.8 Ysbyty Glan Clwyd (YGC) was particularly highlighted as requiring a stronger culture in relation to staff understanding the value and importance of health and safety. The need for stronger clinical leadership in relation to health and safety across the whole of the organisation was also raised, and that as a group, ward managers as local leaders are very variable in approach and understanding. It was suggested that a training analysis would be a helpful tool to identify hotspots across the Health Board. It was proposed that health and safety policy and infrastructure is in place, but that operational implementation requires strengthening and ensuring that all fundamentals are in place.

3.12.9 The importance of having an executive champion for H&S was raised, especially in holding departments to account. Mental Health was used as an example, and the observation policy, which requires staff to be trained in risk assessment and be process driven. It was also highlighted that it was very important that an executive chaired the Strategic Health and Safety Group to demonstrate the importance of the work and risk, and un-obstruct any potential blocks.

3.12.10 Additionally, the need for the estate to be refurbished in a number of areas was brought up and the direct correlation to contemporary health and safety practice that this has. Work on fire prevention work was highlighted as ongoing with the fire authorities, and the Board, and the need for continuous assessment to be undertaken in areas of risk when estates are challenged.

3.12.11 Safeguarding was also mentioned on a number of occasions and suggestions made that the operating model should not be solely aligned to the nursing portfolio, and that it should be recognised that the subject matter is nowadays much wider, with a modern safeguarding portfolio holding a variety of components such as county lines, deprivation of liberty safeguards, prevention of terrorism, trafficking, modern slavery, and others.

3.12.12 An opportunity to strengthen regular senior safeguarding attendance at Health Board Leadership Team meetings (HLBT) to enable a pan BCUHB position on all components of safeguarding was highlighted. Although, it should be noted that discussion has taken place recently at the BCUHB HBLT meeting, as to intended engagement in relation to the Joint Inspection of Child Protection Arrangements (JICPA).

3.12.13 Other comments which were raised in relation to safeguarding work were that at the time of discussion, it was thought that no one held executive responsibility as the Mental Capacity Act (MCA) lead in their portfolio, although this was subsequently clarified. It was also raised that there was a possible [redacted] This committee reports directly to Board and is currently vacant pending the new IMs allocation of roles.

3.12.14 Other concerns raised were the need to strengthen involvement for safeguarding involvement within the BCUHB work of Health Inspectorate Wales (HIW), Care Inspectorate Wales (CIW), Health and Safety Executive (HSE) coronial work, risk, and Make it Safe initiatives. The need to link up safeguarding with wider work such as the work on estates was also identified. Risks aligned to this are such as that outdated estate which is potentially not fit for purpose or requires significant investment or modernisation, increases the likelihood of falls or poor observation of patients. In addition, work on legislation such as Martyn's Law[6] will aim to help further improve public safety and reduce the risk to the public from terrorism by the protection of public premises and events.

3.12.15 The need to consider the Disclosure and Barring Service (DBS) checks was also highlighted, and it was currently recognised that the checks are only 'as good as the day they are undertaken'. An exemplar identified was local authority working, where a rolling programme was in place for continuous updates to be made as were relevant.

3.12.16 It was raised during discussion that professional allegations being made had increased during and post-pandemic, and that this should be identified as a risk.

3.12.17 Additionally, it was highlighted that the workload was increasing, due to the breadth of work covered and the need to stay on top of any new threats or risks that were identified, locally, nationally, and internationally. A business case to expand had been undertaken previously, however, it was queried as to whether this would now be successful.

4.0 SUPPLEMENTARY INFORMATION PROVIDED POST DISCUSSION

4.1 Following discussion, a number of people spoken with, offered up associated documents to support or evidence points made.

4.2 In relation to *Health and Safety*, several concerns were raised in discussion, as to the need to embed a culture of health and safety more strongly across all areas of BCUHB as an organisation. It was suggested that this included the need for senior leadership to support and promote what a contemporary health and safety approach should translate to, and the value that such a strong health and safety culture can bring to both patient and staff safety, with a move away from the more traditional and rules and regulation that can sometimes be at risk of being maligned as overly officious.

4.3 Attention was drawn to, and information provided on a gap analysis of 31 key pieces of legislation which was undertaken in 2019 by the BCUHB Health and Safety Team, Occupational Health, and Manual Handling Manager in partnership with the Trade

[6] https://homeofficemedia.blog.gov.uk/2022/12/19/martyns-law-factsheet/

Union Representatives. This work was undertaken over a 6-week period from 17 June - 31July 2019 and highlighted gaps in compliance and proposed solutions to the issues identified. It included site visits of 117 site specific inspections including Acute, Mental Health Community Services GP and Wrexham HMP.

4.3.1 A full review of legislative compliance was also undertaken to identify if the safety management systems within the Board were appropriate, as well as mapping to the relevant components of the Well-Being of Future Generations (Wales) Act 2015[7]. The report suggested that considerable work was required to ensure that assurance to the Board could be and continue to be evidenced in all service areas. Setting out an Occupational Health, Safety & Wellbeing Strategy 2019-2022, the report highlighted areas of concern and good practice and made recommendations on its findings and went to the Strategic Occupational Health and Safety Group on 29 August 2019.

4.3.2 It was reported that the audits identified 15 pieces of legislation deemed to be non-compliant, 13 partially compliant, and 3 fully compliant. It was stated that the overall impression of safety management systems was that Occupational Health and Safety (OHS) performance had become fragmented, with central control taking responsibility from sites with limited overall evidence of training, good quality risk assessments and safety management systems being implemented, and that clear lines of responsibility and accountability were not being evidenced in a number of service areas. Concern was highlighted over the management of key areas of the business including Health and Safety training, such as level of competence, asbestos management, legionella, contractor management and control, stress management, permits to work systems, work at height, manual handling, and control of substances hazardous to health.

4.3.3 The report stated that "*the lack of structure and systems makes the individuals who work for the Board and others who may be affected by its work activities at risk of serious harm. The risk leaves the Board open to enforcement action prosecution and fines for the most serious offences. A fundamental shift in the safety culture is needed to improve safety outcomes for staff, visitors, patients, contractors, and volunteers*". The report proposed a clear plan and framework for action to firstly identify hazards and place suitable controls in place; and stated that "*this will require appropriate funding and a determined effort to change attitudes and behaviours*".

4.3.4 It was also stated that "*there is a willingness to be open about the current state of OHS compliance in many service areas. There is also an acceptance that 'this is how it is' and that we are not telling the organisation anything new. Funding of services was often raised as a concern which makes compliance difficult to achieve. There are areas of excellent practice in place, however the overriding safety culture requires significant improvement. A lack of structure*

[7] https://www.gov.wales/well-being-of-future-generations-wales

in terms of responsibility for sites in the community make safety seem like someone else's problem and therefore no one takes ownership of OHS".

4.4 *Safeguarding*: again, as set out above, safeguarding is a fundamental of care and there are wide and varied components expected of modern safeguarding practice. The safeguarding portfolio is in line with legislation and statutory accountability, relating to statutory and operational delivery and holds a national, regional, and local responsibility, accountability, and reporting, and crosses over into England. This means it is significantly large and sits across all of BCUHB as a geographical footprint. To function safely and effectively there must be a clear operational and strategic infrastructure, to enable staff at all levels to fully understand their accountabilities and reporting structures and requires strong executive support for safeguarding leadership and practice.

