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

Ysbyty Gwynedd, Penrhosgarnedd
Bangor, LL57 2PW

Daniel Collier
Deputy Committee Clerk
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Dyddiad / Date: 29 July 2013

Dear Mr Collier

Public Accounts Committee 18th July 2013
Requests for further information

Thank you for your email of the 19th July requesting additional information following the Health Board's attendance at the PAC on the 18th July.

Please find below the information requested:-

Further information on the categories and amount of re-charging made to cross-border Health Authorities.

Cross border activity and recharges are governed and regulated by the ***Cross Border Protocol*** agreed between the Welsh Government and the Department of Health.

This Protocol sets out the agreed procedure for:

- Securing NHS healthcare for residents in England who are registered with a GP in Wales.
- Commissioning NHS healthcare for residents in Wales who are registered with a GP in England.

Specific rules apply to the following border counties:

Areas of Wales bordering England	Clinical Commissioning Groups bordering Wales
Flintshire	NHS South Cheshire
Wrexham	NHS West Cheshire
Denbighshire	NHS Wirral
Powys	NHS Herefordshire
Monmouthshire	NHS Shropshire
	NHS Telford and Wrekin
	NHS Gloucestershire
	NHS South Gloucestershire

For these specific border counties, the following rules apply:

Residency	GP Location	Funding Responsibility
Wales	Wales	LHB
England	Wales	LHB
Wales	None / (unknown)	LHB
Wales	England	CCG
England	England	CCG

For patients resident elsewhere in England or Wales who are registered with a GP on the other side of the border, responsibility for commissioning or for planning and securing their healthcare will remain with the PCT or LHB area where the patient ***defines his or her usual place of residence.***

Patients from across the UK are entitled to use the services provided by the Health Board, and the income arising from caring for patients from outside the Health Board's borders is subject to standard processes, including tariffs and contractual arrangements where appropriate.

For areas from which there is a longstanding relationship, such as patients from Western Cheshire, Shropshire and North Powys, formal contracts are held which ensure that the costs of caring for patients are reimbursed in a regular and timely manner. These contracts provide long-term planning stability to both the provider and the commissioner of care.

In addition to the cross border counties, as a result of travel and tourism into North Wales, the Health Board also treats patients from across the wider UK regions. Income is collected for these patients based upon admitted patient care (inpatient or outpatient treatment), and is charged at National Cost Tariffs.

It is important to note however that Cross Border Recharges cannot be made for an ***Attendance at A&E*** as A&E Services are paid for by the local LHB / Trust irrespective of patient residency or GP registration. If a non-BCU resident attends A&E and is then admitted to a ward they then become an A&E Admission in which case the LHB is able to recharge for the cost of their treatment.

There are a number of challenges to collecting the income due to the Health Board for treating non-BCU patients:

- Residency status between Welsh Health Boards is dependent on the patient's postcode, and between English PCTs residency is dependent on the patient's GP. Cross border arrangements determine residency on the patient's GPs but only between certain English PCTs and certain administrative areas with BCUHB, otherwise "local" rules then apply. This can be very complex.

- Charging requires the prompt and accurate coding of activity.

- Overseas Visitors' entitlement to free NHS care is subject to complex rules, and staff do not always feel confident to challenge patients in respect of their residency and entitlements. The Health Board is able to charge the Welsh Government for patients from Countries where the UK has reciprocal agreements, otherwise we will charge individual patients our local "private patient" prices.

- There are approximately 7,000 Residents of Shropshire and Western Cheshire with a registered GP in North Wales, for which the Healthcare responsibility lies with BCUHB.

- There are approximately 8,500 residents of North Wales (Flintshire, Wrexham, Denbighshire) registered with Shropshire, Wirral or Western Cheshire GPs for which the Healthcare responsibility lies with the relevant English CCG.

- For patients registered with a BCUHB GP and resident elsewhere in England, the CCG of "usual residence" is the responsible commissioner, however identifying the "usual residence" can be challenging.

- For patients with no registered GP, the home address as given by the patient determines the responsible LHB / CCG. It is difficult to challenge a patient on their declared home address.

The Health Board has a range of controls and measures in place to ensure that it captures all external income due to it, and regularly uses Internal Audit to test these controls and assurances.

During 2012/13 the Health Board recovered £15.633 million of external healthcare income, which represents 1.3% of its total £1.2 billion resource allocation

Further information on the number of patients affected by the delay in elective procedures caused by the emergency expenditure controls in the final weeks of the 2012-13 financial year.

The number of patients affected by the decisions made December 2012 for the final quarter of 2012/13 was approximately a combined 1250 inpatient and day case and 1600 follow up outpatient reviews.

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A note on when the Board and Quality and Safety Committee first became aware of concerns with the *C Difficile* outbreak.

On the 7th March 2013 the Quality and Safety Committee of the Board met. This Committee received the minutes of the Infection Control meeting held in January 2013 which had been chaired by Mrs J Galvani, the Executive Nurse Director at that time. C Difficile rates were reported to the committee at this meeting, as is routine. What was reported is as follows:-

"December 2012 data indicates a 10% improvement overall with a 30% improvement at Wrexham Maelor Hospital."

On the 22nd March 2013 a C Difficile major outbreak was declared on the Ysbyty Glan Clwyd hospital site and the Acting Chief Executive was notified immediately. Comprehensive arrangements were urgently put in place in line with the Major Infection Outbreak Control Plan.