4.4.1 Training and keeping up to date is a key part of safeguarding practice and post discussion, information was provided on compliance at the point of March 2023 which was reported to the Corporate Safeguarding Governance and Performance Group on 18 April 2023. Training compliance is under BCUHB's key performance indicator of 85% compliance. The report states that there is a positive picture where safeguarding training compliance is following a steady upward trajectory in all health economies compared to Q3. However, two of the health economies are below target compliance in all safeguarding modules; Corporate Services and Integrated Clinical Delivery – Primary Care.

4.4.2 Information was also provided which highlights that corporate safeguarding had requested a meeting with Workforce and Organisational Development (WOD) to discuss if they could provide assurance and timeframes in relation to attaching Level 3 safeguarding training competencies to individual staff on ESR. The report highlights that this action had not progressed since Q4 and WOD was aware that Risk 3756 is aligned to them.

5.0 OTHER INFORMATION CONSIDERED

5.1 <u>Other papers considered</u>

5.1.1 A significant number of papers were also requested by the author of this report, triggered by some of the discussion, and subsequently provided to examine. Triggers were for example, to understand the future direction of the patient safety work across BCUHB, and, considering whether issues disclosed had also been identified and addressed in previous and current BCUHB assurance processes with mitigations of identified or potential patient safety risk. This also included how the concerns raised in relation to health and safety, and safeguarding as noted within section four, had been followed up and monitored.

5.1.2 Many of the previous minutes and papers examined, frequently do not offer what might be considered a robust audit trail reflective of discussion and

escalation evidence, or formal analysis of patterns and themes. Bundles of papers were also extremely long, often sometimes running into several hundreds of pages, and are difficult to navigate.

5.1.3 It is clear that patient safety, experience and outcomes has warranted much BCUHB discussion with a significant number of papers produced over various timelines, setting out aims and plans for work being, or to be progressed. These included:

- The proposed Quality Governance Framework (Version 1.1 - 11 April 2023) which identified core principles of BCUHB quality committees, with aims of bringing together structures in relation to patient safety, patient and carer experience, clinical effectiveness, infection, prevention, and control, and safeguarding and public protection.

- A presentation paper entitled “Operational Governance and Assurance Framework Developing Service Governance – November 2022” states the plan to “have a golden thread of Governance from ward to Board but minimise the meeting burden”.

- The Operational Governance and Assurance Framework 2022 (V3.1) set out plans such as that to give the Board assurance of delivery structures and clarity of lines of accountability and improve the line of sight from Floor to Board through increased governance discipline and application.

5.2 Meetings observed

5.2.1 As part of this initial exploratory work, an opportunity arose to observe a small number of meetings. These were the IHC East Senior Team Catch Up meeting and the East IHC Quality Delivery Group, and the BCUHB Concerns and Incidents Improvement meeting and the BCUHB Strategic Patient Safety Group.

5.2.2 *East IHC Quality Delivery Group Meeting held on 23 May 2023*: this Quality Delivery Group meeting took a system wide approach, reflected in the multi-professional membership, and had a strong agenda. An ambition was discussed to move away from the model that nursing ‘has’ patient safety and experience and medicine ‘has’ clinical effectiveness. A programme of deep dives is set out, alongside the identification of themes and patterns and hotspots/exemplars. There was good chairing and participation. It would also be helpful to attend the other two IHC meetings to compare and contrast how quality is being monitored, evaluated, and improved.

5.2.3 *BCUHB concerns and incidents improvement meeting held on 24 May 2023:* this meeting is chaired by one of the two Deputy Executive Directors of Nursing and is to address the backlog position for complaints and incidents as a weekly scrutiny meeting. The focus of the meeting is to review overdue backlog for complaints and incidents within areas of responsibility. Data

regarding cases to be discussed are forwarded on a Thursday for discussion at the Wednesday meeting. The detail expected is 1. named lead for the case 2. feedback re reason for the delay 3. actions to be taken, and 4. an anticipated closure date. The meeting was well attended, with evidence of focus, progress on the backlogs and good working between the corporate teams and the wider teams.

5.2.4 *BCUHB Strategic patient safety group meeting held on 24 May 2023:* The Terms of Reference (ToR) for this meeting state that the PSG is a formal subgroup of the Health Board Quality Delivery Group (QDG) and is the single point of focus for all patient safety related activity across the Health Board. The PSG has a direct line of accountability to the Health Board Quality Delivery Group. The agenda included rotational deep dive patient safety reports from the IHCs, assurance reports on safety alerts, and reports from subgroups

5.3 Wider staff engagement

5.3.1 It is reiterated that the number of people spoken with is small within this report, and that there has been no work at this stage on actively sourcing opinions from a wider group of staff. It is also highlighted that the individuals spoken with at this stage of this work were of a more senior level who had disclosed or who had relevant experience or roles aligned to the subject matter of this review.

5.3.2 Although there was more of a general mix of staff roles and seniority at the meetings observed, those staff tended to be working within specific quality or safety aligned roles, so would naturally have a better grasp of the subject matter. Therefore, it remains unclear as to the understanding or operationalisation of patient safety in the wider sense of the workforce. The paper "*Ysbyty Gwynedd Review September 2022*" and authored by two executive staff, reported on an internal review in response to areas of concern raised by staff anonymously and work with the Speak out Safely Multi-Disciplinary Team to provide opportunities for feedback on experiences, views and concerns, doing so anonymously if they wished.

5.3.3 The information details feedback from staff at Ysbyty Gwynedd and included concerns about patient safety and reports of not being able to give the level of patient care staff would want to. 22 recommendations are proposed with a follow up survey to be undertaken in 12 months. It is also highlighted that these are proposals and that there is work to be undertaken to co-develop a number of Measures with staff at Ysbyty Gwynedd to address the concerns they have raised.

5.3.4 10 feedback sessions were held in Ysbyty Gwynedd in September to ask what staff thought of the recommendations in the report to check if anything had been missed. The report states that the feedback received was positive,

affirming that capture of feedback and the feeling of staff. Additional areas were also then included in the action plans.

5.3.5 It is also noted that concerns were raised by student nurses in the later part of 2021 into alleged poor clinical practice, poor patient experience and matters of safeguarding concern on a ward at Llandudno Hospital. Findings included a delay concerning the escalation of professional concerns and further assurance across Nurse Leadership Teams to the Executive Nurse Director to prevent further events was put in place. The initial student contact stage of the escalation process was also to be reviewed to ensure students are asked explicitly if the concern they are raising is specifically learning related and if there are any concerns about patient care or safeguarding.

5.4 Work in train across the Health Board

5.4.1 It should also be noted that some of the concerns disclosed are being, or have been, addressed by current quality improvement work. However, it is considered that this should not preclude information being included or associated recommendations being made, but that any specific points identified, whether historical or aligned to a more current timeline, can still provide helpful learning and benchmarks for the relevant quality improvement work.

5.4.2 Again, it must be reiterated, that only a small number of people have been spoken with and in relation to the breadth of the issues raised, it is likely that further information exists within the Health Board which could provide additional information. Therefore, as this paper is presenting initial findings it is considered that this information only represents a ‘snapshot’ of activity and suggested that further work is required to more formally map against both identified risk and opportunity.

5.4.3 Discussions with staff working within current quality roles were positive about their opportunities to make change to the current patient safety infrastructure and their agreement that there is a need for a new quality strategy. Although a key requirement for patient safety is understood to sit with all staff, no matter what level or role, the Executive Director of Nursing and Midwifery (EDoNM) currently is formally accountable for quality within her executive portfolio.

5.4.4 The EDoNM is progressing a restructure of the quality infrastructure some of which was acknowledged by staff spoken with and is referenced below. Two new Deputy Executive Directors of Nursing (EDoN) have been appointed, with one having responsibility for patient safety and the other for patient experience, and a plan to ‘swap’ portfolios after 12 months. The Deputy Director of Quality has responsibility for ‘central quality’, regulation, inspection work such as Healthcare Inspectorate Wales (HIW), inquests, legal, and they also line manage the Governance Teams within their portfolio. All three deputies report directly to the EDoNM. The Deputy EDoNs report that they

work closely with the Deputy Executive Medical Directors to ensure a multi-professional approach. The EDoNM meets quarterly and separately with the BCUHB Ward Managers, Heads of Nursing, and Matrons.

5.4.5 The need to move from 'firefighting' to being proactive and strategic in relation to all things affiliated to patient safety was mentioned several times during the discussions which took place. Changes being made were described as work in progress and included:

- The need to significantly reduce the complaints backlog. As described within paragraph 5.2.5, work is being led by the Deputy Executive Directors of Nursing at corporate level to address this and numbers have significantly decreased, although there is more work to do.
- Work on articulating and embedding the roles of the Patient Safety Team was also highlighted as being progressed, although timelines were estimated as this being potentially a large piece of work which also will include WOD, as some components of this are contractual and involve the need to 'upskill' staff.
- It was highlighted that work in relation to 'Human Factors' is being considered, as it is understood that this is another 'golden thread' running through everything. It was acknowledged that there is "a lot to do" but with a strong accompanying statement that often staff are working hard in circumstances out with their control and a need for compassionate leadership.
- Work taking place in the Emergency Department (ED) at YGC was reported as being of an intense support approach in the waiting room by the Patient Experience Team. Face-to-face staff training especially around empowering staff for local resolution was reported as providing a de-escalation of complaints, although it was acknowledged there was also a rise in referrals to the Patient Advice and Liaison Service (PALS).
- The Patient Experience Team was also progressing in work with the Urology Service, by writing to patients to explain delays for biopsies and offering "well-being advice". The team was also supporting patients with QR codes on the back of chairs (such as within ED) for information about PALS. The team had additionally been part of the Small Business Research Initiatives from Welsh Government which is in relation to improving communications with patients and the instigation of a project using a digital application to pass updates and information on to families and carers. Patients had been part of the development work as had a number of staff.
- Meetings in place, such as a daily patient safety meeting, followed by Make it Safe Plus and Rapid Learning, a monthly Harm Free Group, and an Organisational Learning Forum.

6.0 ESCALATION

6.1 As stated at the beginning of this report, BCUHB is a significantly large and complex organisation and to investigate and provide assurance in relation to the delivery of

patient safety, quality and experience requires the assessment of several components, including the processes in place of monitoring, assurance, and improvement. Therefore, this initial work has been to gain detail of the information which was previously confidentially disclosed in relation to concerns of patient safety. This was also, to ensure that any potentially identified deficiencies or risks in process were as a priority escalated and mitigated.

6.2 Information gathered has been principally qualitative, with much of it based within a broad narrative, rather than the reporting of specific incidents and/or complaints. This work has also been taking place simultaneously to the wider work being progressed under the response to Special Measures and the objectives and outputs aligned to that work.

6.3 No formal escalation was therefore required to investigate a specifically identified incident or complaint, however, as the information was obtained, and while maintaining the agreed confidential parameters, it has also fed informally into discussion at meetings and updates such as the regular Independent Advisor (IA) meetings, meetings with relevant BCUHB staff members, and at a Board and IA workshop which was held in May 2023.

7.0 PROPOSED AREAS FOR FOCUS

7.1 BCUHB is a significantly large and complex organisation and as per agreed Terms of Reference the first function of this review has been to understand more in relation to the issues raised around BCUHB affiliated patient safety and the associated investigative work which requires to be progressed.

7.1.1 The number of people spoken with is small, however, there are concerns that are repeated by different individuals, which it is considered demonstrates that there is further work to be undertaken in relation to achieving assurance in relation to BCUHB's approach to quality, and especially patient safety.

7.2 It is also acknowledged that BCUHB quality improvement work being progressed, for example, aligned to the proposed Quality Governance Framework, or the new operating model, may already be addressing these proposed areas or the associated comments. However, it is considered that this should not preclude the information being included or associated proposals being made. Specific points identified, whether historical or aligned to a more current timeline, can still provide helpful learning and benchmarks for the relevant quality improvement work, is an opportunity to undertake checks and balances, and plans for addressing transitional timelines and any associated risk in the transition period of change which requires mitigating.

7.3 As set out within this document the concerns disclosed, and the complementary information identified can be principally divided up within this initial work, into the following categories/themes: infrastructure, culture, specific specialties of concern, and other issues raised or commented upon.

7.4 The following are proposed as areas for focus within *table two:*

INFRASTRUCTURE	*Proposed areas for focus*	*Suggested level of prioritisation*
	In general, there is a need to design and implement a systematic approach using data effectively alongside a set of agreed Key Lines of Enquiry (KLOEs) in relation to assurance of optimal patient safety, experience, and outcomes. To be able to undertake this effectively the handling and accessibility of data and information needs strengthening and positioning in order to support robust and accessible real-time data being available electronically as a dashboard holding one 'single version of the truth' to accurately inform and support staff with all aspects of quality work, alongside formal analytical support to provide trend analysis and the ability for staff to understand and benchmark at all levels, ward/IHC/Health Board and externally, both nationally/internationally. Additionally, the aligned support of the transformation team is needed to work alongside local leadership to embed this approach as business as usual proactively.	**High priority**
	It is proposed that the implementation and embedding of the new quality framework would benefit from review, particularly around new clinical governance components coming together effectively as a collective organisational quality framework and system. This should include areas such as, but not limited to, safeguarding, health and safety, clinical effectiveness and research, audit, risk management, and education and training (both in relation to medical and non-medical learners). It is acknowledged that change will take some time to embed, however, it is proposed that this review could be commenced as soon as possible to evaluate simultaneously as its' implementation progresses, and learning can also be fed in to ensure ongoing adaptation as required. It is also suggested that by enabling the new quality strategy to be co-developed that this will strengthen it being co-owned by all and not 'seen as' potentially being imposed on staff.	**High priority**
		High priority