The Quality and Safety Committee next met on the 4th April 2013 and at this meeting the C Difficile outbreak was discussed.

A copy of the Health Board's risk register.

Cyfieithiad o'r cwestiynau ar gyfer yfory

Further information on actions undertaken by the Health Board to address Risk Adjusted Mortality Index (RAMI) figures.

The Health Board has been aware of a month on month increase in RAMI in Ysbyty Gwynedd for the last 7 months of validated data (now up to April 2013). In the last few months, the RAMI in Ysbyty Glan Clwyd has also increased and the RAMI in Wrexham Maelor is higher than that seen in the other two hospitals but has been relatively stable over the same time period. This matter is being thoroughly investigated and regular written updates are being provided directly to the Chief Medical Officer for Wales. Further detailed information in relation to all aspects of the mortality reviews and methodology and further investigations into the RAMI data are detailed in the attached correspondence.

561 Ruth Hussey.doc

589 Ruth Hussey.doc

2013-07-25 MD Letter RH (m).doc

Yours sincerely

Grace Lewis-Parry

Grace Lewis- Parry
Director of Governance and Communications

Summary Corporate Risk Register - July 2013

Risk/Issue	Current Risk Rating				Action Required	Progress to date including Timescales for Action	Target Risk Rating if controls are in place			Risk Owner	Board Committee
	Impact / Consequence	Likelihood	Score	Change in score			Impact / Consequence	Likelihood	Score		
Failure to control healthcare associated infections.	5	4	20	↑	1) Immediate full compliance with medical pathway, monitored via local infection control meetings reporting to IPICSC with no reported breaches. 2) Move to antimicrobial policy as opposed to empirical guidelines with monitoring via IPICSC 3) Progress the plan for integrated nurse based surveillance system 4) Full compliance with bare below the elbows 5) Develop and audit cycle for infection control. 6) Implement recommendations from PHW report & roll out best practice identified as a result of Glan Clwyd major outbreak 7) Await findings of Professor Duerden report for implementation 8) Undertake full establishment review of the Infection control service. 9) Sustained Communication campaign to ensure the high profile of infection prevention and control is continued. 10) Comprehensive review and update of all infection control policies, protocols and guidelines. 11) Identification of a Lead Doctor for infection prevention and control for the Health Board. 12) Develop improved Isolation and Cohort facilities on three DHG sites	1) Full compliance with the Clostridium Difficile Integrated Care Pathway mandated by the Acting Medical Director and Acting Director for Nursing and Patient Services. Non compliance being monitored by the local infection control and decontamination meetings and breaches in compliance escalated for action. 2) Update awaited 3) IT system in YGC (ICNET) is being upgraded in 2013. Ongoing project looking at procurement of an IT system for all Wales. 4) Full compliance achieved in nursing and therapies. Update awaited in relation to Medical Staff 5) Update awaited 6) Update awaited 7) Professor Duerden is due to report by the end of July 8) An external Nurse Consultant is providing additional support to BCU in terms of undertaking an establishment review. Timescale for completion to be agreed. 9) Improvements to the Infection Control web site completed. Communication and performance reports sent monthly to Matrons and ACOS. Deputy Director of Nursing and Patient Services and Infection Control Team have met Ward Sisters at YGC and will be meeting Ward Sisters at YG and YM by 20th August 2013. 10) Underway and will be completed by 1st October 2013 11) Update awaited 12) Business case to be prepared and submitted to the Board by 1st October 2013	4	4	16	Director of Nursing , Midwifery and Patient Services	Quality & Safety
Failure to deliver statutory financial duties in 2013/14 and in the future	5	4	20	↓	1) Robust budgetary management 2) Oversee the co-ordination and delivery of saving plans 3) Ensure effective strategic and operational planning aligns with the resources available	1) Robust Corporate Governance and risk management is required to avoid unintended consequences for patient care arising from the changes necessary to deliver sustainable financial balance. 2) The process to appoint to the Director of Operations role, and the Operational Turnaround Support, has been given specific focus to ensure that key issues around the sustainable delivery of targets are being addressed. 3) Further work is required to ensure that there are appropriate delivery plans in place to support the plans approved by the Board. This should assist the Board operate sustainably over the medium term.	5	3	15	Director of Finance	Finance and Performance

Summary Corporate Risk Register - July 2013

Failure to deliver appropriate access to planned care within a reasonable time including the management of the follow up backlog.	5	5	25	➔	1) Participate in all-Wales Orthopaedic Delivery Board. Access Board plan and monitor delivery across BCU weekly. 2) Finance and Performance: scrutinise performance and consider appropriate allocation of funding based on clinical risk. 3) Consistent application of INNUs and use of alternatives to surgical intervention. 4) Outsourcing some orthopaedic activity while sustainable solutions implemented during the year. 5) Outsource of high risk urology patients where clinical skill limited for certain procedures within BCU 6) Surgery & Dental CPG risk register to reflect in more detail the risks/control actions associated with the delivery of the Orthopaedic Plan, Ophthalmology transition to community based model of care for non surgical patients. 7) Work to improve administrative and clinical validation, listing practice and engagement with primary care. 8) Follow through commissioning intent based on capacity plan and efficiency gain within resources.	1) Attendance at all Wales Orthopaedic Delivery Board by lead Clinicians is assured. Orthopaedics is included on the Access agenda on a weekly basis, at which the profiles for delivery, risks and mitigating actions are discussed. 2) Approval given by Finance and Performance Committee for RTT investment on 23 July 2013, supported by the implementation of an accountability, improvement and scrutiny process. 3) Improvement Lead within Surgical CPG actively engaged with lead clinicians and primary care with a structured approach to delivery of INNU and other appropriate pathways 4) Contracted levels of volume and cost for orthopaedic agreed with RJAH. Progression of improvement work for spinal with clinical input ongoing as remains highest risk to delivery within the outsourced work 5) Contract with Christies agreed for monthly activity for high risk urology patients. 6) Further work with Surgical & Dental CPG via monthly Performance meetings during August/September will assure the inclusion of the delivery and safety risks related to access. 7) An RTT Competency Framework has been agreed by WOD Sub-Committee to ensure appropriate training for staff to reduce requirement for validation. Monthly audit of specialties undertaken by Information to identify any risk areas. Ongoing work for listing practices e.g. variation in urgents, treat out of turns etc. 8) 7% demand management strategy and delivery plans included within capacity planning template. Some risks remain where solutions have yet to be identified. The inclusion of 100% productivity gains within the delivery plans presents a significant risk to delivery and this improvement in productivity will be supported by the Interim appointed to support turnaround of the planned care pathway. The risk associated with delivery of the commissioning intent remains high. 9) Cancer Access - the health board has recovered and is likely to sustain access for 31 day non USC patients and has a recovery plan in place for delivery of 62 day USC access by end of September 2013. This has been given the highest priority of all the elective access requirements and is being micro-managed. 10) Follow up backlog - this area continues to present significant concerns and is growing in volume. Clinical validation is demonstrating that approximately 28-30% of patients can be discharged with no further clinical need for secondary care follow up. However, clinical validation is also identifying areas of increased clinical risk due to the delay. Where these are identified these are being given priority slots for clinical review , which in itself may increase the waiting times for newly referred patients. Given the increasing volume on the follow up backlog waiting list, a more radical approach will be required, this will be the subject of discussion at the next Quality and Safety Committee.	5	3	15	Acting Director of Improvement and Business Support	Finance & Performance
Insufficient Medical Staff to support service provision taking account of changes to Medical training and taking account of the impact of EWTD.	5	4	20	➔	1) Consider new models of service delivery as part of service reviews. 2) Continue to develop the Medical Workforce Recruitment Strategy. 3) Postgraduate Deanery new marketing campaign to encourage doctors to consider Wales when applying to training programmes to be implemented. 4) Curriculum redesign (C21 Project) being undertaken by Cardiff University.	1) Clinical Engagement in the development of service reviews and develop new models of service delivery 2) Continue recruitment campaigns 3) Continuing to work with the Wales Postgraduate Deanery to ensure that its reconfiguration plans do not disadvantage North Wales and lead to improved recruitment. Support for Bangor University in bidding for funding to sustain the academic and organisational component of the North Wales Clinical School.	5	4	20	Acting Executive Medical Director	Workforce & OD