	In relation to the development and implementation of the new BCUHB operating model[8]: the scheme of delegation and structures between the executives and the senior IHC leadership teams require more clarity, and further detailing of ways of working, sharing of intelligence, risk, and opportunity. It is proposed that this information and any aligned Standard Operating Procedures should be disseminated to all staff, not just the leadership teams, so all staff fully understand ways of working and particularly in relation to understanding, implementing, and embedding quality monitoring, assurance and improvement in everyday practice, learning, and culture.	
	There is a need for the quality committees to have strong but respectful 'challenge' in addressing variations in patient safety practice, outcomes, and culture across the different sites; with a high standard of papers and note taking to trigger the relevant discussion and provide a robust recording of decision-making, actions, and evaluation. The cycles of all the BCUHB quality meetings across the organisation should be arranged to ensure that the calendar order of meetings taking place culminate in the pan-BCUHB assurance committees and Board receiving as near to contemporaneous data as possible by the time those meetings are being held. Governance should ensure that Board and Committee structures are in place; from a clinical perspective the Quality and Safety Committee needs to be strongly established with a clear rolling programme and key areas identified that need reporting, including for example how the process for "Duty of Candour" is to be adopted across the Health Board.	**High priority**
	Ensuring that there is an effective procedure for learning from incidents and that preparations for inquests, and the HSE, are proactive, clear, and effective.	**High priority**
	Examination of whether the model of medicine 'leading' clinical effectiveness and nursing 'leading' quality remains the most appropriate model and offers	**This priority is linked to the work on**

[8] BCUHB People Strategy and Plan 2022/25 Mewn Undod mae Nerth \| Stronger Together How We Organise Ourselves - Our New Operating Model (January 2023)

	the model required for robust impartial interrogation of data and associated initiatives; as well as a strong multi-professional leadership triumvirate of medicine, nursing, and allied health professionals (AHPs) to role model multi-professional working and professional respect across the organisation.	**executive portfolios which is currently taking place.**
	Review of and consideration of the local Putting Things Right (PTR) process including PTR compliance, associated inquests and claims management, complaints and serious incidents and external investigation processes would also strengthen the assurance and review of the quality system.	**Priority should be linked to the ongoing work on the new quality framework**
Culture	*Proposed areas for focus*	*Suggested level of prioritisation*
	Review of how patient experience and involvement is being used to support and inform quality processes and develop services and provide assurance that the voice of the patient is being listened to and actioned.	**High priority**
	Review of the mechanisms for strong multi-professional clinical engagement and involving staff in relation to ‘user feedback’ of quality systems. Draw up recommendations for improvement in engagement. This could include reviewing any patterns/themes in the data (albeit anonymous) in relation to the Speak Out Safely Campaign, which provides the option for staff to have an anonymous conversation with a member of the Speak Out Safely Team or Speak Out Safely Guardian.	**High priority and linked to the work on workforce and organisational development which is currently taking place.**
	Identifying, training, and supporting good local leadership in driving improvement and transformation.	**High priority**
	Embedding the duty of candour and quality into ‘business as usual’ ways of working and all practice.	**This priority is linked to the work on workforce and organisational development which is currently taking place.**

	Implement and embed a cultural change programme to address the reported variations in culture around a lack of understanding risk and mitigation and individual as well as organisational accountabilities being understood and actioned.	**This priority is linked to the work on workforce and organisational development which is currently taking place.**
	Review and consider the extent to which organisational learning is taking place and is being embedded.	**This priority is linked to the work on workforce and organisational development which is currently taking place.**
Specific Specialties of concern	*Proposed areas for focus*	*Suggested level of prioritisation*
	A number of services/specialties were mentioned either in the discussions which took place, or meetings observed (*Appendix two and Appendix four*). They are in no specific order. • Vascular • Stroke • Sepsis • Dermatology • Ophthalmology • Primary Care • Mental Health • Urology • Dental Access • Gastroenterology • Speech and Language Therapy • Physiotherapy • Crisis Response Team • Emergency Care • Children and Young People It is recognised that both vascular and mental health services have additional assurance work currently in train. It is also acknowledged that the disclosures did not raise specific incidents or complaints and at times described concerns as more of a sense that assurance work was requiring to be undertaken. Therefore, it is	**High priority**

	suggested that there is more work to be undertaken to gain a more detailed assurance of ways of working and patient safety, experience, and outcomes.	
	Wider professional discussion would strengthen as to what form this might take, while also taking account of the disclosure comments specifically in relation to specialties highlighted within paragraphs 3.11 and *Appendix two.*	**High priority**
	Reviewing an agreed statistically significant sample of data in relation to Complaints, Datix, Serious Incidents, and Never Events to consider establishment of any patterns or themes in relation to these specialties or others.	**High priority**
Other issues raised or commented upon	*Proposed areas for focus*	*Suggested level of prioritisation*
	In relation to safeguarding there is opportunity to include data such as that on training compliance as metrics in the design of a systematic approach alongside a set of agreed Key Lines of Enquiry (KLOEs) in relation to patient safety, experience, and outcomes.	**High priority**
	Safeguarding training compliance data should also be triangulated with practice outcomes, for example, specific Deprivation of Liberty Safeguards training, where the safeguarding team had targeted areas of low compliance and/or where audit activity identified the need for greater awareness and improvement. It is reported that the compliance data does not always correlate with evidenced clinical practice, and this triangulated approach provides additional assurance.	**High priority**
	Good safeguarding training compliance particularly in areas such as GP practices is clearly important. This was reported at times to fall below the expected compliance rate, and where a single presentation at a GP appointment might be the only opportunity a vulnerable patient has to access help, low compliance rates can escalate a risk of a safeguarding issue being missed. It is reported that there has been a number of requests from GP Clusters requesting bespoke safeguarding training for GP Practices and that this a matter being reviewed due to the demand. Additionally, attention is drawn to the reported variants of	**High priority**

	compliance levels within the Emergency Departments. It is also well recognised that ED staff should be particularly competent in safeguarding practice and knowledge, as this again might be the only chance vulnerable patients have to receive help if they present as an isolated case.	
	The need to link up safeguarding with wider work such as the work on estates was also identified. Risks aligned to this are such as that outdated estate which is potentially not fit for purpose or requires significant investment or modernisation, increases the likelihood of falls or poor observation of patients. In addition, work on legislation such as Martyn's Law will aim to help further improve public safety and reduce the risk to the public from terrorism by the protection of public premises and events.	**High priority**
	There is an opportunity to strengthen regular senior safeguarding attendance at and within various pieces of senior internal and external work, such as the Health Board Leadership Team meetings (HLBT) meetings, and the BCUHB work of Health Inspectorate Wales (HIW), Care Inspectorate Wales (CIW), Health and Safety Executive (HSE) coronial work, risk, and Make it Safe initiatives.	**This priority is linked to the work on executive portfolios which is currently taking place.**
	The need to consider the Disclosure and Barring Service (DBS) checks was also highlighted, it was currently recognised that the checks are only 'as good as the day they are undertaken'. An exemplar identified was local authority working, where a rolling programme was in place for continuous updates to be made as were relevant.	**This priority is linked to the work on workforce and organisational development which is currently taking place.**
	In relation to Health and Safety there is opportunity to ensure that significant work has been undertaken to ensure that there is robust control of systems and processes, including policies, and training. Again, there is opportunity to include relevant data as metrics in the design of a systematic approach alongside a set of agreed Key Lines of Enquiry (KLOEs) in relation to patient safety, experience, and outcomes and for staff to understand that this area is central to delivering quality for both patients and staff.	**High priority**

	The importance is raised in having strong and visible executive leadership for Health and Safety work, and an executive always chairing the Strategic Health and Safety Group to demonstrate the importance of the work and risk, and un-obstruct any potential blocks.	**High priority and linked to work on executive portfolios which is currently taking place.**
WORKFORCE	*Proposed areas for focus*	*Suggested level of prioritisation*
	There is opportunity to include relevant workforce data as metrics in the design of a systematic approach alongside a set of agreed Key Lines of Enquiry (KLOEs) in relation to patient safety, experience, and outcomes.	**High priority**
	It remains unclear as to the understanding or operationalisation of patient safety in the wider sense of the workforce and it is suggested that the opportunity to have a wider dialogue around patient safety across the BCUHB sites other would be useful in some form or other, including potentially an earlier 'check in' on the efficacy of the action plans in progress in relation to the recommendations from the *Ysbyty Gwynedd Review September 2022*.	**High priority and is linked to the work on workforce and organisational development which is currently taking place.**
	The need to encourage more academic and research leadership roles working in partnership with clinical leadership roles to promote and embed the translation of evidence into practice, particularly the strengthening or instigation of these roles within nursing and allied health professions who appear to be less active in this space than medicine e.g. consideration of a Professor of Quality or Patient Safety.	**High priority and linked to work on executive portfolios which is currently taking place.**
	Reviewing staff capability and capacity in relation to understanding, implementing, and embedding quality monitoring, assurance and improvement in everyday practice, learning, and culture.	**This priority is linked to the work on workforce and organisational development which is currently taking place.**

	Ensuring staff have the right tools and support to understand and undertake their role in delivering safe and effective care.	**This priority is linked to the work on workforce and organisational development which is currently taking place.**
	A formal process for talent spotting and succession planning in place to identify and support future clinical leaders.	**This priority is linked to the work on workforce and organisational development which is currently taking place.**
	Reviewing local multi-professional regulatory data and identifying whether any patterns or themes are arising and if education and training could also support and decrease those incidents. It was raised during discussion that professional allegations being made had increased during and post-pandemic, and that this should be identified as a risk.	**This priority is linked to the work on workforce and organisational development which is currently taking place.**

8.0 TRIANGULATION OF ASSOCIATED RISK

8.1 Attention has also been drawn to information which has arisen separately from others undertaking wider work and investigation during the first three months as part of the response to Special Measures. These have arisen out with the scope of this work; however, it is considered triangulation of the identification of these issues add to the weight of the conclusion and associated risk for further work requiring to be undertaken. It is suggested that the proposed areas for focus would also address a significant number of those issues.

8.2 A Coroner has a duty to issue a Regulation 28 Report to an individual, organisations, local authorities or government departments and their agencies should they believe that action(s) should be taken to prevent further deaths. This report recognises that this year, a number of Regulation 28 Reports have been issued or there has been an indication of intention to issue by HM Coroner to the Health Board regarding concerns such as:

- Failure to learn from previous incidents.
- Incomplete investigations that have taken too long.
- A lack of integrated notes.
- Actions identified with unrealistic, rather than informed, dates for completion
- Evidence provided by a staff member at an inquest raised a concern from HM Coroner that there was an absence of a clear policy for responding to patients' needs who are in receipt of community mental health services but did not wish to engage with home treatment services.

8.2.1 HM Coroner has also indicated the opening of inquests into four deaths that were reported by BCUHB, following an independent review by the previously set up Vascular Quality Review Panel as referenced previously. These cases were not referred at the time of death by medical staff. HM Coroner indicated the expectation of a senior witness to attend from the Health Board to explain changes within the vascular service. No dates are currently listed for these inquests.

8.3 The Health Board has previously been notified of a pending prosecution from the Health and Safety Executive (HSE) following the death of an inpatient under the care of BCUHB mental health services. The Health Board has now been notified that the Hearing has been scheduled for 3 August 2023. The prosecution follows from a HSE investigation, after which a Notice of Contravention (NOC) (09 May 2022) was issued identifying breaches of legislation. The NOC identified three issues in the case investigated:

1. Risk assessment and care and treatment plan, specifically not being updated with current risk and management plans/mitigations.
2. Bed safety, specifically the use of a standard hospital bed rather than an anti-ligature bed.
3. Removal of ligatures, specifically providing the dressing gown belt.

8.3.1 It is noted that evidence is being gathered to present in mitigation and legal counsel has been engaged, and while any commentary on this is inappropriate for this report, it was felt relevant to include as Health and Safety and Mental Health concerns were both noted within discussions held and as recorded previously.

8.4 In April 2023, it was noted that the Health Board had received a letter from Healthcare Inspectorate Wales (HIW) following concerns raised by a member of staff stating that issues raised within the Health Board's incident reporting system (Datix) had not been addressed in a timely manner.

8.5 Also in April 2023, it was noted that the Public Service Ombudsman for Wales had reported into the care of a patient at Ysbyty Glan Clwyd (YGC) relating to the care of a patient between May 2019 and May 2020. The Ombudsman accepted the patient was cared for during the early days of the COVID-19 pandemic but was clear that "despite the pressures, health service delivery was to continue to follow the principles

set out in equality and human rights legislation in terms of providing patient centred care." Three elements of concern were identified:

1. Surgical delays in the fitting of stents into a kidney led to post-operative complications, however, the Ombudsman did not uphold this aspect of the concern.
2. The inpatient management and care at the Hospital following the patient's admission which included concerns of inadequate bowel care, the Ombudsman upheld this aspect of the concern and found a failure to conduct a manual bowel evacuation, poor record keeping, resulting in a lack of effective clinical and nursing oversight, and poor pressure sore management.
3. The adequacy and the robustness of the Health Board's complaint response, the Ombudsman upheld this complaint and criticised the Health Board complaint response for lack of clinical thoroughness.

8.5.1 The Health Board accepted the recommendations, and learning, and the Ombudsman issued this as a Public Interest Report. However, this is also felt relevant to include as fundamentals of care concerns were noted within discussions held and as recorded previously.

8.6 It should also be noted that the Executive Director of Nursing and Midwifery (EDoNM) has been contacted by the Nursing and Midwifery Council (NMC) raising concerns aligned to a number of services which they identified through media coverage. These services are apparently aligned to the recent inquests and Coroner's concerns, the Health and Safety Executive prosecution of the Health Board and an Ombudsman case.

8.6.1 The EDoNM was to meet with the NMC at the earliest opportunity to discuss these concerns and further detail to be shared once the meeting has taken place. However, this is also felt relevant to include as a risk of increased regulatory referrals was noted within discussions held and as recorded previously.

8.7 A Royal College of Surgeons Invited Review of the Urology Service at Ysbyty Gwynedd has been undertaken and immediate feedback following the review visit in March 2023 identifies a number of issues raised by the review team in relation to:

- Facilities and Infrastructure
- Workforce
- Robotic Surgery platform
- Team working across the three North Wales Units

8.7.1 A full report will be received in due course and a response to the immediate issues raised is being led via the Office of the Medical Director. However, this is also felt relevant to include as urology services were noted within discussions held and as recorded previously.

9.0 CONCLUSION

9.1 NHS Wales defines patient safety as the avoidance of unintended or unexpected harm to patients during the provision of health care[9]. Organisations across NHS Wales are expected to work within a culture and infrastructure of continuous improvement of safety and quality, developing safer environments and reducing avoidable harm.

9.2 On 27 February 2023, Betsi Cadwaladr University Health Board was escalated to Special Measures in line with the NHS Wales Escalation and Intervention Framework.