Summary Corporate Risk Register - July 2013

Failure to manage and respond to unscheduled care demand in a safe and appropriate way.	5	5	25	➔	Whole system approach to patient flow across unscheduled care to be adopted ensuring: 1) improved alternative pathways to ED attendance in place. 2) improved population education through Choose Well and development of Health and Social Care Single Points of Access 3) Ambulance Conveyance borders reviewed to balance demand and supply. 4) MIU criteria rolled out across BCU. 5) improved integrated pathway working with WAST and OOH services. 6) safe practice adopted for ambulance handover and assessment of patients on ambulances. 7) improved clinical leadership within ED. 8) increased clinical capacity within ED so as to better match demand and supply by time of day and day of week. 9) seasonal and public holiday planning. 10) application of escalation and de-escalation processes. 11) review of on call and site management arrangements. 12) improved use of ambulatory care, CDU and AMU facilities. 13) review of bed occupancy, discharge processes, 11am and weekend discharges. 14) optimise use of community facilities. 15) work to implement Academy of Medicine recommendations for 7 day working as part of National programme for Flow in USC (FISH programme).	1) & 2) Choose Well Campaign launched, and is now in the evaluation stage, and will be going to the next Unscheduled Care Delivery Board in July 2013. H&SC Single Points of Access, Denbighshire's demonstrator site looking to go live in October, currently process mapping existing services to streamline processes. Other NW areas currently being supported to develop their Single Point of Access through Regional Collaborative Funding (Flintshire LA as lead agency) a Regional group including Health and the Third Sector representation will oversee the development of the programme. 3) Ambulance Conveyance borders data currently being reviewed by the Unscheduled Care delivery group for Central & West, Central & East data being obtained. 4) One senior Consultant has been assigned to review MIU criteria. Guidance being updated. 5) WAST alternative care pathways are being produced for Falls, resolved hypoglycaemia and resolved epilepsy 6) Ongoing work with the criteria. Currently different practices are carried out on different sites and work is ongoing to standardise. 7) Reconfigured Clinical Leadership within all 3 DGH Sites 8) Consultant cover across BCU has been reconfigured to match site and national staffing requirements. Some additional consultants have been appointed in the West and some nursing relocation. 9) Continued planning for August bank holiday, and preparation for winter planning underway.	4	4	16	Acting Director of Improvement and Business Support	Finance & Performance
					16) work with partner organizations to improve delayed transfer of care - LA and 3rd sector. 17) roll out of HECs. 18) work to improve end of life pathway for patients in community. 19) work to improve psychiatric liaison services. 20) improve use of real time data for operational management and decision making eg live bed state.	10) Work has been ongoing to ensure compliance to the policy and process within them. 11) Senior Site Managers still remain in post, being assessed to consider future continuation 12) Changes to the opening hours of CDU in central have taken place and admission guidance have been reviewed. Please note that the Observation unit and CDU have different criteria. 13) All monitored as part of daily process with site management teams, discharges processes also being looked at in more detail to understand bottlenecks within the system. 14) Collaborative joint working with social care and voluntary services ensuring access to locality based resources. 15) As part of the National flow programme, piloting 7 day working within Cardiology, lessons learned and good practice will be rolled out using PDSA methodology. 16) Workshop being arranged with LAs and Third Sector to look at discharge process, agree single streamlined process for discharge planning, explore opportunities for improvement in the assessment process to shorten the discharge pathway and agree PDSAs for these, Identify capacity constraints. 17) Roll out of HECS ongoing 18) Caroline Ysborne is taking the lead within BCU on the end of life pathways and Chris Stockport within the localities. Spot purchase beds are also planned so that appropriate end of life care is carried out in the appropriate setting. 19) Work ongoing to expand this service to formally cover 24 /7 with a band 6 nurse service supported by a consultant. 20) Work has been undertaken to review IT systems and actual availability of beds in clinical areas; manual process still being used (site managers contact wards daily). 21) Senior site management has increased since May 2013. 22) Performance has improved from June 2013, with YG delivering over 95% on 4 hour wait and 0 12 hour breaches for first time since Aug 2010 and improvement noted on the other 2 sites. Trajectory of improvement submitted to WG for the rest of 2013-14.					

Summary Corporate Risk Register - July 2013

Failure to manage concerns effectively and learn lessons to improve patient safety.	4	4	16	➔	1) Deliver Concerns Improvement Plan. 2) Quality & Safety Lead Officers Group and Quality & Safety Committee to monitor progress. Ensure clear lines of holding CPGs to account and reporting up to Q&SLOG/Q&S Committee 3) Develop and update Being Open, and PTR Policy. 4) CPG Concern Leads Group established and individual performance meetings scheduled. Ensure clear lines of holding CPGs to account and reporting up to Q&SLOG/Q&S Committee 5) Develop a strategic approach to measuring the effectiveness of sharing and acting on lessons learnt. 6) Deliver training programme to improve consistency and quality of investigations.	In May 2013, the Board agreed that the Quality and Safety agenda should lead by a single clinical executive director ,the Executive Nurse. This will include the management of concerns from 1st August. The Improvement Plan is being implemented and monitored by the concerns scrutiny group overseen by the independent member lead for concerns The Being Open and PTR policies and procedures have been revised and are currently being discussed with the Executive Nurse prior to going to consultation with staff. The Corporate and CPG Concerns leads meet on a regular basis to improve communication and provide opportunities for learning and training. A draft framework for organisational learning from experience has been developed . The PTR Facilitator has set up training sessions for all CPGs To date, general awareness training has been provided to over 300 staff, and training specific to staff groups has been undertaken.	4	2	8	Director of Nursing , Midwifery and Patient Services	Quality & Safety
Failure to put 20% of Doctors, with whom BCUHB have a prescribed connection, through the revalidation process by April 2014.	5	3	15	➔	1) Increase in Medical Appraisal Support Officer hours to support process locally. 2) Monitoring of the uptake of the IT appraisal system for secondary care for those Doctors going through the revalidation process within the first year.	1)The Executive Medical Director as responsible officer oversees the implementation and management of the revalidation process for Doctors. This is underpinned by an IT based appraisal system held by the OMD. 2) Enhancing links to other Deaneries may be an option in the future	5	2	10	Acting Executive Medical Director	Workforce & OD
Exposure to asbestos fibres and a loss of clinical service as a result of asbestos contamination.	4	3	12	➔	1) Asbestos Policy and Asbestos Management Plan. 2) Appointed Asbestos Consultants supporting Duty to Manage. 3) Agreed and funded phased removal programme over a 7 to 8 year.	1) Complete - Asbestos Policy and Site Specific AMP in place. 2) Complete - Contract in place for Asbestos Consultant 3) Ongoing - YGC Redevelopment Board with responsibility for project delivery. 4) Complete - background air monitoring in place within original building H block including ground and first floors, regular audit and inspection by appointed asbestos consultants. 5) Appointed Licensed Asbestos Removal Contractors on site providing 24/7 cover.	4	2	8	Director of Planning	Quality & Safety
Failure to ensure that we have the right staff, with the right skills at the right time within budgeted resources.	3	2	6	➔	1) In partnership with staff organisations ensure effective operation of policies and procedures e.g. recruitment, OCP, appraisal. 2) Comprehensive delivery of appraisal/PADR across all work areas. 3) Workforce Plans incorporated within 2013/14 operational planning process. High level scrutiny of rosters by managers, to ensure appropriate challenge 4) E-rostering reports provided to operational managers on a monthly basis to optimum deployment and safe levels of staffing. High level scrutiny of rosters by managers, to ensure appropriate challenge around rosters.	Regular reporting to W&OD Committee and to CPGs/CSFs via Workforce Intelligence report. Focus on PADR and Mandatory training compliance levels which are below acceptable standards. Workforce plans for 2013/14 noted and approved at July W&OD Committee.OCP group continues to meet to review progress.	2	2	4	Director of Workforce & OD	Workforce & OD
Increased maintenance backlog and delayed asset replacement programme due to reductions in the All Wales Capital Programme.	3	4	12	➔	1) Review of Capital prioritisation based on future years funding and WG allocation.	Backlog maintenance has been identified and prioritised. The allocation of discretionary capital to address backlog maintenance is agreed on an annual basis via the Estate Strategy Group and the Asset Management Committee.	2	4	8	Director of Planning	Finance and Performance

Summary Corporate Risk Register - July 2013

Unsustainable service models leading to failure to deliver safe and affordable clinical services.	4	4	16	➔	1) Implementation of the 3 Year and Annual Service and Financial Plan. 2) Clinical symposium to be undertaken to ensure engagement and delivery. 3) Engagement and consultation on the Acute Services Strategy. 4) Implementation of the 'Healthcare in North Wales is Changing' recommendations. 5) Work to establish acute intervention teams on all 3 main hospital sites.	1) BCU Three year plan developed and approved by board in March 2013. Plan being refreshed for WG by end September 2013 informed by work below and supported by Corporate Planning Group. 2) Series of three Clinical symposium meetings were held in March, April and May to develop areas for transformational change in response to BCU commissioning intentions / Triple Aim. Plan approved by Delivery Board and F&P Committee in July. Proposal to engage external support developed. 3) Acute Clinical Services Strategy project is underway supported by a series of stakeholder workshops. Timescale October for recommendations to Board 4) Implementation of Healthcare in North Wales is Changing is underway. High level progress reports being made to Board. Awaiting final confirmation from Minister on areas outstanding for agreement with CHC	4	4	16	Director of Planning	LHB Board
Failure to create a climate and culture that puts the patient first.	4	4	16		1) Implement the National Governance Framework 'Safe Care, Compassionate Care'. 2) Develop and implement a programme of work in line with the themes from The Francis recommendations. 3) Deliver "Dignity in Care" agreed actions 4) To develop continued effective systems for listening to patients and staff 5) Refine and promote organisational values 6) Monitor and respond to breaches in the fundamentals of care. 7) Respond to the HIW/WAO review	1) Detailed action plan approved at the Board meeting on 25th July 2013. 2) World Cafe events are being held as part of the response to the Staff Survey. 3) Programme of face to face meetings being held and imprioved communication underway following the HIW/WAO review.	**3**	**4**	12	Acting Chief Executive	LHB Board
Failure to provide information which supports effective governance, assurance and decision making.	4	3	12	➔	1) Develop further integrated Quality and Safety Report. 2) Publish mortality data monthly. 3) Develop and publish the Annual Quality Statement. 4) Implement the Board Level Improving Quality Together programme 5) Support the delivery of a formal Board Development Programme and Leadership walkrounds. 6) Review structure of Board and Committee agendas and papers to allow for effective scrutiny	1) Integrated Quality and Safety Report on July Board agenda for discussion 2) Mortality data is published on a monthly basis 3) Annual Quality Statement in final draft	**N/A**	**N/A**	**N/A**	Acting Director of Improvement and Business Support	Quality & Safety
Failure to quality assure commissioned services.	4	4	16	➔	1) Continue to develop and monitor commissioning and contractual arrangements. 2) Ensure clear lines of communication are in place to identify and address issues of concern.	1) Contracts review group established to oversee external secondary care contract management and changes to patient pathways. Group meet monthly to discuss key contracting issues and actions to manage contract performance. Paper developed for exec approval to strengthen contracting arrangements going forward and specifically around link with specialist services and responding to Francis /commissioning for quality. 2) Reporting to F&P via Assistant Director of Finance. Key Issues and actions presented and discussed with Execs / CoS at Board of Directors.	4	4	16	Director of Planning	Quality & Safety
Failure to locate and provide patient and corporate records to underpin the delivery of safe patient care in a timely manner	4	4	16	➔	1) Maintain record audits and reporting mechanisms. 2) Consider reallocation of resources to conduct full audit of current health and corporate records storage facilities and develop future proposals. 3) Secure funding and reallocation of resources to implement digitalisation of records.	1) Record audits and KPI reporting mechanisms in place. 2) Additional Storage Accommodation being provided by Estates on Bryn y Neuadd site. 3) Scanning pilot commenced to identify exact resource allocation required for BCUHB to develop future proposal for funding of digitalisation of records. Standards of Health Records Training programme started - emphasising the importance to CPG of casenote tracking	4	2	8	Executive Medical Director/Director of Governance & Communications	Information Governance

Risk Matrix

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Maximum Impact	**5**	**10**	**15**	**20**	**25**
4 Major	**4**	**8**	**12**	**16**	**20**
3 Moderate	**3**	**6**	**9**	**12**	**15**
2 Minor	**2**	**4**	**6**	**8**	**10**
1 Negligible	**1**	**2**	**3**	**4**	**5**