9.3 The first three months of the Health Board's response to intervention has focused upon understanding some of the issues that underpin the rationale for Special Measures and developing solutions. This work has been part of that approach and focussed on gaining detail of the information which was previously confidentially disclosed in relation to concerns of patient safety and the associated investigative work which requires to be progressed.

9.4 It should be noted that colleagues are leading significant other work in relation to workforce and organisational development, compassionate leadership, and engagement which also reads across to some of this work. The initial findings within this report complement components of that other work and learning, which is considered helpful as a process of assurance and triangulation. The identification of other information has been collated under the proposed headings for further areas for focus. Additionally, no formal escalation was required to raise a specifically identified incident or complaint which might not have been identified before.

9.5 It is also important to recognise that there is good work happening across BCUHB in addition to the areas where improvements need to be made, and some disappointment has been fed back in that poor practice can often over-shadow the recognition of that other good practice. The infrastructure in relation to quality and safety has recently been reviewed and is starting to be structured differently in approach and the roles within it. External support and advice have been welcomed and often requested, information and papers have been shared, with additional suggestions of other helpful reading, and invitations offered to observe relevant meetings.

9.6 It must also be noted that in relation to the significant breadth of the issues raised, it is likely that further information exists within the Health Board which could provide additional information, although this was not easily found. Consequently, assessment could only currently be made on the information available, and at this stage, commentary and conclusions are drawn with the appropriate caution and caveats aligned to this.

[9] https://du.nhs.wales/patient-safety-wales/#:~:text=Patient%20Safety%20is%20the%20avoidance,environments%20and%20reducing%20avoidable%20harm.

9.7 Although the number of people spoken with is currently small, this must also be weighed up against the fact that there are concerns that are repeated by different individuals, which it is considered demonstrates that there is further work and investigation to be undertaken to gain a more detailed assurance of ways of working in relation to patient safety, experience, and outcomes. Additionally, the recognition of recent or ongoing issues, as set out within section eight, can be triangulated with some of the disclosure information and it is considered add to the weight of conclusion that there is associated risk of a need for further work to be undertaken as per the areas proposed for focus (*table two*).

9.8 Therefore, in conclusion, it is clear that a great deal of work is progressing as to developing a strong quality infrastructure and embedded organisational culture across BCUHB as to patient safety being everyone's responsibility. However, it is evident that some challenges are ongoing. For that reason, it is recommended that more detailed work is required aligned to the wider work on Special Measures. Proposed areas for focus are presented within *table two* as suggested next steps to either feed into already established workstreams, or addressed separately, but ultimately to support the shared goal of ensuring that BCUHB's approach to quality, and especially patient safety, is on a robust foundation of monitoring, assurance, and improvement.

10.0 ACKNOWLEDGEMENTS AND THANKS

10.1 Thanks are given to all the individuals who helped provide information and support, both verbal and written, referenced within this report. **[END]**

APPENDICES

Appendix One

PATIENT SAFETY REVIEW
TERMS OF REFERENCE April 2023

1.0 BACKGROUND

1.1 On 27 February 2023, the Minister for Health and Social Services announced that she was escalating the intervention status of Betsi Cadwaladr University Health Board (BCUHB) to special measures with immediate effect. This decision reflected serious and outstanding concerns about board effectiveness, organisational culture, service quality and reconfiguration, governance, patient safety, operational delivery, leadership, and financial management.

1.2 A number of Independent Advisors (IAs) have been appointed to form a BCUHB improvement and support team to provide the support and advice necessary to enable BCUHB to implement the changes required to deliver improvements. The support and advice in this instance refer to an objectively derived blend of measures (monitoring, assurance, evaluation, guidance, encouragement, and support) which in combination will provide assurance to stakeholders (including patients, staff and the wider public).

1.3 The Advisors will focus specifically on the following:

- Governance and board effectiveness.
- Workforce and organisational development.
- Finance and audit
- Leadership and culture
- Clinical governance and patient safety.
- Operational delivery and service transformation

1.4 Additionally, discussions with staff and previous Independent Members have highlighted a number of concerns around BCUHB affiliated patient safety. The Minister when escalating the health board to special measures requested that a separate investigation be conducted into these matters, and these Terms of Reference set out the parameters of this work

2.0 PATIENT SAFETY REVIEW APPROACH

2.1 A patient safety review is to be undertaken, complementary to the IA's work as set out above, and underpinned by the information of the issues which were previously raised in relation to patient safety and others that have been identified as part of the scoping of this work.

2.2 The first function of this review is to understand more in relation to the issues raised and the associated investigative work which requires to be progressed.

2.3 It is considered that the work of the patient safety review will constitute several components, including but not limited to:

- Speaking in confidence with staff who previously raised the concerns to understand and identify any deficiencies in the patient safety process
- Reviewing relevant data surrounding incidents such as complaints, Datix, serious incidents, and never events to consider establishment of any patterns
- Reviewing and considering current and proposed future clinical governance components as a collective effective organisational process and system, including safeguarding infrastructure
- Reviewing and considering whether current and proposed future systems and procedures are consistent with the recent Duty of Candour guidance[10] issued by Welsh Government
- Considering clinical staff capability in relation to understanding, implementing, and embedding quality monitoring, assurance and improvement in everyday practice, learning, and culture
- Reviewing how patient experience is being used to support and inform quality processes
- Reviewing and considering the local Putting Things Right (PTR) process including PTR compliance, associated inquests and claims management, complaints and serious incidents and external investigation processes
- Reviewing and considering the extent to which organisational learning is taking place and is embedded

2.4 It should be noted that the any disclosures received concerning patient safety issues will not be reported on individually, but that confidential information shared will help to understand and identify any deficiencies in the patient safety process. Following consideration of this and the information considered above, a report will be provided identifying and advising where possible, recognised, or potential risks, gaps, and opportunities regarding the current and proposed future quality management system. This will be principally in relation to areas such as quality management, assurance, and the embedding of continuous improvement across BCUHB within a culture of supporting ongoing quality improvement and organisational learning to help enable the delivery of the best outcome and experience for patients, their families, and carers.

3.0 INFORMATION TO BE CONSIDERED

3.1 Information and background reading which will also underpin and inform this work includes, but is not limited to:

- Background reading for Independent Advisors (iBabs);

[10] https://www.gov.wales/nhs-duty-candour#:~:text=From%20April%202023%20The%20duty,harm%20whilst%20receiving%20health%20care

- Minutes of the Quality, Safety and Experience Committee meetings – 20 January 2023, 1 November 2022, 6 September 2022, 6 July 2022, 1 March 2022, 11 January 2022;
- The Quality, Safety and Experience Committee Chair's Report 20 January 2023;
- The Quality, Safety and Experience Committee's Terms of Reference;
- BCUHB Risk Management Strategy 2022-2025;
- BCUHB Clinical Services Strategy June 2022 V0.1;
- BCUHB Integrated Medium Term Plan 2022-2025;
- BCUHB Operational Governance and Assurance Framework November 2022;
- BCUHB Patient Safety Report December 2022 – January 2023;
- Health and Social Care (Quality and Engagement) (Wales) Act 2020;
- Nurse Staffing Levels (Wales) Act 2016: statutory guidance (version two);
- Overview of BCUHB Service Governance 8 February 2023;
- Organogram North Wales Regional Partnership Board;
- North Wales Collaborative[11];

3.2 Views and/or findings from a number of internal and external stakeholders will also help with the understanding of the associated investigative work and/or assessment of the work which requires to be progressed. These stakeholders may include, but not be limited to, staff, patients and carers, and relevant external agency reports such as Audit Wales[12].