1 to 3	Low risk
4 to 6	Moderate risk
8 to 12	High risk
15 to 25	Extreme risk

Assessment of risk

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Maximum Impact**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days Agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Maximum Impact**
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint - escalation Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low achievement of performance/delivery requirements Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards / performance requirements

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Maximum Impact**
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance levels if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low achievement of performance/delivery requirements Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Low achievement of performance/delivery requirements Severely critical report

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Maximum Impact**
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage - short-term reduction in public confidence Elements of public expectation not being met	Local media coverage - long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5-10 per cent over project budget Schedule slippage	Non-compliance with national 10-25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1-0.25 per cent of budget Claim less than £10,000	Loss of 0.25-0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5-1.0 per cent of budget Claim(s) between £100,000 and £1 million	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Claim(s) >£1 million

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Maximum Impact**
Service/business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas within a location and possible flow onto other locations.	Loss/interruption of >1 week All operational areas of a location compromised. Other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environmental impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic/critical impact on environment.

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Betsi Cadwaladr
University Health Board

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Dyddiad / Date: 21 June 2013

Dear Ruth

RE: MORTALITY IN BCU HEALTH BOARD - WEST

Thank you for your letter dated 11 June 2013 regarding the above.

In response to your request for an update, I set out below the approach we have taken:

1 Data Focusing

In collaboration with colleagues in CHKS, we have analysed all the deaths for the period July to March 2013, and on their advice regarding selection criteria, reduced the number by about 50% (ie c300).

This exercise has also revealed some uncoded and inadequately coded notes. The uncoded notes have been addressed. Those inadequately coded are being reviewed by our coding team for immediate action.

As this only covers up to March, we have asked CHKS to run the same process on April and May data when available to them.

In addition, we have identified significant differences in the coding for patients receiving their care from GPs in our community hospitals. These are now coded by hospital coders, and the notes for 85 classified as “GP Other Deaths” have been requested for re-coding - *Timeframe anticipated 2 weeks*.

Once completed, CHKS will repeat the screening process on all the patients for the period July 2012 – May 2013 -*Turnaround <1 week.*

2 Corroborating Data from Other Sources

Looking to more fully understand the nature of the problem, we are currently running in parallel analysis of other system data. These are as follows:-

- Unscheduled Care
- IR1 and complaints system
- Staffing - Medical, Nursing and A&C

We will then compare any issues or trends highlighted from this data with the cases in question.

3 A Case Notes Based Review

Further to a recent meeting of 1000 Lives regarding evidence based mortality review, we are incorporating these minimal changes into our proforma, and will be ready to use this for the envisaged case notes review process.

Initial death reviews have commenced looking into stroke and respiratory causes (respiratory the top cause from current analysis).

4 Local Action Group

The Local Action Group based at Ysbyty Gwynedd has been convened to capitalise on local knowledge and experience. This is chaired by the Assistant Medical Director with members including the Assistant Director of Nursing, Site Manager, Assistant AMD and Local Clinical Director (Medicine). This commenced on 7 June 2013. The initial action plan is set out below:

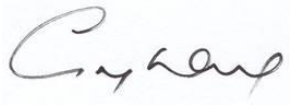
Continue to work with CHKS and Patient Safety Team to understand the data	Ongoing
Drill down using local knowledge by consultant team and ward/hospital	19/6/13
Focussed case note review of areas/specialities showing excess mortality	commenced 19/6/13
Triangulation with other data e.g. ward staffing, bed occupancy, locum usage etc. in view of advice from IHI and 1000 Lives colleagues that case note review alone unlikely to identify causation	ongoing
Immediate review of medical and nurse ward staffing	ongoing
Review numbers of deaths associated with C. diff in relation to rise in RAMI	*see below
Review coding procedures particularly in relation to palliative care and Llandudno/Community Hospital transfers	26/6/13
Preliminary report to Executive Team	17/7/13

* I can now confirm that we have reviewed the number of deaths where C.diff was reported as a factor on the death certificate against our increase in RAMI at Ysbyty Gwynedd. There is no correlation. We will, however, be reviewing all these deaths as part of our focussed case note reviews.

It is anticipated with this approach we will be moving to case notes review within the next 4 weeks. Recognising this represents potentially c500 notes after initial screening, which from experience will each take 20 – 30 minutes to review, we will seek advice from Public Health Wales on sampling, and whether this can be considered acceptable.

I trust that this update provides the information you require. Should you wish to discuss any detail relating to this matter please do not hesitate to make contact.

Yours sincerely



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Dyddiad / Date: 10 July 2013

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Dear Ruth

RE: RAMI IN BCUHB, WITH A FOCUS ON YSBYTY GWYNEDD

Further to your letter of the 26 June 2013, I can assure you that we are actively and urgently investigating the slow increase in RAMI in Ysbyty Gwynedd over the last year. A similar rise is now noted at Ysbyty Glan Clwyd in the last three months. For this reason we are now doing a similar investigation of RAMI at these two sites and at Ysbyty Wrexham Maelor to establish the full picture.