4.0 COMPLEMENTARY ROLE OF THE INDEPENDENT ADVISERS IN RELATION TO THE REVIEW

4.1 One of the clinical IAs has been specifically commissioned to undertake this work and will report back to the SRO of the Welsh Government and the other IAs as set out above.

4.2 Other IAs will most likely also identify information which can assist in the progression or consideration of different components of this work. This is considered to be in relation to areas such as clinical governance, as this particularly encompasses various components coming together to monitor, assure and improve safety, quality and experience including patient/client feedback, effective leadership, evidence-based practice, education and training, audit and managing risk.

4.2.1 Therefore, feedback and discussion on this review as it progresses will be a standing item on the BCUHB Independent Advisors regular meeting chaired by the SRO of the Welsh Government.

4.3 It is also understood that BCUHB executive portfolios have recently changed, and work is progressing in relation to a new quality strategy and infrastructure. It is

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[11] https://www.northwalescollaborative.wales/north-wales-social-care-well-improvement-collaborative/

[12] Betsi Cadwaladr University Health Board – Review of Board Effectiveness Audit year: 2022-23 Date issued: February 2023 Document reference: 3370A2023

expected that this patient safety review will be welcomed in relation to providing support and advice on this new quality work as it progresses, and associated identification of recognised, or potential risks, gaps, and opportunities regarding the current and proposed future quality management system from the information gathered will be useful intelligence to help shape strategy and structure.

5.0 REPORTING & GOVERNANCE

5.1 The clinical IA specifically commissioned to undertake this work will report back to the SRO of the Welsh Government and the other IAs as set out above.

5.2 Additionally, to ensure that any relevant learning or identified risk is fed contemporaneously into the development of the new quality strategy and implementation/embedding of this work, any specific points identified whether historical or aligned to a more current timeline will be escalated without delay to the Welsh Government SRO of this work, and the relevant BCUHB executive(s).

6.0 TIMELINES

6.1 A commission of 20 days to support and develop the work required related to patient safety considerations has been awarded.

7.0 REVIEW OF TERMS OF REFERENCE

7.1 These Terms of Reference will be reviewed after one month or if it should be deemed necessary before this as the scope of the work is better understood. **[END]**

Appendix Two

Specific specialties of concern

Specialty	Concerns and Comments
Vascular	The challenges in relation to vascular services are well documented and underpinned by significant improvement work and actions as recommended by a number of reviews[13]. However, vascular was also a recurring theme within several discussions with opinions voiced that there was still much to do within the Speciality including improving clinical leadership, and culture.
Stroke	The treatment of stroke was mentioned on a few occasions as a concern. It should also be noted that within the Report of the BCUHB Vascular Quality Review Panel (2023) that recommendations also included the need to explore how well integrated the stroke and vascular teams are, in addition to what treatment options are available locally for acute stroke. The Vascular Quality Review Panel report also stated that on several occasions that the daily input of a geriatrician (Care of the Elderly) could have helped the overall medical course of certain patients as it is recognised the role this position has in strengthening links to other teams such as the palliative care and the stroke teams.
Sepsis	One participant queried the reporting of sepsis and the accuracy of the figures. They raised a concern that the local process of reporting sepsis was apparently changed without consultation, they reiterated that they considered that there was no specific intent to deceive with the change, but that it was more from a position of naivety. However, they still considered that the figures were now 'not stacking up'.
Dermatology	The dermatology service was highlighted in discussion. A descriptor of the service was that it runs like an extended secondary care service and the network need "sorting out". Although one participant suggested that dermatology and plastics had issues that were easier '"to fix" than other 'challenged services'.

[13] Betsi Cadwaladr University Health Board Vascular Quality Review Panel Report - submitted: 25 January 2023.
Royal College of Surgeons' Report on 44 clinical records relating to vascular surgery on behalf of Betsi Cadwaladr University Health Board Review visit carried out on 19 July 2021, report issued 20 January 2022.
Royal College of Surgeons England (RCSE) Report on the Vascular Surgery Service Betsi Cadwaladr University Health Board Review visit carried out on 11- 13 January 2021 and Report issued 15 March 2021.

	However, other issues associated with the service were raised as a refusal to share budgets, that there was a power base differential with service resistance to change or embrace new ways of working such as tele-dermatology. It was stated that one consultant refuses to transform, and no one will challenge them and that another 'very good' consultant left due to the 'pack mentality'.
Ophthalmology	One participant suggested that the ophthalmology network required review. No specific concerns or risks detailed, or specific data could be provided, just that as a pan-BCUHB service and a sense that it was considered that it would be helpful to review.
Primary Care	A number of participants suggested that it would be helpful "to shine a spotlight" on primary care. It was suggested that the importance of prevention is not understood or valued. The variation in ways of working of managed and GMS practices was raised as needing understood. The importance of a system-wide approach was strongly supported and suggested that the IHCs and their leadership could be key in this space. However, it was also raised that the IHC model is not for acute focus only but there was a risk that it is thought in this way and is not recognised as embedding a system approach and model. Another person stated that they considered that community risk is not being robustly examined and they were worried about this, another also alluded to this and specifically highlighted the need to examine community medicines management. It should also be recognised that particularly good practice was raised within the community nurses' team caring for ventilated patients.

Mental Health	Again, the challenges in relation to mental health services are well documented and underpinned by turnaround work and actions as recommended by a number of reviews. However, mental health services continued to be a recurrent theme as requiring improvement. Several participants also queried as to why mental health sits 'outside' of the other clinical services and has a different reporting structure. A participant voiced specific concerns about mental health services and described that there was an inequity across North Wales and stated that mental health was frequently not recognised or seen as important. They highlighted concerns as to Child and Adolescent Mental Health Services (CAMHS), delays in neuro-development assessment and referenced a long waiting list for the North Wales Autism Service, voicing that there was too long a wait for assessment and no correlation with long term risk and work to do on benchmarking. Another participant highlighted that the mental health model is an old-fashioned approach with a triumvirate of medicine/nursing/director and that to stand alone could bring vulnerability and risk.
Urology	One person raised concerns as to delays in urology. Another reported that they considered that there was a good staff appetite within the urology service, to make change and progress was being made.
Dental Access	One person raised that dental access is an issue, however, they did acknowledge that this is a similar challenge across the UK.