You raise two concerns:

1 That mortality reviews are not routine across BCUHB

We have had systems for mortality reviews within the Health Board, but these have been inconsistently applied in different clinical directorates. Earlier this year we put in place a thematic examination of mortality in different clinical situations; for example, we have currently been examining mortality following orthopaedic surgery and of course, in relation to Health Care Associated Infection. We accept the need to strengthen this process and make examination of all deaths in hospital consistent and routine. There does not appear to be an agreed methodology across Wales for this. In view of concerns about our specific RAMI we have reached a clear view that at this time we should implement a two-stage sampling method immediately.

a Screening questions, using mortuary / bereavement services on all death
b Any concerns evident from clinicians or others, or involving significant incidents
c Review those notes flagged up as giving cause for concern on a weekly basis at DGH level
d Additionally review certain specified deaths e.g. HCAI
e Supplement with specific themed reviews

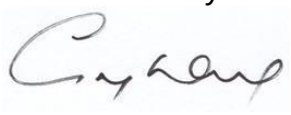
2 There is inconsistency over sampling methods and capacity for the investigation

The sampling issue has been the subject of considerable debate and discussions with PHW, Grant Robinson and Russell Cavanagh. We are currently doing this as follows:

a Reviewing all deaths from July 2012 to end May 2013
b Broken down by specialty and from this identify those where excess mortality is suggested
c Selectively looking at deaths in specialties with excess mortality
d We are seeking support from HIW scrutinise this list and advise how we focus further

We are meeting Grant Robinson on 15 July 2013 and will discuss this further. Martin Duerden will provide you with fortnightly updates.

Yours sincerely



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cc Dr Martin Duerden

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Dyddiad / Date: 25th July 2013

Dear Ruth,

Re: Mortality reviews and investigating change in RAMI in BCUHB

You have asked for an update on our RAMI investigations. As you are aware we have noticed a month by month increase in RAMI in Ysbyty Gwynedd for the last seven months of validated data (now up to April 2013). In the last few months the RAMI in Ysbyty Glan Clwyd has also increased. Also the RAMI in Wrexham Maelor is higher than that seen in the other two hospitals but has been relatively stable over the same time frame.

Mortality reviews and methodology

We met up with Grant Robinson and colleagues on 15th July 2013. This was very helpful. He will visit us again in early September. The observations he made about the mortality review processes we currently have in place are as follows:

We were impressed with the open and transparent approach your health board is taking in this area, with the involvement of the multidisciplinary team, and nurses in particular, in the deaths review process.

The actions you may wish to consider include:

- *Close working in respect of deaths review processes with the newly created site management arrangements on acute hospital sites*
- *Further strengthening of links between the central health board team and site operations in the West*
- *Adopting an approach which twin tracks continuing analysis with an iterative but immediate approach to improvement actions*
- *Close tracking of 12 hour waits in all three emergency departments*

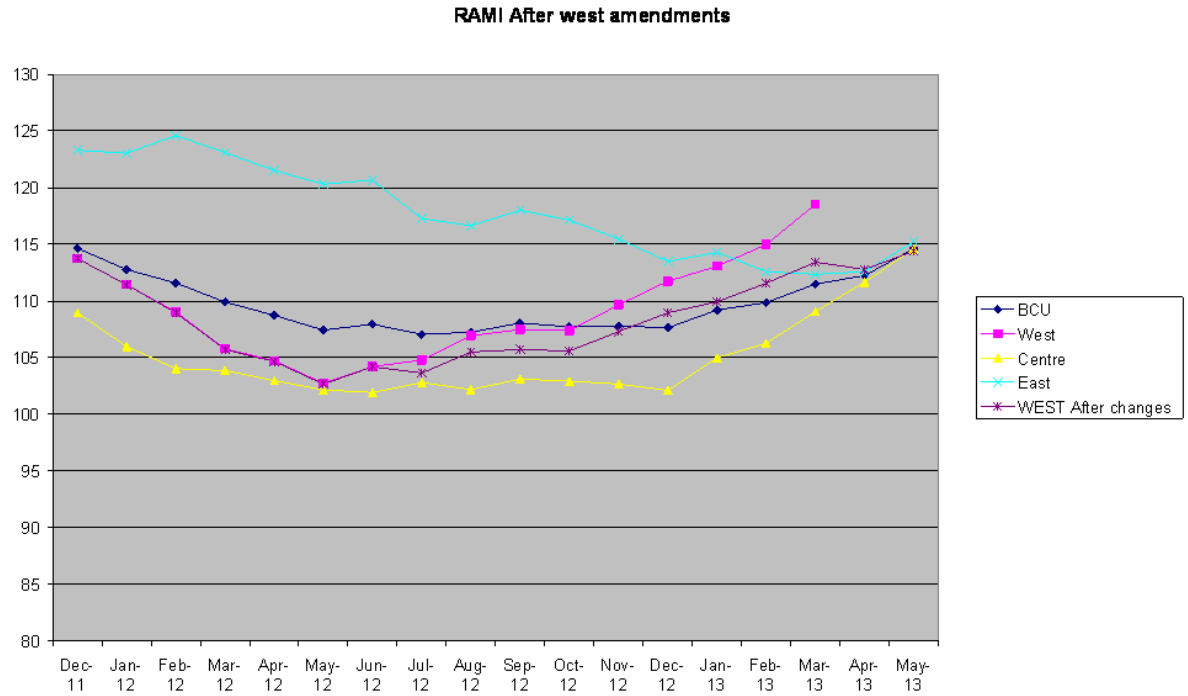
- *Separate reporting of the RAMI for the main acute site and community hospitals to be consistent with other acute sites in Wales and allow a proper understanding of the effects of patient flow*

- *Immediate action to address the vacancies currently being held and current restrictions on overtime in clinical coding*

We were concerned to hear that, following a period when clinical coding within your health board has led the way in Wales, there currently appears to be some difficulty in the Clinical Coding Department as it undergoes restructuring at a time of financial pressure, and that clinical coding rates are currently running at only 80%. We strongly suggest that this is addressed as a matter of urgency.

We accept all of these recommendations and are in the process of incorporating them into our mortality review process. The issues in the Clinical Coding Department are being rapidly addressed.

As suggested by Grant, the below is a preliminary attempt to separate RAMI in community settings from the acute sites (using 2012 methodology) and does change the figures quite substantially although the upward trends are still evident. As you can see this does bring the acute sites to a similar position, although this may be coincidental.



You asked for named leadership of the new system. Dr Brian Tehan, Assistant Medical Director is the BCUHB lead on this process. He has been setting up systems in the three acute hospital sites. The reviews are already taking place at each site (as described in our

last letter on RAMI dated 10th July) although there are still concerns about consistent application. I hope to confirm consistency of methodology with you in my next update to you in two weeks.

RAMI Investigations

As far as the Ysbyty Gwynedd investigation is concerned we are getting closer to completing this but because of the time required to do the formal medical records reviews a formal report will not be completed for three weeks.

The comments below are provided by Paul Birch, Assistant Medical Director following a further Local Action Group meeting this week:

- The Local Action Group (LAG) is currently meeting weekly with excellent engagement from senior clinicians and managers.
-
- The LAG has specifically focussed on Medicine as earlier investigations of RAMI in other specialities has not proved to be of concern.
-
  - **Staffing**
    - Nursing
      - Compared to 2011/12 the period of rising RAMI coincided with a decrease in nurse staffing levels on medical wards and a deterioration in skill mix. Although there is evidence of attempted mitigation by nurse managers (closing beds etc.) this was often thwarted by the extreme patient flow pressures during the period from Oct. 2012 to June 2013. Vacancy levels have now improved and further work is ongoing on skill mix, staffing levels and patient acuity led by the AND.
    - Medical
      - Junior doctor staffing levels from Sept. 2012 were less than the previous year with significant use of locums.
      - This has also improved although concern remains at middle grade with continuing rota gaps.
    - Sickness
      - Sickness rates for both medical and nursing staff increased continuously throughout 2011/12 and 2012/13 although there are concerns about the quality of data for medical staff.
  - **Bed occupancy**
    - There was no direct correlation between recorded bed occupancy and specific areas identified as having high RAMI or excess numbers of actual deaths. Actual numbers for each area are small which affects validity.
  - **C. Diff**
    - These have already been looked at a part of the HBs routine processes. A further analysis using the mortality review methodology is ongoing and will be completed in 3 weeks.
    - There is no correlation between C. Diff rates, C. Diff deaths and the rise in RAMI. Both the former remain unchanged over the period in question.

- **Review top 4 RAMI by HRG**
  - Respiratory
    - Case note review commenced. To date no concerns except coding issues. Quality of care good against BTS guidelines.
  - Cardiology
    - Commenced this week.
  - Stroke
    - Commenced. Initial work has revealed no concerns with improved performance against standards and targets over the period in question.
  - Fracture neck of femur
    - Completed. Analysis on a BCU wide basis ongoing. Concerns identified outside this process about the quality of care of a small number of patients but RAMI for this group is below 100.
- **Community Hospitals and GP patients**
  - Review completed. 25 of 85 cases incorrectly coded. CHKS to rerun calculations.
- **Incidents and Complaints**
  - Complaints rose significantly throughout 2012 and 2013.
    - All level 4 complaints and those concerning medical and nursing care or delays in treatment will be reviewed.
  - Incident numbers are difficult to compare over the period as systems changed significantly late 2012.
    - All level 3 and 4 incidents will be reviewed by the AMD/AND.
- **BCU Case Note Review**
  - Communication with local medical staff and managers needs improving.
  - Medical CPG locally will continue to take forward and ensure availability of medical staff.
- **Palliative Care Coding**
  - The use of this code appears to be significantly less at YG than the rest of BCU.
    - Informatics will run a query to see if use of this code has changed between 2011-13.
- **Keogh report**
  - Some members haveread the report in detail. It was noted the methodology used to assess the Trusts involved may be applicable locally. The next LAG will discuss whether the methodology can be utilised here and what resource would be required.

A similar review of RAMI is being undertaken at the other two acute sites. The records review components will largely be managed by accelerating the prospective mortality review process and making it more comprehensive.

I hope this is satisfactory. I will update you further in two weeks' time.

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Yours sincerely

Dr Martin Duerden
Cyfarwyddwr Meddygol a Gwasanaethau Clinigol Dros Dro
Acting Medical Director and Director of Clinical Services

cc Geoff Lang, Acting Chief Executive
Angela Hopkins, Director of Nursing
Brian Tehan, Assistant Medical Director Secondary Care