Appendix Three

Terms of Reference components checklist of progress

Component	Update
Speaking in confidence with staff who previously raised the concerns to understand and identify any deficiencies in the patient safety process	Completed
Reviewing relevant data surrounding incidents such as complaints, Datix, serious incidents, and never events to consider establishment of any patterns	Included as an area for focus, under *specific specialties of concern.*
Reviewing and considering current and proposed future clinical governance components as a collective effective organisational process and system, including safeguarding infrastructure	A number of components separately commented upon with this report, such as safeguarding. Additionally included as areas for focus, under *infrastructure,* and, *other issues raised or commented upon*, with a specific proposal that the implementation and embedding of the new quality framework would benefit from review, particularly around new clinical governance components coming together effectively as a collective organisational quality framework and system. This should include areas such as, but not limited to, safeguarding, health and safety, clinical effectiveness and research, audit, risk management, and education and training (both in relation to medical and non-medical learners). It is acknowledged that change will take some time to embed, however, it is proposed that this review could be commenced as soon as possible to evaluate simultaneously as its' implementation progresses, and learning can also be fed in to ensure ongoing adaptation as required. It is also suggested that by enabling the new quality strategy to be co-developed that this will strengthen it being co-owned by all and not 'seen as' potentially being imposed on staff.
Reviewing and considering whether current and proposed future systems and procedures are consistent with the recent Duty of Candour guidance issued by Welsh Government	Discussed within this report and proposed that further work is undertaken as an area for focus under *Culture* to support the embedding the duty of candour and quality into 'business as usual' ways of working and all practice. This priority is linked to the work on workforce and organisational development which is currently taking place.

Considering clinical staff capability in relation to understanding, implementing, and embedding quality monitoring, assurance and improvement in everyday practice, learning, and culture	Discussed within this report and proposed that further work is undertaken as an area for focus under *workforce.* This priority is linked to the work on workforce and organisational development which is currently taking place.
Reviewing how patient experience is being used to support and inform quality processes	Discussed within this report and proposed that further work is undertaken as an area for focus under *culture* to support and inform quality processes and develop services and provide assurance that the voice of the patient is being listened to and actioned.
Reviewing and considering the local Putting Things Right (PTR) process including PTR compliance, associated inquests and claims management, complaints and serious incidents and external investigation processes	Included as an area for focus, under *infrastructure*.
Reviewing and considering the extent to which organisational learning is taking place and is embedded	Discussed within this report and proposed that further work is undertaken as an area for focus under *workforce.* This priority is linked to the work on workforce and organisational development which is currently taking place.

Appendix Four

IHC East risks – referenced East IHC Quality Delivery Group Meeting held on 23 May 2023

Gastroenterology	The risk is described as a risk of significant workforce absence, caused by consultant vacancy, and increase in workload. It is also highlighted that existing staff seek to reduce contracted sessions which will have an impact on capacity and demand, also resulting in difficulty to recruit and retain gastroenterologists. A risk due to a lack of permanent administrative staff in the gastroenterology Speciality was also noted with an administrative related backlog was also noted, and example given as delays to correspondence to GP surgeries to advice on future management plans for patients etc.
	Controls in place are such as the use of locum consultants but recognised as an inadequate mitigation due to the nature of locum consultancy work, particularly in relation to the giving of notice at short notice.
	The consultant ward rota being run between four gastroenterology doctors from mid-2023 with assistance from the registrars and junior doctors.
Speech and Language Therapy (SLT)	The risk is described as patients with swallowing and communication difficulties at risk of not receiving timely clinical SLT assessments, and that the well-being of SLT staff could be compromised due to critically reduced staffing levels in the East IHC team.
	Controls in place are such as 1.2WTE SLT cover in Ysbyty Wrexham Maelor from January 2023 without additional actions; three headcount part-time. Swallow screening test in place and embedded practice. Embedded clinical prioritisation system in place for senior SLTs to dynamically prioritise daily clinical demands.
	Key further actions to be completed are prioritisation of dysphagia training for junior SLTs, and that nurses will be guided to re-screen (twice or three times repeat) with SST.
Physiotherapy	The risk is described as that outpatient physiotherapy services will not be delivered in a timely manner in the Wrexham County, caused by the lack of an outpatient physiotherapy department in Ysbyty Wrexham Maelor, due to reconfiguration which allows other services to be housed in the physiotherapy department to comply with infection prevention and control processes and social distancing Measures due to Covid-19. It is noted that this is also caused by a lack of alternative available space to accommodate sufficient numbers of patients for follow-up appointments.
	The impact of the risk is described as the potential to lead to poor patient outcomes such as pain disability and an impact on ability to work. A possible subsequent implication is impact on other services

	such as the Emergency Department (ED), Primary Care, and Clinical Musculoskeletal Assessments and Treatment Services (CMATS), as well as potential inability to meet Welsh Government Referral to Treatment Times (RTT). Possible additional pressures to the Pain Management Service, and Early Intervention Team are also mooted.
	Controls in place are such as utilisation of available but limited face-to-face outpatient access at Chirk Hospital. Village halls and leisure facilities being utilised to support group therapy classes. Using the limited access to clinic space available in WMH to its potential. Offering some appointments in Flintshire Mold and Deeside Hospitals, dependent upon urgency and ability to travel. The optimisation of virtual consultations and home working options, although it is noted that further space is required to increase this. The use of 'Physio-Direct Service' to triage and assess the level of risk and clinical need.
	Key further actions to be completed are the lease or purchase of suitable accommodation, confirmation of move to another purchased building.
Three emerging risks identified as in development	
Crisis Response Team	This is described as a risk that information for community and acute inpatients/discharges is unreliable and non-auditable.
	Controls in place are such as the regular review of permissions, the members of the home first and information teams validating information, with regular training being given to staff.
	Key further actions to be completed are to develop a Situation, Background, Assessment, Recommendation (SBAR), to set up a workgroup to identify a new system that will work with stream or Wales Patient Access Schemes (WPAS), and to submit a mandate to informatics for support identification or development of new system.
Emergency Care	This is described as a risk that time critical interventions are delayed or are no longer viable caused by the inability to provide time critical transfers by WAST within the necessary timeframe due to system-wide pressures and no sufficient alternative service provision. It states that this could lead to delay or failure to provide time critical interventions for patients requiring vascular surgery, Percutaneous coronary intervention (PCI), and thrombectomy procedures and that "such delays can lead to worsened prognosis and death".

	Controls in place are such as the nurse in charge/emergency practitioner in charge to request clinician opinion at Welsh Ambulance Service Trust (WAST) if call centre unable to appropriately allocate as immediate transfer at time of booking. Additionally, this is to be escalated if allocated transfer remains insufficient, with further escalation if issue is not resolved. It is also noted that an attempt can be made to secure alternative transport with Adult Critical Care Transfer Service (ACCTS); however, it is highlighted that this is a limited resource and is unable to support with primary percutaneous coronary intervention transfers.
	Key further action to be completed is the provision of ring-fenced transport for time critical transfers.
Children and Young People	This is described as a risk that the neurodevelopment (ND) team will fail to meet the performance targets around waiting times for children, caused by the significant increases in demand, which are far above the capacity the service has to meet the need within the required timeframe. A number of reasons as to why this is set out, including unintended consequences of a new assessment and diagnosis process agreed regionally, and the success of current external provider activity.
	It is raised that this is negatively impacting patient experience through long waiting lists for ND diagnostic assessments, increased complaints, and failure to meet Welsh Government performance targets.
	Controls in place are described such as of November 2021 that a regional development group was established to take over from the regional steering group, with terms of reference being agreed with a key aim of “sustainability of solutions”. Provision of access to some interventions without having to have had a diagnosis is in place, to ensure that some common difficulties can be addressed whilst awaiting assessment. Template tools and reports have been addressed to speed up the completion of assessments. Additional funding has been identified in the current ITMP plan up until 2024. It is also noted that there is of a programme of work to review current ways of working and the introduction of a new service model to meet the needs of the services.

[END]